Law and Ethics Course

6 Hrs/Units

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1. Scope of Practice

1A. MFT Scope of Practice

Overview

SB 801: The 2022 Updated MFT Scope of Practice

SB 801 does not change the MFT scope of practice. Instead, it modernizes the language to better articulate how MFTs practice on a daily basis and the various therapeutic services MFTs provide (CAMFT).

MFT Scope of Practice BBS Full Update

Scope of Practice: Marriage and Family Therapy

Amendments have been made to the marriage and family therapy scope of practice in order to modernize and clarify it. The marriage and family therapy scope of practice now reads as follows:

BPC §4980.02.
(a) For the purposes of this chapter, the practice of marriage and family therapy shall mean the application of psychotherapeutic and family systems theories, principles, and methods in the delivery of services to individuals, couples, or groups in order to assess, evaluate, and treat relational issues, emotional disorders, behavioral problems, mental illness, alcohol and substance use, and to modify intrapersonal and interpersonal behaviors.
(b) The application of marriage and family therapy principles and methods includes, but is not limited to, all of the following:
(1) Assessment, evaluation, and prognosis.
(2) Treatment, planning, and evaluation.
(3) Individual, relationship, family, or group therapeutic interventions.
(4) Relational therapy.
(5) Psychotherapy.
(6) Client education.
(7) Clinical case management.
(8) Consultation.
(9) Supervision.
(10) Use, application, and integration of the coursework and training required by Sections 4980.36, 4980.37, and 4980.41, as applicable.
(c) The amendments to this section made by the act adding this subdivision do not constitute a change in, but are declaratory of, existing law. It is the intent of the Legislature that these amendments shall not be construed to expand or constrict the existing scope of practice of a person licensed pursuant to this chapter.

Required LMFT and LPCC Coursework: Prognosis
In the 2019 Committee Bill (SB 786, which was signed into law and became effective January 1, 2020), the Board sponsored an amendment to Business and Professions Code (BPC) sections 4980.36, 4980.37, 4980.81, 4999.32, and 4999.33.

Previously those sections, which list required education and practicum for LMFT and LPCC licensure, required training in assessment, diagnosis, and prognosis.

The Board proposed an amendment replacing the term "prognosis" with the term "treatment planning," because it believed treatment planning is a more accurate representation of the course of psychotherapy. This became law via SB 786.

However, an unintended consequence of this change was that some other mental health professions began interpreting the Board's law change as meaning LMFTs and LPCCs are not permitted to perform prognosis. This was not Board's intent, and therefore the word "prognosis" has been added back into the above-listed sections.
The following is a scope of practice summary according to the Attorney General:

- ✓ MFTs and LCSWs "may practice psychotherapy" as it relates to the treatment of relational issues and social adjustments.
- ✓ MFTs and LCSWs may diagnose and treat mental disorders as it relates to the treatment of relational issues and social adjustments.
- ✓ MFTs and LCSWs may administer psychological tests, as long as the testing instrument used is within a therapist's scope of competence as established by education, training, or experience and as long as the test is administered within the context of providing therapy. In other words, stand-alone testing of persons who are not psychotherapy clients would be outside the scope of practice for MFTs and LCSWs.

Circumstances exist in which a "special relationship" is presumed by law to exist when one person is particularly vulnerable and dependent on another person who, correspondingly, has some control over the person's welfare. The relationship between a therapist and his or her patient constitutes this type of relationship. This special relationship imposes an affirmative duty on the therapist to protect others from either the therapist's own negligence or from the client's dangerousness towards self or others

1B. LCSW Scope of Practice

LCSW scope of practice is defined in *Section: 4996.9 of the California Business and Professions Code*, "The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a non-medical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services; or doing research related to social work. "Psychotherapy, within the meaning of this chapter, is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes."

1C. LPCC Scope of Practice

***Section* §4999.20 *: of the California Business and Professions Code*: SCOPE OF PRACTICE; TREATMENT OF COUPLES OR FAMILIES**

(a) (1) "Professional clinical counseling" means the application of counseling interventions and psychotherapeutic techniques to identify and remediate cognitive, mental, and emotional issues, including personal growth, adjustment to disability, crisis intervention, and psychosocial and environmental problems. "Professional clinical counseling" includes conducting assessments for the purpose of establishing counseling goals and objectives to empower individuals to deal adequately with life situations, reduce stress, experience growth, change behavior, and make well-informed rational decisions. (2) "Professional clinical counseling" is focused

exclusively on the application of counseling interventions and psychotherapeutic techniques for the purposes of improving mental health, and is not intended to capture other, nonclinical forms of counseling for the purposes of licensure. For the purposes of this paragraph, "nonclinical" means non mental health. (3) "Professional clinical counseling" does not include the assessment or treatment of couples or families unless the professional clinical counselor has completed all of the following additional training and education, beyond the minimum training and education required for licensure: (A) One of the following: (i) Six semester units or nine quarter units specifically focused on the theory and application of marriage and family therapy. (ii) A named specialization or emphasis area on the qualifying degree in marriage and family therapy; marital and family therapy; marriage, family, and child counseling; or couple and family therapy. (B) No less than 500 hours of documented supervised experience working directly with couples, families, or children. (C) A minimum of six hours of continuing education specific to marriage and family therapy, completed in each license renewal cycle. (4) "Professional counseling" does not include the provision of clinical social work services. (b) "Counseling interventions and psychotherapeutic techniques" means the application of cognitive, affective, verbal or nonverbal, systemic or holistic counseling strategies that include principles of development, wellness, and maladjustment that reflect a pluralistic society. These interventions and techniques are specifically implemented in the context of a professional clinical counseling relationship and use of a variety of counseling theories and approaches. (c) "Assessment" means selecting, administering, scoring, and interpreting tests, instruments, and other tools and methods designed to measure an individual's attitudes, abilities, aptitudes, achievements, interests, personal characteristics, disabilities, and mental, emotional, and behavioral concerns and development and the use of methods and techniques for understanding human behavior in relation to coping with, adapting to, or ameliorating changing life situations, as part of the counseling process. "Assessment" shall not include the use of projective techniques in the assessment of personality, individually administered intelligence tests, neuropsychological testing, or utilization of a battery of three or more tests to determine the presence of psychosis, dementia, amnesia, cognitive impairment, or criminal behavior. (d) Professional clinical counselors shall refer clients to other licensed health care professionals when they identify issues beyond their own scope of education, training, and experience.

(a) Incorporating the words “licensed professional clinical counselor” and shall not state that they are licensed to practice professional clinical counseling, unless they are otherwise licensed to provide professional clinical counseling services. (b) Nothing in this chapter shall be construed to constrict, limit, or withdraw provisions of the Medical Practice Act, the Clinical Social Worker Practice Act, the Nursing Practice Act, the Psychology Licensing Law, or the Marriage and Family Therapy. (c) This chapter shall not apply to any priest, rabbi, or minister of the gospel of any religious denomination who performs counseling services as part of his or her pastoral or professional duties, or to any person who is admitted to practice law in this state, or who is licensed to practice medicine, who provides counseling services as part of his or her professional practice. (d) This chapter shall not apply to an employee of a governmental entity or a school, college, or university, or of an institution both nonprofit and charitable, if his or her practice is performed solely under the supervision of the entity, school, college, university, or institution by which he or she is employed, and if he or she performs those functions as part of the position for which he or she is employed. (e) All persons registered as interns or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.

2. Unprofessional Conduct, Negligence, Law, Ethics, and Standard of Care

The following is derived from *Statutes and Regulations Relating to the Practice of Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, Clinical Social Work*, Board of Behavioral Sciences, Kim Madsen, Executive Officer, January 2020. A summary of these statutes will follow the precise wording in a later section:

2A. Unprofessional Conduct and Negligence

§ 4982. UNPROFESSIONAL CONDUCT

“The board may deny a license or registration or may suspend or revoke the license or registration of a licensee or registrant if the licensee or registrant has been guilty of unprofessional conduct.

Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to them-self any controlled substance or using of any of the dangerous drugs specified in Section 4022, or of any alcoholic beverage

to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

(d) Gross negligence or incompetence in the performance of marriage and family therapy.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the licensee or registrant or otherwise misrepresenting or permitting misrepresentation of the licensee's or registrant's education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee or registrant, allowing any other person to use the licensee's or registrant's license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a

client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a marriage and family therapist.

(l) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee, registered associate, or applicant for licensure under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. This subdivision does not prevent collaboration among two or more licensees in a case or cases. However, a fee shall not be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of any registered associate, trainee, or applicant for licensure by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform mental health services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a trainee, registered associate, or applicant for licensure under one's supervision or control to perform, or permitting the trainee, registered associate, or applicant for licensure to hold themself out as competent to perform, mental health services beyond the trainee's, registered associate's, or applicant for licensure's level of education, training, or experience.

(u) The violation of any statute or regulation governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(w) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(x) Failure to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(y) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(z) Failure to comply with Section 2290.5.

(aa) (1) Engaging in an act described in Section 261, 286, 287, or 289 of, or former Section 288a of, the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a

compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(ab) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123." (*Statutes and Regulations Relating to the Practice of Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, Clinical Social Work*, Kim Madsen, Executive Officer, Janauary 2020).

2B. Summary of Unprofessional Conduct and Negligence

The Business and Professions Code, Section 4982 indicates examples of unprofessional conduct including "negligence or incompetence in the performance of marriage and family therapy; misrepresentation involving type of license held, educational credentials, professional qualification or professional affiliations; performing, or holding oneself out as being able to perform services outside the scope of the license; failing to maintain confidentiality, except as otherwise permitted or required by law; and soliciting or paying remuneration for referrals. Unprofessional conduct is punishable by revocation or suspension of a license or an intern's registration; it is also a misdemeanor punishable by imprisonment in the county jail not exceeding six months, by a fine not exceeding $2,500, or both."

In regards to record keeping, the failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered is considered unprofessional conduct.

No person may, for remuneration, engage in the practice of marriage and family therapy or social work as defined by *Section 4980.02*, unless he or she holds a valid license as a Marriage and Family Therapist or social worker, or unless he is specifically exempted from such requirement, nor may he advertise himself or herself as performing the services of a marriage, family, child, domestic, or marital consultant, or in any way use these or any

similar titles to imply that he or she performs these services without a license as provided by this chapter.

1. When an intern employed in private practice is supervised by someone other than the employer, the supervisor must be employed by and practice at the same site as the intern's employer.

2. Interns are not to be supervised by anyone with whom they have a personal relationship. Nor should interns receive supervision from their psychotherapists.

3. Individual supervision means one supervisor and one person being supervised. The intent of law is that supervision will occur face to face.

4. Group supervision means a group of no more than eight persons being supervised by a supervisor. Two supervisors for a group of sixteen supervisees is not acceptable.

5. A supervisor may supervise an unlimited number of interns and trainees in any appropriate work setting, but is limited to supervising two interns when those interns are employed in private practice.

6. Hour requirements: During each week in which experience is claimed, the intern must have at least one hour of individual supervision or two hours of group supervision, for each work setting. Three hours is the maximum amount of supervision that can be credited during any single week. Group supervision is optional, but the intern must have at least one hour of individual supervision per week (the weeks need not be consecutive) for a minimum of 52 weeks.

The following laws outline the possible penalties for unprofessional conduct and list examples of such conduct:

B&PC 4982 (Denial, Suspension, Revocation, Grounds)

The Board may refuse to issue an intern registration or a license or may suspend or revoke the license or intern registration of any registrant or licensee if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of

discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or under this chapter. A plea or verdict of guilty or a following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing any such person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using of any of the dangerous drugs specified in Section 4211, or of any alcoholic beverage to the extent, or in such manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that such use impairs the ability of such person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof. The board shall deny an application for a registration or license or revoke the license or registration of any person other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

(d) Gross negligence or incompetence in the performance of marriage and family therapy.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation

of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(h) Aiding or abetting any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a marriage and family therapist.

(l) Performing, or holding one's self out as being able to perform, or offering to perform or permitting, any trainee or intern under supervision to perform any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner which is false, misleading, or deceptive.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naiveté of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of any intern or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.
B&PC 4983 (Penalties)

Any person who violates any of the provisions of this chapter is guilty of a misdemeanor punishable by imprisonment in the county jail not exceeding six months, or by a fine not exceeding two thousand five hundred dollars ($2500), or by both.

4983.1 (Proceedings, Court Action)

2C. Law

Laws provide direction concerning both what to do and what not to do under certain circumstances and define provisions and penalties for non-compliance that include fines and incarceration. The law comes from three sources: statutes and regulations that are established by the legislature, boards authorized by the legislature, and through court cases.

Important legal requirements associated with the clinical practice of psychotherapy in the state of California include the following:

- Abiding by laws established to protect and maintain client confidentiality.
- Complying with responsibilities to report abuse and danger to others to the appropriate authorities, and to protect clients who are dangerous to themselves.
- Abiding by laws pertaining to the need for consent to treat a minor.
- Following laws that forbid sexual contact with clients and distributing to clients the pamphlet “Professional Therapy Never Includes Sex” if clients disclose that another therapist engaged in sexual misconduct.
- Disclosing fees prior to the commencement of treatment.
- Abiding by laws prohibiting making or receiving payments for client referrals.
- Securing patient authorization to release or obtain confidential information.

- Keeping patient records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.
- For therapists who are “covered entities” under HIPAA, certain additional laws pertaining to the Federal Privacy Act must be adhered to which set forth further restrictions to protect the privacy of a client's records and specify the language to be used to inform clients of these additional rights and restrictions.

2D. Ethics

The term “ethics” is characterized by behavior, practices, and standards considered "right and good" and established by professional organizations (e.g. NBCC, NASW & CAMFT). The provisions for enforcement include social or professional sanctions including suspension, revocation, or loss of license. Failure to comply with or act in the spirit of professional ethical standards can expose a therapist to legal liability and charges of negligence or unprofessional conduct.

Important tasks associated with professional ethical behavior include, but are not limited to:

- Establishment and maintenance of professional boundaries to protect the welfare of the patient. Examples: the regulation of physical contact in the counseling setting, providing a therapeutic frame with consistent session times, and commonly understood office policies, roles and responsibilities.

- Avoidance of dual relationships by not entering into business or social relationships with clients simultaneous with or shortly after the termination of therapy.

- Obtaining a client's informed consent for treatment by providing necessary information about the nature of the therapeutic process so that the client can make meaningful decisions for or against treatment.

By law, informed consent *must* include:

1) Fee disclosure and the basis for how fees will be determined *prior to* the commencement of treatment.

2) the name and license designation of the practice owner(s) must be disclosed if a therapist has a fictitious business name.

3) that therapist is required to conspicuously display his or her professional license in his or her primary place of business.
4) that an intern or associate shall disclose to clients their pre-licensed status prior to the commencement of treatment.

Failure to provide other relevant information could mean that a therapist is providing an inadequate standard of care. The following includes additional recommended, although not required by law, elements of informed consent:

1) The process of treatment (explanations of psychotherapy etc.)

2) The limitations of confidentiality

3) The potential risks, drawbacks, and benefits of therapy.

4) Client access to records

5) Length of time the therapist retains records

6) Alternatives to treatment, which may include no treatment at all

7) Applicable CAMFT & NASW Ethical Standards regarding the patient therapist relationship

8) The therapist's professional qualifications and theoretical orientation

9) The length of time the therapist has been in practice

10) The expected length of sessions and treatment

11) The mutual right to terminate therapy by both the patient and the therapist

12) Procedures for collecting and raising fees

12) Cancellation policy

13) Telephone policy

14) Therapist availability between sessions, for vacations, and in emergencies

2E. Standard of Care

Defining the standard of care requires that clinician's ask the question, *what would a reasonable therapist do under similar circumstances?* Competent clinicians operating within the minimum standard of care are:

- Skillful
- Knowledgeable
- Careful and competent

Activities that are necessary for complying with the standard of care are:

- **Assessment:** Gather information about the client via intake, observation, inventories, test instruments, etc. Information gathered should be incorporated into the progress notes. Some information gathering examples include:
  - ✓ What are the clients problems and concerns?
  - ✓ What are the precipitating events?
  - ✓ What is the unit of treatment
  - ✓ Is the motivation for being in therapy strong or weak?
  - ✓ Any previous therapy?
  - ✓ Human diversity and/or cultural considerations?
  - ✓ Socio-economic, political, or spiritual considerations?
- **Evaluation:** What does this information mean? How will I interpret this information and take action when/where necessary? Some evaluation examples include:
  - ✓ Scope of competence and practice? These standards can best be referenced in the Code of Ethics and The BBS Statutes and Regulations.
  - ✓ Does this client need to be referred?

- ✓ Evaluating medical needs, the need for psychological testing, and community resources.

- **Management:** This phase is more active and therefore requires action from the clinician. Some management examples include
  - ✓ Creating a treatment plan.
  - ✓ Referral to a psychiatrist for a medication evaluation.
  - ✓ Consulting with colleagues as well as other providers regarding treatment possibilities.

Other standard of care essentials include but are not limited to:

- **Character:** The BBS expects clinicians operating under the standard or care to demonstrate honesty, integrity, and character just to name a few. The priority for the BBS is consumer protection which necessitates character among it's licensed clinicians.
- **Law:** Adherence to the law is fundamental for a clinician. There are many laws but perhaps the most important include the standard of care because it involves what you do everyday with clients. Currently, *over half* of BBS disciplinary investigations are *alcohol related*. This number is staggering.
- **Professional Curiosity:** Remaining professionally invested and curious is important to clinical and professional growth. Are you trying to hone your skills via continuing education?

The BBS Statutes and Regulations Publications are an excellent resource for all clinicians who desire to adhere to the standard of care.

Medical Standard of Care Definitions

A standard of care is a medical or psychological treatment guideline, and can be general or specific. It specifies appropriate treatment based on scientific evidence and collaboration between medical and/or psychological professionals involved in the treatment of a given condition.

Some common examples include:

- Treatment standards applied within public hospitals to ensure that all patients receive appropriate care regardless of financial means.
- Treatment standards for gender identity disorders

In legal terms, it is the level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners

would have managed the patient's care under the same or similar circumstances. The medical malpractice plaintiff must establish the appropriate standard of care and demonstrate that the standard of care has been breached.

Standard of care can also be defined as “the average degree of skill, care, and diligence exercised by members of the same profession, practicing in the same or similar locality.” For therapists, this would be "the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful therapists would possess and use in similar circumstances." (*California Approved Civil Instructions (CACI) 502*) Standard of care is a legal concept used to prosecute or defend therapists accused of negligence or incompetence.

Examples of maintaining a standard of care include, but are not limited to:

- Giving a complete diagnostic evaluation
- Conducting adequate assessments which may include a personal history, medical history, family history, and mental status
- Documenting a treatment plan
- Consulting with corresponding treatment providers such as doctors and psychiatrists.
- Making appropriate and necessary referrals
- Taking reasonable and appropriate measures to ensure the well being and safety of a client
- Obtaining a signed informed consent prior to the onset of treatment
- Remaining in your area of competence/scope of practice

Goals

Treatment goals should always be carefully and thoughtfully developed and customized to each specific client. The following acronym is helpful when developing and documenting treatment goals:

SMART

- S=Specific
- M=Measurable
- A=Achievable
- R=Relevant/Realistic

- T=Time bound

Standard of Care and Suicide

By far, the most common liability issue clinicians face today is suicidality. Most liability cases originate from surviving family members who file suit on behalf of their deceased loved one's estate.

Remember that a good clinician is skillful, knowledgeable, and careful who assess, evaluate, and manage. Managing options may include but are not limited to:

- ✓ Increased contact with client.
- ✓ Increased sessions (even if not approved by HMO).
- ✓ Have client sign a "Safety Agreement" or "Safety Pledge" which has more empirical support than a historically used "No Harm Contract".
- ✓ Risk reduction measures.
- ✓ Voluntary or involuntary hospitalization.
- ✓ Thorough documentation
- ✓ Customized treatment plan to client's life and circumstances (no boiler plate treatment plans)

One of the best overviews of the profession (LPCC, MFT, LCSW, LEP) is the BBS Examination Handbook for each respective license. This resource is often forgotten about and overlooked after passing the licensing exam. However, continuing to reference, utilize, and follow this valuable handbook renders credibility as clinicians. The Board of Psychology is extremely similar in this area and it's publications as well.

3. Legal Issues

3A. Privilege

Privilege is essentially the client's right not to have confidential information revealed during a legal proceeding without their prior authorization. Privilege protects clients from confidences being revealed publicly without prior authorization. Psychotherapist-client privilege applies not only to licensed providers but also to MFT interns, associate social workers, and

trainees. MFT's and LCSW's have a legal responsibility to assert privilege on behalf of their client unless the client or the court direct otherwise.

The right to hold, assert, and waive privilege is clarified in California Evidence Code, Section 1013, which defines the holder of privilege as:

- The patient (regardless of age) when there is no guardian or conservator.
- A guardian ad litem (guardian for purposes of litigation) or conservator when the patient has a guardian ad litem or conservator.
- The personal representative of the patient if the patient is dead.

California Evidence Code identifies those who can *assert* privilege as:

- The person who holds privilege.
- A therapist on behalf of a client must asset privilege until directed to do otherwise by the client or by court order.
- MFT's, LCSW's, Psychologists, and Psychiatrists can and are required to assert privilege on behalf of their clients whenever a client's confidential information is sought pursuant to a legal proceeding.

California Evidence Code identifies those who can *waive* privilege as:

- A client waives his or her own privilege. However, under certain circumstances, privilege can be waived by people other than the client.
- Circumstances in which privilege may be exercised by someone other than the client:

  1) If the client has a legally designated conservator or guardian ad litem, then that person may exercise the privilege.

  2) If the court has appointed an attorney as guardian ad litem, then that person may exercise the privilege (the attorney would also be entitled to access to the client's treatment records).

  3) If the client has no legally designated conservator or guardian ad litem, then the judge can waive the privilege.

4) If the client is deceased, then the personal representative of the decedent can exercise the privilege.

California Evidence Code states in regards to minors that:

- The minor client holds privilege, unless there is a legally designated guardian ad litem or conservator.
- Parents may not exercise the privilege on behalf of their child simply because they are that child's parents.
- A parent may exercise a minor child's privilege only if designated a guardian ad litem by the court. Although we commonly think of a child's parent as the child's "guardian," this is not the same as being the "guardian ad litem."
- A therapist who receives a subpoena for the records of a minor client would not look to the parents or guardians for instructions on whether to release the records, but would instruct the parents or guardians to petition the court for guardian ad litem status. (See example of a guardian ad litem petition below).
- An individual cannot act as a guardian ad litem unless s/he is represented by an attorney or is an attorney.
- An attorney (or other person) appointed guardian ad litem has the right to access a minor client's treatment record.

California Evidence Code identifies exceptions to privilege which explains that:

- Under certain circumstances, the law says, "there is no privilege."
- If as a psychotherapist, you believe upon receiving a subpoena that the situation represents an "exception to privilege" (for example, a patient has introduced his or her emotional condition into a legal proceeding) your first responsibility is to assert privilege.
- It is beyond the scope of practice of a psychotherapist to decide if an exception applies in any given circumstance.

- The court determines if one of the following exceptions applies.

    a. the client has introduced his or her emotional condition in a legal proceeding. (Evidence Code 1016)

    b. the client has treated privileged information as though it were not confidential. (Evidence Code 1012)

    c. breach of duty (Evidence Code 1020)

        1) The therapist sues the client for non-payment (content of therapy remains confidential).

        2) The client sues the therapist for malpractice.

    d. If the therapist has been appointed by the court to examine the client (Evidence Code 1017)

    e. If the client has sought psychotherapy to commit a crime and/or escape punishment for a crime. (Evidence Code 1018)

    f. If the client is under 16 years of age and has been the victim of a crime (e.g. extortion, statutory rape) (Evidence Code 1027)

    g. In a proceeding requested by a defendant to determine sanity. (Evidence Code1023)

    h. If the client is dangerous to self or others (Evidence Code 1024), there is no privilege if the therapist needs to act to prevent a client's threatened danger to self or the person or property of others."

    i. In a proceeding brought by or on behalf of a client to establish competence. (Evidence Code 1025)

    j. If a coroner requests information in the course of an investigation of deaths involving public health concerns, abuse, suicides, poisonings, accidents, SIDS, suspicious deaths, unknown deaths, criminal deaths, or when authorized by the decedent's representative.

3B. Search Warrants

California Evidence Code, Section 1015 identifies the following in relationship to a search warrant:

- If a search warrant names the therapist as being suspected of criminal activity, the records that the search warrant is seeking must be surrendered.

- If the therapist is not suspected of criminal activity and the subject of the search warrant is a client of the therapist:

  1) The warrant must be issued in conjunction with Section 1524 of the Penal Code requiring a special master appointed by the court to conduct the search.

  2) A special master is a lawyer appointed by the court and can be identified by paperwork certifying his or her status.

  3) If the search warrant is not accompanied by a special master, the therapist must assert privilege in accordance with Section 1015 of the Evidence Code.

3C. Subpoenas

California Evidence Code, Section 1015 outlines the following in relationship to Subpoenas:

- A subpoena commands a witness to appear before the court in order to produce testimony that may be either in oral or written form.

- A subpoena “duces tecum” is a command to produce records or written evidence.

- Subpoenas can be issued by a judge or by an attorney.

- Due to psychotherapist-patient privilege, therapists have a legal duty to assert the privilege.

- A therapist must assert privilege on behalf of a client when testimony or records are sought.
- The source of the subpoena should be identified.
- After receiving a subpoena, a therapist:

  a. Should contact the client to determine if s/he wants to assert or waive the psychotherapist-client privilege.

  b. May want to obtain a release authorization to talk to the client's attorney.

  c. If the client asks questions about the subpoena, the therapist should not give legal advice because it is not in the realm of scope of practice.

- If the client decides to assert privilege, the client's attorney files a motion to quash the subpoena.
- The judge either grants the motion and the subpoena is considered void, or denies the motion and the therapist must comply with the subpoena.

3D. Confidentiality

California Evidence Code, Section 1012 states "confidential communication between patient and psychotherapist means information, including information obtained by an examination of the patient, transmitted between a patient and his 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 no third persons other than those who are present to further the interest of the patient in the consultation, or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the psychotherapist is consulted, and includes a diagnosis made and the advice given by the psychotherapist in the course of that relationship."

The patient holds the privilege to release confidential information in legal proceedings. While objections may exist to the patient using these records, solid grounds must exist in order to object. The holder of the privilege also retains the right to read all information in his or her file with the exception of

your personal notes which belong solely to you as the provider. Many therapists keep separate files in order to ensure that their personal notes do not become integrated into the patient's legal record.

3E. Exceptions to Confidentiality: Child Abuse, Dependent Adult and Elder Abuse, Tarasoff, Danger to Self and/or Others

Section 5150

Section 5150 is a section of the California Welfare and Institutions Code allows a qualified officer or clinician to involuntarily confine a person deemed (or feared) to have a mental disorder that makes them a danger to him or herself, and/or others and/or gravely disabled. A qualified officer, who includes any California peace officer, as well as any specifically designated county clinician, can request the confinement after signing a written declaration. When used as a term, *5150* can informally refer to the person being confined or to the declaration itself.

When any person, as a result of a mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, a member of the attending staff ... of an evaluation facility designated by the county, designated members of a mobile crisis team ... or other professional person designated by a county, may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation. Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or professional person, and stating that the officer, member of the attending staff, or professional person has probable cause to believe that the person is, as a result of a mental disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on a statement of a person other than the officer, member of the attending staff, or professional person, such person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

5150 Rights

Inst. Code § 5325; 9 C.C.R. § 865.2):

- The right to wear one's own clothing. (Although many 5150 designated facilities have large contraband lists, for example often

times patients are not allowed to have shoelaces, wire bras, belts, hair-ties, or short tops).

- The right to keep and use one's own personal possessions, including toilet articles, in a place accessible to the patient.
- The right to keep and spend a reasonable sum of one's money for small purchases.
- The right to have access to individual storage space for one's own use.
- The right to see visitors each day.

The right to have reasonable access to phones both to make and receive The 5150 hold may be written out on Form MH 302, *Application for 72 Hour Detention for Evaluation and Treatment*.

Welfare and Institutions Code (WIC) 5150 is interpreted by the LA County LPS Designation Handbook, page 5, as *an application for involuntary admission*. According to this interpretation, WIC 5150 is not (page 5) ... *a direct admission form and does not of itself authorize the involuntary admission; it merely gets the individual to the door. Then, as described in WIC 5151: Prior to admitting a person to the facility, the professional person in charge of the facility or his or her designee shall assess the individual in person to determine the appropriateness of the involuntary detention*. Further, according to the LA County LPS Designation Handbook ... *The ability to place a person on an involuntary hold in the community is the only situation outside of law enforcement where an individual may take away another individual's right to freedom and detain him or her against his or her will…*

During the period of confinement, a confined individual is evaluated by a mental health professional to determine if a psychiatric admission is warranted. Confinement and evaluation usually occurs in a county mental health hospital or in a designated emergency department. If the individual is then admitted to a psychiatric unit, only a psychiatrist may rescind the 5150 and allow the person to either remain voluntarily or be discharged. On or previous to the expiration of the 72 hours, the psychiatrist must assess the person to see if they still meet criteria for hospitalization. If so, the person may be offered a voluntary admission. If it is refused, then another hold for up to 14 days, the 5250 (WIC-5250), must be written to continue the involuntary confinement of the person. A Certification Review Hearing (W&I 5256) must occur within four days before a judge or hearing officer to determine whether probable cause exists to support the 5250. Alternatively, the person can demand a writ of habeas corpus to be filed for their release

after they are certified for a 5250, and once filed, by law, the person must be in front of a judge in two (2) days, which, is two days sooner than the Certification Review Hearing. If the person demands to file a writ of habeas corpus right at the time of being given notice of certification, the Certification Review Hearing will not take place. Many patients wait to see how things go at the Certification Review Hearing first, because if the person loses at the Certification Review Hearing, he/she can then take advantage of the right to file writ of habeas corpus and end up having two hearings, instead of just one. If the 72-hour timeframe has elapsed before the person is offered a voluntary admission or placed on the 5250 hold, the person must be immediately released.

A 5150 hold written by a peace officer is valid in any county in California; therefore, a person could theoretically be moved from one county to another according to available resources. When the 5150 hold is written by a designated clinician, the hold is only valid in that county. The designated clinician is only able to write a 5150 hold while present at the facility where they work, unless they work as part of a Psychiatric mobile response team.

The person under a 5150 hold has a limited ability to contest the legality of the hold. While the person has the right of demanding a writ of habeas corpus, it is up to the county public defender whether to file it or not. Since such a writ may take a day or two to file, the public defender usually chooses not to pursue it as the hold would expire before the anticipated court date.

The criteria for writing requires probable cause. This includes *danger to self*, *danger to others* together with some indication, prior to the administering of the hold, of symptoms of a *mental disorder*, and/or *grave disability*—as noted below. The conditions must exist under the context of a mental illness.

1. Danger to self: The person must be an immediate threat to themselves, usually by being suicidal. Someone who is severely depressed and wishes to die would fall under this category.
2. Danger to others: The person must be an immediate threat to someone else's safety.
3. Gravely disabled (W&I 5008(h)):
    - Adult (patients over 18 years of age): The person's mental condition prevents him/her from being able to provide for food, clothing, and/or shelter, and there is no indication that anyone is willing or able to assist him/her in procuring these needs. This does not necessarily mean homeless, as a homeless person who is

able to seek housing (even in a temporary shelter) when weather demands it would not fall under this category. Also, the mere lack of resources to provide food, clothing, or shelter is not dispositive; the inability must be caused by the psychiatric condition.

- Minor (patients under 18 years of age): The person is unable to provide for his/her food, clothing, and/or shelter or to make appropriate use of them even if these are supplied directly--for example, a psychotic adolescent who refuses to eat because he/she believes their parents are poisoning them.

4. Mental disorder: Though undefined by statute or regulation, this is generally taken to refer to a diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders. Page 14 of the LA County LPS Designation Manual states that *the initiator must be able to articulate behavioral symptoms of a mental disorder either temporary or prolonged* (People v. Triplett, 144 Cal. App. 3d 283).

Tarasoff and the Duty to Warn

Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976), was a case in which the Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a "duty to protect" the intended victim. The professional may discharge the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

Prosenjit Poddar was born into the Dalit ("untouchable") caste in Bengal, India. He came to UC Berkeley as a graduate student in September 1967 and resided at the International House. In the fall of 1968 he attended folk dancing classes at the International House, and it was there he met Tatiana Tarasoff. They saw each other weekly throughout the fall, and on New Year's Eve she kissed Poddar. He interpreted the act to be a recognition of the existence of a serious relationship. This view was not shared by Tatiana who, upon learning of his feelings, told him that she was involved with other men and otherwise indicated that she was not interested in entering into an intimate relationship with him. This gave rise to feelings of resentment in Poddar. He began to stalk her and soon had feelings of killing her.

As a result of this rebuff Poddar underwent a severe emotional crisis. He became depressed and neglected his appearance, his studies and his health. He remained by himself, speaking disjointedly and often weeping. This condition persisted, with steady deterioration, throughout the spring and into the summer of 1969. The defendant had occasional meetings with Tatiana during this period and tape recorded various of their conversations in an attempt to ascertain why she did not love him.

During the summer of 1969 Tatiana went to South America. After her departure Poddar began to improve and at the suggestion of a friend sought psychological assistance. Prosenjit Poddar was a patient of Dr. Lawrence Moore, a psychologist at UC Berkeley's Cowell Memorial Hospital in 1969. Poddar confided his intent to kill Tatiana. Dr. Moore requested that the campus police detain Poddar, writing that, in his opinion, Poddar was suffering from paranoid schizophrenia, acute and severe. The psychologist recommended that defendant be civilly committed as a dangerous person. Poddar was detained, but shortly thereafter released, as he appeared rational. Dr. Moore's supervisor, Dr. Harvey Powelson, then ordered that Poddar not be subject to further detention.

In October, after Tatiana had returned, Poddar stopped seeing his psychologist. Neither Tatiana nor her parents received any warning of the threat. Poddar then befriended Tatiana's brother, even moving in with him. Several months later, on October 27, 1969, Poddar carried out the plan he had confided to his psychologist, killing Tarasoff. Tarasoff's parents then sued Moore and various other employees of the University.

Poddar was convicted of second-degree murder, but the conviction was later appealed and overturned on the grounds that the jury was inadequately informed. A second trial was not held, and Poddar was released on the condition that he return to India.

The California Supreme Court found that a mental health professional has a duty not only to a patient, but also to individuals who are specifically being threatened by a patient. This decision has since been adopted by most states in the U.S. and is widely influential in jurisdictions outside the U.S. as well ("Protection and Advocacy, Inc., Contracted by the State of California to advocate for involuntary persons, Hearing Options". http://www.pai-ca.org/pubs/502401.pdf. 72-Hour Hold and Hearing Options).

In the majority opinion, Justice Mathew O. Tobriner famously stated: "... the confidential character of patient-psychotherapist communications must yield

to the extent that disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins." Justice Clark dissented, stating in his minority opinion that "the very practice of psychiatry depends upon the reputation in the community that the psychiatrist will not tell".

Child Abuse

When, in the course of his/her professional capacity, a psychotherapist either knows or reasonably suspects that a minor is being abused, they have a legal obligation to report what he or she knows of the situation to the proper authorities (Child Protective Services, police, county probation offices or county welfare office) by telephone as soon as possible, with a written follow-up required within 36 hours. Reasonable suspicion exists when it is objectively reasonable for a person to entertain such a suspicion, based on his or her training and experience.

Child abuse must be reported when one who is a legally mandated reporter, has knowledge of or observes a child in his or her professional capacity, or within the scope of his or her employment that he or she knows or reasonably suspects has been the victim of child abuse. The report must be made to a "child protective agency." Including a county welfare or probation department or a police or sheriff's department. Exceptions are reports by commercial print and photographic print processors, which are made to the law enforcement agency having jurisdiction. The mandated reporter must report the known or suspected incidence of child abuse to a child protective agency immediately or as soon as practically possible by telephone. Mandated reporters may not make an anonymous report. Mandated reporters, however, are not legally required to tell involved individuals that a report is about to be made. The law does not require mandated reporters to tell the parents that a report is being made. It can be very beneficial to give clients the opportunity to make the reports themselves in the therapist's presence. A self-report, however, does not negate the therapist's mandate to report. The role of a mandated reporter is to report and not investigate the allegation. Any attempts to investigate may have a negative clinical impact on the child and family.

The following types of abuse must be reported by legally mandated reporters: Physical Abuse: Physical injury inflicted by other than accidental means.

Sexual Abuse: Sexual abuse includes sexual assault and sexual exploitation. Sexual assault includes rape and rape in concert, oral copulation and

sodomy, lewd and lascivious acts upon a child under the age of 14, penetration of a genital or anal opening by a foreign object and child molestation. Unlawful sexual intercourse with a child under the age of 16 when the perpetrator is over the age of 21 is reportable as child abuse. Sexual abuse is also defined as lewd and lascivious acts with a child of 14 or 15 years of age when the perpetrator is more that 10 years older than the victim. Sexual exploitation includes conduct involving matter depicting minors engaged in obscene acts; promoting, aiding or assisting a minor to engage in prostitution, a live performance involving obscene sexual conduct or posing for a pictorial depiction involving obscene conduct for commercial purposes; and depicting a child in or knowingly developing a pictorial depiction in which a child engages in obscene sexual conduct. Consensual, non-abusive sex between two 13-year-olds is not reportable, but would become reportable when one partner reaches the age of 14. Sexual assault is defined as rape and rape in concert: This includes any forced sexual activity with anyone under age 18, or helping someone else rape a minor. Incest is any sexual activity between parents and children, ancestors and descendants, siblings and between uncles or nieces and aunts or nephews.

Lewd and lascivious acts upon a child under the age of 14: This refers to any sexual touching or intercourse with a male or female child under the age of 14, even if it is consensual. If “lewd and lascivious” behavior occurring between minors, when each is under the age of 14 years, is not reportable, as long as the minors are of roughly the same age and there is no coercion involved. However, lewd and lascivious acts with a child of 14 or 15 years of age when the perpetrator is more than 10 years old than the victim is reportable.

Sexual Exploitation - Conduct depicting a minor engaged in obscene acts, including preparing, selling or distributing the obscene matter and/or employing a minor to perform obscene acts; any person knowingly promoting, aiding or assisting, employing, using, persuading, inducing or coercing a child, or any parent or guardian of a child under his or her control knowingly permitting or encouraging a child to engage in or assisting either to engage in prostitution or a live performance involving obscene sexual conduct or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, picture or other pictorial depiction involving obscene sexual conduct for commercial purposes; any person depicting a child in or who knowingly developing, duplicating, printing or exchanging any film, photograph, videotape, negative or slide in which a child is engaged in an act of obscene sexual

conduct.

Severe neglect is defined as “the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive.” Severe neglect also means those situations of neglect where “any person having the care or custody of a child willfully causes or permits the person or health of the child such that his or her person or health is endangered including the intentional failure to provide adequate food, clothing, shelter or medical care.”

General neglect is defined as “the negligent failure of a person having the care or custody of a child to provide adequate, food, clothing, shelter, medical care or supervision where no physical injury has occurred.”

If a therapist learns about suspected child abuse from a third party (hearsay), and reasonable suspicion exists, the therapist must make a report if the information was revealed to the therapist within their professional capacity.

The identity of all reporters is considered confidential and is disclosed only between child protective agencies. Mandated reporters have immunity from criminal and civil liability for reporting as required. Any other person who reports a known or suspected case of child abuse is also protected from civil and criminal liability, unless it can be proven that the person deliberately made a false report. The Child Abuse Reporting Law takes precedence over laws governing the psychotherapist-patient privilege. A failure to report known or suspected child abuse when mandated to do so is considered a misdemeanor and is punishable by a term in jail not to exceed six months or by a fine not to exceed $1,000 or by both.

Elder and Dependent Adult Abuse Reporting

A mandated reporter must report a known or suspected instance of elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she (1) has observed or has knowledge of an incident that reasonably appears to be physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; (2) is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; or (3) reasonably suspects abuse.

Optional Reports: Mandated reporters may report a known or suspected instance of elder or dependent adult abuse when they have knowledge of or reasonably suspect that a form of elder or dependent adult abuse for which a report is not mandated has been inflicted upon an elder or dependent adult or that the elder or dependent adult's emotional well-being is threatened in any other way.

Definition of Elder: An "elder" is a person who is age 65 years or older.

Definition of Dependent Adult: A dependent adult is a person, between the ages of 18 years and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights.

Mandated reporters, including therapists, are now required to report the following:

- Known and reasonably suspected physical abuse of an elder or dependent adult. Instances of known and reasonably suspected neglect, financial abuse, abandonment, abduction, and/or isolation of an elder or dependent adult, and any other treatment that results in physical harm, pain, or mental suffering.

- As a mandated reporter, a psychotherapist is required to make a report of known or suspected elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she has observed or has knowledge of an incident that reasonably appears to be abuse, is told by an elder or dependent adult that he or she has experienced behavior constituting abuse; and/ or reasonably suspects abuse.

Abuse of an elder or dependent adult includes the following categories: Physical abuse, neglect, financial abuse, abandonment, abduction, isolation, and any other form of treatment that results in physical harm, pain, or mental suffering. Mental suffering may consist of fear, confusion, severe depression, agitation, or other serious emotional distress caused by threats, harassment, or other forms of intimidating behavior.

Physical Abuse includes assault, assault with a deadly weapon or with force likely to cause great bodily injury; battery; sexual assault, unreasonable physical restraint; prolonged or continual deprivation of water or food; and

the use of physical or chemical restraint for punishment, for a period of time beyond that for which the medication was ordered through instructions from a licensed physician or surgeon caring for the elder or dependent adult, and/ or for any purpose not authorized by the elder or dependent adult's physician or surgeon.

Neglect refers to the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a similar position would provide. Neglect also includes self-neglect, the negligent failure of an elder or dependent adult to provide a reasonable degree of care to himself or herself.

Specific examples of neglect include the failure to assist in personal hygiene or in the provision of food, clothing, or shelter,; the failure to provide medical care for physical or mental health needs and the failure to prevent malnutrition or dehydration.

Financial Abuse means concealing, taking, or appropriating an elder or dependent adult's property or money to any wrongful use or with the intent to defraud.

Abandonment, desertion or willful abandonment by a person having the care or custody of the elder or dependent adult person under circumstances in which a reasonable person would continue to provide care and custody.

Isolation, deliberately preventing an elder or dependent adult from receiving his or her mail or phone calls. False imprisonment; and/or the physical restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with his or her visitors.

Reports of known or reasonably suspected elder or dependent adult abuse must be filed by telephone immediately or as soon as practically possible. A written report must then be sent within two working days.

Reporters should generally make reports to their county's adult protective agency or a local law enforcement agency. There are two exceptions to this, however: First, if the abuse occurred in a state mental health hospital or state developmental center, the report should be made to designated investigators of the State Department of Mental Health or the State Department of Developmental Services or to the local law enforcement agency. Second, if the abuse occurred in a long-term care facility (other than a state mental hospital or a state developmental center), reports should be made to the local ombudsman or to the local law enforcement agency.

Any person legally required to report elder or dependent adult abuse who knowingly fails to report can be found guilty of a misdemeanor that is

punishable by not more than six months in the county jail or a fine not to exceed $1,000 or both imprisonment and a fine. A therapist who fails to make a timely mandated elder or dependent adult abuse report may also face disciplinary action by their governing board and civil action for damages. The law provides that no person required making a report of elder or dependent adult abuse shall be criminally or civilly liable for such a report, as long as it cannot be proven that the report was made falsely.

3F. Treatment of Minors

The law designates that minors hold privilege. However, except in special circumstances, the parents of a non-emancipated minor in treatment have the right to waive the privilege for the minor client. The confusion over this issue stems from the fact that Evidence Code 1013 refers to clients with guardians or conservators as not holding the privilege. Most courts have interpreted this to mean that minors do NOT hold the privilege, or do not have the right to waive the privilege. Parents are, therefore, recognized as having the right to waive the privilege for the minor client, even though the minor legally has the privilege. However, recent cases have upheld that the privilege belongs to the child, as the patient. This means that, in a legal proceeding, regardless of the minor's wishes and despite the fact that the minor holds privilege, his or her parents could permit the release of information about the minor's treatment.

The parents also have a legal right to access information about their minor's treatment. This is true even of noncustodial parents. At the same time, in situations in which parental access to a minor's records “would have a detrimental effect on the provider's professional relationship with a minor patient or the minor's physical safety or psychological well-being, a therapist is legally permitted to deny parental access to those records.” Therapists have to take steps to maintain a careful balance between a minor's legal and ethical right to a confidential relationship and a parent's legal right to access information.

Emancipated minors are treated legally as adults and, thus, may be treated without parental permission. Therapists can treat minors age 12 or over without parental permission when the minor is mature enough to participate intelligently in mental health treatment or counseling and the minor would present a serious danger of physical or mental harm to him or herself or others without treatment or counseling or is the alleged victim of incest or child abuse. The minor does hold privilege when being treated without parental consent (unless he or she has a guardian or foster parent.) However,

when treating minors under these circumstances, the therapist can act as the "claimer" of the privilege, but must obtain the minor's permission in order to access the minor's medical records.

A therapist should protect the confidence of minors, even from the minors' parents. Therefore, when working with a minor with parental knowledge and consent, a therapist should, at the beginning of therapy, clearly outline for both the parents and the minor, his or her policies with regard to confidentiality and include this policy in the written Consent for Treatment. The parent or guardian of a minor has the right to assert privilege on behalf of the minor, except when the minor is a victim of a crime or when the therapist is seeing the minor without parental consent.

Parents also have a legal right to inspect a therapist's records regarding the child in treatment. However, therapists can deny the parents access to these records of a minor in the following circumstance: *Where the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being.* The parents also have the right to waive the privilege, which might require the therapist to testify in a legal proceeding regarding the content of sessions with a minor client. This is true even if the minor client does not want the therapist to testify. Further, when communication of information involves a non-courtroom situation, it would also be the parents, not the child, who determine whether or not the information will be released.

Release of treatment information about minors becomes more complex when noncustodial parent are involved. While only a custodial parent may give consent to treatment, the law stipulates that "Notwithstanding any other provisions of law, access to records and information pertaining to a minor child, shall not be denied to a parent because such parent is not the child's custodial parent" When dealing with requests from either custodial or noncustodial parents, the therapist has an ethical obligation to act in the best interests of the minor and would not reveal information about the client if doing so would cause harm to the client.

A minor may become emancipated if they legally marry, enlists in the military or files an emancipation petition with the courts stating that he or she is at least 14 years of age, is willingly living separate and apart from parents or guardians with their consent or acquiescence, is managing his or

her own financial affairs and is not deriving illegal income. The court will grant the petition unless it judges that emancipation would be contrary to the minor's best interests.

Legally, minors under age 12 are considered essentially unable to make their own choices. Therefore, minors under the age of 12 may not receive any type of treatment without parental consent. There is one exception, all minors, regardless of their age, may consent to hospital, medical and surgical care related to the prevention or treatment of pregnancy. However, hospital, medical and surgical care does not include “mental health treatment or counseling.”

Minors age 12 or over, on the other hand, can receive psychological services without parental knowledge and consent under the circumstances defined by law excluding electroshock therapy, psychosurgery, or psychotropic drugs. When a therapist determines that it is legal and appropriate to treat a minor age 12 or over without parental consent, there are certain procedures that must be followed. The therapist must document in the minor’s record the date and time that contact with the minor's parent or legal guardian was attempted and whether the contact was successful or unsuccessful, or state why it was not appropriate to contact the parent or legal guardian. In addition, the law specifies that the parent(s) of the minor is not responsible for the expenses of treatment if the parent(s) of the minor does not give consent for treatment.

When a therapist treats a minor age 12 or over without parental consent or knowledge, the therapist can act as the claimer of the privilege. This claim of privilege does not extend beyond the therapeutic setting. The therapist would not, for example, be able to obtain the minor client's medical records. To get the records, he or she would have to get the minor client's consent; a client age 12 or over, in treatment without parental knowledge or consent for reasons defined in the law, may sign an authorization for release of his or her medical records.

3G. Sex with Clients

Psychotherapists can be prosecuted both civilly and criminally for engaging in sexual relations with their clients. Prosecution may also occur if a therapist engages in sex with a former client prior to two years following the termination of therapy. In accordance with C.C. 43.93, therapists are civilly liable when they engage in sexual relations with former clients prior to two years after the termination of therapy. According to B.&P.C. 729, criminal

liability in such cases results only when therapists terminate therapy solely for the purpose of engaging in sexual relations with a client. A client has a cause for civil action against a psychotherapist when sexual contact occurs during the course of therapy, within two years following termination of therapy and/or by means of deception. This law also requires the therapist to give a brochure that explains the client's right to any client that revealed prior sexual contact with their therapist. Failure to distribute this brochure is considered unprofessional conduct.

Criminal liability can result if a therapist engages in sex with a current client or if he or she terminates a therapeutic relationship with a client for the purposes of beginning a sexual relationship with that client. In addition, under licensing laws, a clinician who has sex with a client can have his or her license revoked.

When a client reveals a previous or ongoing sexual relationship with his or her former or other therapist, the client's subsequent or other therapist has a legal obligation to give the client the updated 2019 brochure called *Therapy Never Includes Sexual Behavior* which outlines client's rights and responsibilities.

Professional Therapy Never Includes Sex 2019 Update :

In 2019, the California Department of Consumer Affairs publication *Professional Therapy Never Includes Sex* was updated with the publication *Therapy Never Includes Sexual Behavior (2019)* with the following excerpt "California's lawmakers and licensing boards want the public to know that professional therapy never includes sexual contact between a therapist and a client. It also never includes inappropriate sexual suggestions, or any other kind of sexual behavior between a therapist and a client. Sexual contact of any kind between a therapist and a client is unethical and illegal in the State of California. Additionally, with regard to former clients, sexual contact within two years after termination of therapy is also illegal and unethical. It is always the responsibility of the therapist to ensure that sexual contact with a client, whether consensual or not, does not occur." (*Therapy Never Includes Sexual Behavior,* California Department of Consumer Affairs, 2019)

Definition of Terms

Throughout this booklet, the terms "therapist," "therapy," and "client" will be used. "Therapist" refers to anyone who is licensed to practice psychotherapy, or is training to become licensed, and includes:

- Psychologists

- Physicians and Surgeons (Psychiatrists are Physicians and Surgeons)
- Registered Psychologists
- Psychological Interns
- Psychological Assistants
- Licensed Clinical Social Workers
- Registered Associate Clinical Social Workers
- Social Work Interns
- Licensed Marriage and Family Therapists
- Registered Associate Marriage and Family Therapists
- Marriage and Family Therapist Trainees
- Licensed Professional Clinical Counselors
- Registered Associate Professional Clinical Counselors
- Professional Clinical Counselor Trainees
- Licensed Educational Psychologists
- Registered Research Psychoanalysts

"Therapy" includes any type of counseling from any of the licensed or registered professionals listed above. "Client" refers to anyone receiving therapy, or counseling, or other services. "Sexual contact" means the touching of an intimate part of another person, including sexual intercourse. "Sexual behavior" means inappropriate contact or communication of a sexual nature. This definition does not include the provision of appropriate therapeutic interventions relating to sexual issues. "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. "License" includes certificate, registration, or other means to engage in a business or profession regulated by Chapter 1, General Provisions, section 475 of the Business and Professions Code.

1Social Work Interns, Marriage and Family Therapist Trainees, and Professional Clinical Counselor Trainees are still in their master's degree program and have not yet earned their graduate degree. They also are not registered with the Board of Behavioral Sciences yet. Complaints about these individuals should be directed to their supervisor, the agency that employs them, or their academic institution.

According to California law:

- ❖ 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) and 4992.3(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.

WARNING SIGNS

In most sexual misconduct cases, other inappropriate behavior comes first. While it may be subtle or confusing, it usually feels uncomfortable to the client. Some clues or warning signs are:

- Sending obscene images or messages to the client.
- Telling sexual jokes or stories.
- Unwanted physical contact.
- Excessive out-of-session communication (e.g., text, phone, email, social media, etc.) not related to therapy.
- Inviting a client to lunch, dinner, or other social and professional activities.
- Dating.
- Changing the office's business practices (e.g., scheduling late appointments when no one is around, having sessions away from the offce, etc.).
- Confiding in a client (e.g., about the therapist's love life, work problems, loneliness, marital problems, etc.).
- Telling a client that he or she is special, or that the therapist loves him or her.
- Relying on a client for personal and emotional support.

- Giving or receiving significant gifts.
- Suggesting or supporting the client's isolation from social support systems, increasing dependency on the therapist.

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.
- Providing or using alcohol (or drugs) during sessions.
- Providing or using alcohol or drugs during sessions.

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.

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.

✓ Any violation of the patient's rights as a consumer (see Patient Bill of Rights).

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.

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.

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.

Client Options

Clients have several options including:

- **Reporting the Therapis**t —Perhaps the client wants to prevent the therapist from hurting other patients. 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."
    - Recovery — If the client decides to do this, there are several options including therapy or support groups.
    - Moving On — The client may wish simply to move on past the experience as quickly as possible and get on with their life.

Remember —the client has the right to decide what's best for them.

Reporting Options

If a client decides to report a therapist's behavior that is believed to be unethical and illegal, there are four different ways to do so. All of these reporting options are affected by time limits. These options and their time limits are discussed in more detail on following pages:

- ✓ **Administrative Action** — File a complaint with the therapist's licensing board.
- ✓ **Professional Association Action**— File a complaint with the ethics committee of the therapist's professional association.
- ✓ **Civil Action** — File a civil lawsuit.
- ✓ **Criminal Action**— File a complaint with local law enforcement.

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; and registered marriage and family therapist interns.

Board of Psychology
2005 Evergreen Street, Suite 1400
Sacramento, CA 95815
(916)263-2699

www.psychboard.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.medbd.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.

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.
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. The therapist's ability to practice may be impacted and thereby protect other patients from similar misconduct.

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. 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 a case is tried.

Patients Don't Always Win
Some cases end up being decided in favor of the therapist, rather than the patient.

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:

1. The therapist has sexual contact with a patient during therapy, or

2. 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 the local law enforcement agency. Many agencies in larger cities have sexual assault units that handle these complaints.

- ✓ Contact the local victim/witness assistance program for help through the legal process.

3H. Record Retention and Storage

"§ 4980.49. CLIENT RECORDS: RETENTION

"(a) A marriage and family therapist shall retain a client's or patient's health service records for a minimum of seven years from the date therapy is terminated. If the client or patient is a minor, the client's or patient's health service records shall be retained for a minimum of seven years from the date the client or the patient reaches 18 years of age. Health service records may be retained in either a written or an electronic format.

(b) This section shall apply only to the records of a client or patient whose therapy is terminated on or after January 1, 2015." (*Statutes and Regulations Relating to the Practice of Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, Clinical Social Work*, Kim Madsen, Executive Officer, Januaury 2020).

In summary, clinical records should be retained by the clinician for a minimum of seven years following termination. The records of both active and inactive clients should be stored in a secure, locked file cabinet or storage area. It is also advantageous to have a "key policy" which outlines who is in possession/has access to the file cabinet key and where the key is stored.

Following the seven year record retention period, *The Psychologist's Legal Handbook,* Stromberg explains that "records should not simply be placed in

the trash, since methods of trash collection and disposal can be haphazard and can result in confidential papers being seen by passerby. Instead, records should be shredded and destroyed".

There are many important issues associated with the storage of records and confidentiality. It is necessary to store information about clients out of sight of people unauthorized to view the information. Thus, chart documents should be placed inside of a chart or protective covering. The protection of a client's name may seem excessive but the person seeking mental health needs to be treated with confidentiality.

The security of charts in an unattended area is another issue. There should be a lock between the charts and anyone unauthorized to view those charts. An important question to ask oneself may be "What steps would we want a therapist to take if it was my charts containing my deepest secrets, personal history, conflicts, and diagnosis?"

3I. Termination

Clients may terminate treatment at any time. Therapists may terminate treatment for both clinical and/or ethical reasons. Termination of the therapeutic relationship should be addressed during the early stages of treatment. The termination process as well as termination possibilities should be addressed in writing as a part of the informed consent. Many therapists experience this as a helpful way to introduce the concept of termination at the onset of treatment. Termination is not advised when a client is hospitalized, in crisis, or actively suicidal. Terminating a client during a crisis could yield potentially unwanted liability including client abandonment. The following includes the legal/ethical reasons for termination:

- Non-payment
- Lack of treatment benefit/progress
- The therapist is physically or emotionally unable to continue treatment
- Ethical conflicts and conflicts of interest

Documentation of the termination process is essential, including:

- Reason(s) for terminating
- Number of termination sessions
- The clients awareness that treatment has ended and that the therapist is no longer responsible for the client's mental health care.
- Client's response to termination
- Referrals (at least three written referrals are recommended)

NASW Ethical Standards and client termination:

l. 1.16 (a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

2. 1.16 (b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

3. 1.16 (c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

4. 1.16 (d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

5. 1.16 (e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

6. 1.16 (f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

CAMFT Ethical Standards and client termination (updated Code of Ethics 2019):

1.3 TREATMENT DISRUPTION: Marriage and family therapists are aware of their professional and clinical responsibilities to provide consistent care to clients/patients and to maintain practices and procedures that are intended to provide undisrupted care. Such practices and procedures may include, but are not limited to, providing contact information and specified procedures in case of emergency or therapist absence, conducting appropriate terminations, and providing for a professional will.

1.4 TERMINATION: Marriage and family therapists use sound clinical judgment when terminating therapeutic relationships. Reasons for termination may include, but are not limited to, the client/patient is not benefiting from treatment, continuing treatment is not clinically appropriate, the therapist is unable to provide treatment due to the therapist's incapacity or extended absence, or due to an otherwise unresolvable ethical conflict or issue. (See also sections 3.8 Client/Patient Benefit and 5.11 Scope of Competence.)

1.5 NON-PAYMENT OF FEES: When terminating client/patient relationships due to non-payment of fees, marriage and family therapists do so in a clinically appropriate manner.

1.6 EMPLOYMENT AND CONTRACTUAL TERMINATIONS: When terminating employment or contractual relationships, marriage and family therapists primarily consider the best interests of the client/patient when resolving issues of continued responsibility for client/patient care.

1.7 ABANDONMENT: Marriage and family therapists do not abandon or neglect clients/patients in treatment. If a therapist is unable or unwilling to continue to provide professional services, the therapist will assist the client/patient in making clinically appropriate arrangements for continuation of treatment.

3J. Informed Consent

Informed consent is a legal condition whereby a person can be said to have given consent based upon a clear appreciation and understanding of the facts, implications and future consequences of an action. In order to give informed consent, the individual concerned must have adequate reasoning faculties and be in possession of all relevant facts at the time consent is given. Impairments to reasoning and judgment which would make it impossible for someone to give informed consent include such factors as severe mental retardation, severe mental illness, intoxication, severe sleep deprivation, Alzheimer's disease, or being in a coma. The ability to give informed consent will be governed by a general requirement of competency. In common law jurisdictions, adults are presumed competent to consent. This presumption can be rebutted, for instance, in circumstances of mental illness or other incompetence. This may be prescribed in legislation or based on a common-law standard of inability to understand the nature of the procedure. In cases of incompetent adults, informed consent--from the patients or from their families--is not required. Rather, the medical practitioner must simply act in the patient's best interests in order to avoid negligence liability.

By contrast, 'minors' (which may be defined differently in different jurisdictions) are generally presumed incompetent to consent. In some jurisdictions (e.g. much of the U.S.), this is a strict standard. In other jurisdictions (e.g. England, Australia, Canada), this presumption may be rebutted through proof that the minor is ‘mature’ (the ‘Gillick standard’). In cases of incompetent minors, informed consent is usually required from the parent (rather than the 'best interests standard') although a parens patriae order may apply, allowing the court to dispense with parental consent in cases of refusal.

The process of informed consent provides the client and therapist an opportunity to ensure adequate understanding of their shared venture. It is a process of communication and clarification. Are expectations clearly stated? Does the client understand the approach the therapist will be using? Informed consent involves making decisions. The therapist must decide if the patient is competent to exercise informed consent. The therapist must evaluate if the competent client has relevant information in which to make a decision and sufficiently understands the information.

3K. Malpractice

According to the law, malpractice is a type of negligence in which the misfeasance, malfeasance or nonfeasance of a professional, under a duty to act, fails to follow generally accepted professional standards, and that breach of duty is the proximate cause of injury to a plaintiff who suffers damages. It is committed by a professional or her/his subordinates or agents on behalf of a client or patient that causes damages to the client or patient. Perhaps the most publicized forms are medical malpractice and legal malpractice by medical practitioners and lawyers respectively, though malpractice suits against accountants (Arthur Andersen) and investment advisors (Merrill Lynch) have featured in the news more recently.

Data from the Insurance Trust of the American Psychological Association reveal the following primary reasons that clinicians are sued:

1. Sexual Impropriety accounts for 53.2% of the costs of malpractice cases and for 20.4% of the total number of claims. Dual relationships, particularly sexual dual relationships comprise the largest share of formal complaints against psychologists.

2. Patient suicide comprises 11.2% of the total costs and about 5.8% of the total number of cases.

3. Incorrect treatment meaning the incompetence in the selection or implementation of the treatment plan comprises about 8.4% of the total costs and about 13.2% of the total claims against psychologists.

4. HIPAA and Third Party Reimbursement for Mental Health Services

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the U.S. Congress in 1996. According to the Centers for Medicare and Medicaid Services (CMS) website, Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for

providers, health insurance plans, and employers. It helps people keep their information private. "Health Insurance Portability and Accountability Act Privacy rule causes ongoing concerns among clinicians and researchers"). The Administration Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system. Title II of HIPAA defines numerous offenses relating to health care and sets civil and criminal penalties for them. It also creates several programs to control fraud and abuse within the health care system. However, the most significant provisions of Title II are its Administrative Simplification rules. Title II requires the Department of Health and Human Services (HHS) to draft rules aimed at increasing the efficiency of the health care system by creating standards for the use and dissemination of health care information.

These rules apply to “covered entities” as defined by HIPAA and the HHS. Covered entities include health plans, health care clearinghouses, such as billing services and community health information systems, and health care providers that transmit health care data in a way that is regulated by HIPAA.

Per the requirements of Title II, the HHS has promulgated five rules regarding Administrative Simplification: the Privacy Rule, the Transactions and Code Sets Rule, the Security Rule, the Unique Identifiers Rule, and the Enforcement Rule.

The HIPAA Privacy Rule regulates the use and disclosure of certain information held by "covered entities" (generally, health care clearinghouses, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions.) It establishes regulations for the use and disclosure of Protected Health Information (PHI). PHI is any information held by a covered entity which concerns health status, provision of health care, or payment for health care that can be linked to an individual. This is interpreted rather broadly and includes any part of an individual's medical record or payment history. Covered entities must disclose PHI to the individual within 30 days upon request. They also must disclose PHI when required to do so by law, such as reporting suspected child abuse to state child welfare agencies (*Wilson J*). "Health Insurance Portability and

Accountability Act Privacy rule causes ongoing concerns among clinicians and researchers".

A covered entity may disclose PHI to facilitate treatment, payment, or health care operations or if the covered entity has obtained authorization from the individual. However, when a covered entity discloses any PHI, it must make a reasonable effort to disclose only the minimum necessary information required to achieve its purpose.

The Privacy Rule requires covered entities to take reasonable steps to ensure the confidentiality of communications with individuals. For example, an individual can ask to be called at his or her work number, instead of home or cell phone number. The Privacy Rule requires covered entities to notify individuals of uses of their PHI. Covered entities must also keep track of disclosures of PHI and document privacy policies and procedures. They must appoint a Privacy Official and a contact person responsible for receiving complaints and train all members of their workforce in procedures regarding PHI.

HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use only the National Provider Identifier (NPI) to identify covered healthcare providers in standard transactions. The NPI replaces all other identifiers used by health plans, Medicare (i.e., the UPIN), Medicaid, and other government programs. However, the NPI does not replace a provider's DEA number, state license number, or tax identification number. The NPI is 10 digits (may be alphanumeric), with the last digit being a checksum. The NPI is unique and national, never re-used, and except for institutions, a provider usually can have only one.

The HIPAA process for a solo or small group of health professionals is a fairly easy task, particularly if you have already been following the laws for privacy within your field. Within a private practice, you can designate yourself as the Privacy officer and take care of the necessary changes rather smoothly.

Some therapists may need to complete and store two sets of notes, learn HIPPA standards regarding patient’s access to records, and develop new forms for Consent for Services and a HIPAA Acknowledgement. Also, revised standards now exist regarding the security of computer records. The recommendations discussed apply to solo practices or those of small groups and do not apply to hospitals or large clinics.

The Standards for Privacy of Individually Identifiable Health Information Privacy Rule establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services Payment encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an individual and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual. Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity. Most uses and disclosures of psychotherapy notes for treatment, payment, and health care operations purposes require an authorization as described below.

Obtaining consent (written permission from individuals to use and disclose their protected health information for treatment, payment, and health care operations) is optional under the Privacy Rule for all covered entities. The content of a consent form, and the process for obtaining consent, are at the discretion of the covered entity electing to seek consent.

4A. HIPAA Privacy Rule and Sharing Information Related to Mental Health

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information. At the same time, the Privacy Rule recognizes circumstances arise where health information may need to be shared to ensure the patient

receives the best treatment and for other important purposes, such as for the health and safety of the patient or others. The Rule is carefully balanced to allow uses and disclosures of information—including mental health information—for treatment and these other purposes with appropriate protections.

In this guidance, we address some of the more frequently asked questions about when it is appropriate under the Privacy Rule for a health care provider to share the protected health information of a patient who is being treated for a mental health condition. We clarify when HIPAA permits health care providers to:

- Communicate with a patient's family members, friends, or others involved in the patient's care;
- Communicate with family members when the patient is an adult;
- Communicate with the parent of a patient who is a minor;
- Consider the patient's capacity to agree or object to the sharing of their information;
- Involve a patient's family members, friends, or others in dealing with patient failures to adhere to medication or other therapy;
- Listen to family members about their loved ones receiving mental health treatment;
- Communicate with family members, law enforcement, or others when the patient presents a serious and imminent threat of harm to self or others; and
- Communicate to law enforcement about the release of a patient brought in for an emergency psychiatric hold.

In addition, the guidance provides relevant reminders about related issues, such as the heightened protections afforded to psychotherapy notes by the Privacy Rule, a parent's right to access the protected health information of a minor child as the child's personal representative, the potential applicability of Federal alcohol and drug abuse confidentiality regulations or state laws that may provide more stringent protections for the information than HIPAA, and the intersection of HIPAA and FERPA in a school setting.

4B. Questions and Answers about HIPAA and Mental Health

Does HIPAA allow a health care provider to communicate with a patient's family, friends, or other persons who are involved in the patient's care?

Yes. In recognition of the integral role that family and friends play in a patient's health care, the HIPAA Privacy Rule allows these routine – and often critical – communications between health care providers and these persons. Where a patient is present and has the capacity to make health care decisions, health care providers may communicate with a patient's family members, friends, or other persons the patient has involved in his or her health care or payment for care, so long as the patient does not object. See 45 CFR

164.510(b). The provider may ask the patient's permission to share relevant information with family members or others, may tell the patient he or she plans to discuss the information and give them an opportunity to agree or object, or may infer from the circumstances, using professional judgment, that the patient does not object. A common example of the latter would be situations in which a family member or friend is invited by the patient and present in the treatment room with the patient and the provider when a disclosure is made.

Where a patient is not present or is incapacitated, a health care provider may share the patient's information with family, friends, or others involved in the patient's care or payment for care, as long as the health care provider determines, based on professional judgment, that doing so is in the best interests of the patient. Note that, when someone other than a friend or family member is involved, the health care provider must be reasonably sure that the patient asked the person to be involved in his or her care or payment for care.

In all cases, disclosures to family members, friends, or other persons involved in the patient's care or payment for care are to be limited to only the protected health information directly relevant to the person's involvement in the patient's care or payment for care.

OCR's website contains additional information about disclosures to family members and friends in fact sheets developed for consumers - PDF and providers - PDF.

Does HIPAA provide extra protections for mental health information compared with other health information?

Generally, the Privacy Rule applies uniformly to all protected health information, without regard to the type of information. One exception to this general rule is for psychotherapy notes, which receive special protections. The Privacy Rule defines psychotherapy notes as notes recorded by a health care provider who is a mental health professional documenting or analyzing

the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. Psychotherapy notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes also do not include any information that is maintained in a patient's medical record. See 45 CFR 164.501.

Psychotherapy notes are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist that typically are not required or useful for treatment, payment, or health care operations purposes, other than by the mental health professional who created the notes. Therefore, with few exceptions, the Privacy Rule requires a covered entity to obtain a patient's authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to a health care provider other than the originator of the notes. See 45 CFR 164.508(a)(2). A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the patient (State laws vary as to whether such a warning is mandatory or permissible).

Is a health care provider permitted to discuss an adult patient's mental health information with the patient's parents or other family members?

In situations where the patient is given the opportunity and does not object, HIPAA allows the provider to share or discuss the patient's mental health information with family members or other persons involved in the patient's care or payment for care. For example, if the patient does not object:

- A psychiatrist may discuss the drugs a patient needs to take with the patient's sister who is present with the patient at a mental health care appointment.
- A therapist may give information to a patient's spouse about warning signs that may signal a developing emergency.

BUT:

- A nurse may not discuss a patient's mental health condition with the patient's brother after the patient has stated she does not want her family to know about her condition.

In all cases, the health care provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care. See 45 CFR 164.510(b). Finally, it is important to remember that other applicable law (e.g., State confidentiality statutes) or professional ethics may impose stricter limitations on sharing personal health information, particularly where the information relates to a patient's mental health.

When does mental illness or another mental condition constitute incapacity under the Privacy Rule? For example, what if a patient who is experiencing temporary psychosis or is intoxicated does not have the capacity to agree or object to a health care provider sharing information with a family member, but the provider believes the disclosure is in the patient's best interests?

Section 164.510(b)(3) of the HIPAA Privacy Rule permits a health care provider, when a patient is not present or is unable to agree or object to a disclosure due to incapacity or emergency circumstances, to determine whether disclosing a patient's information to the patient's family, friends, or other persons involved in the patient's care or payment for care, is in the best interests of the patient.1 Where a provider determines that such a disclosure is in the patient's best interests, the provider would be permitted to disclose only the PHI that is directly relevant to the person's involvement in the patient's care or payment for care.

This permission clearly applies where a patient is unconscious. However, there may be additional situations in which a health care provider believes, based on professional judgment, that the patient does not have the capacity to agree or object to the sharing of personal health information at a particular time and that sharing the information is in the best interests of the patient at that time. These may include circumstances in which a patient is suffering from temporary psychosis or is under the influence of drugs or alcohol. If, for example, the provider believes the patient cannot meaningfully agree or object to the sharing of the patient's information with family, friends, or other persons involved in their care due to her current mental state, the provider is allowed to discuss the patient's condition or treatment with a family member, if the provider believes it would be in the patient's best interests. In making this determination about the patient's best interests, the provider should take into account the patient's prior expressed preferences regarding disclosures of their information, if any, as well as the circumstances of the current situation. Once the patient regains the capacity

to make these choices for herself, the provider should offer the patient the opportunity to agree or object to any future sharing of her information.

Note 1: The Privacy Rule permits, but does not require, providers to disclose information in these situations. Providers who are subject to more stringent privacy standards under other laws, such as certain state confidentiality laws or 42 CFR Part 2, would need to consider whether there is a similar disclosure permission under those laws that would apply in the circumstances.

If a health care provider knows that a patient with a serious mental illness has stopped taking a prescribed medication, can the provider tell the patient's family members?

So long as the patient does not object, HIPAA allows the provider to share or discuss a patient's mental health information with the patient's family members. See 45 CFR 164.510(b). If the provider believes, based on professional judgment, that the patient does not have the capacity to agree or object to sharing the information at that time, and that sharing the information would be in the patient's best interests, the provider may tell the patient's family member. In either case, the health care provider may share or discuss only the information that the family member involved needs to know about the patient's care or payment for care.

Otherwise, if the patient has capacity and objects to the provider sharing information with the patient's family member, the provider may only share the information if doing so is consistent with applicable law and standards of ethical conduct, and the provider has a good faith belief that the patient poses a threat to the health or safety of the patient or others, and the family member is reasonably able to prevent or lessen that threat. See 45 CFR 164.512(j). For example, if a doctor knows from experience that, when a patient's medication is not at a therapeutic level, the patient is at high risk of committing suicide, the doctor may believe in good faith that disclosure is necessary to prevent or lessen the threat of harm to the health or safety of the patient who has stopped taking the prescribed medication, and may share information with the patient's family or other caregivers who can avert the threat. However, absent a good faith belief that the disclosure is necessary to prevent a serious and imminent threat to the health or safety of the patient or others, the doctor must respect the wishes of the patient with respect to the disclosure.

Can a minor child's doctor talk to the child's parent about the patient's mental health status and needs?

With respect to general treatment situations, a parent, guardian, or other person acting in loco parentis usually is the personal representative of the minor child, and a health care provider is permitted to share patient information with a patient's personal representative under the Privacy Rule. However, section 164.502(g) of the Privacy Rule contains several important exceptions to this general rule. A parent is not treated as a minor child's personal representative when: (1) State or other law does not require the consent of a parent or other person before a minor can obtain a particular health care service, the minor consents to the health care service, and the minor child has not requested the parent be treated as a personal representative; (2) someone other than the parent is authorized by law to consent to the provision of a particular health service to a minor and provides such consent; or (3) a parent agrees to a confidential relationship between the minor and a health care provider with respect to the health care service. For example, if State law provides an adolescent the right to obtain mental health treatment without parental consent, and the adolescent consents to such treatment, the parent would not be the personal representative of the adolescent with respect to that mental health treatment information.

Regardless, however, of whether the parent is otherwise considered a personal representative, the Privacy Rule defers to State or other applicable laws that expressly address the ability of the parent to obtain health information about the minor child. In doing so, the Privacy Rule permits a covered entity to disclose to a parent, or provide the parent with access to, a minor child's protected health information when and to the extent it is permitted or required by State or other laws (including relevant case law). Likewise, the Privacy Rule prohibits a covered entity from disclosing a minor child's protected health information to a parent when and to the extent it is prohibited under State or other laws (including relevant case law). See 45 CFR 164.502(g)(3)(ii).

In cases in which State or other applicable law is silent concerning disclosing a minor's protected health information to a parent, and the parent is not the personal representative of the minor child based on one of the exceptional circumstances described above, a covered entity has discretion to provide or deny a parent access to the minor's health information, if doing so is consistent with State or other applicable law, and the decision is made by a licensed health care professional in the exercise of professional judgment. For more information about personal representatives under the Privacy Rule, see OCR's guidance for consumers and providers.

In situations where a minor patient is being treated for a mental health disorder and a substance abuse disorder, additional laws may be applicable. The Federal confidentiality statute and regulations that apply to federally-funded drug and alcohol abuse treatment programs contain provisions that are more stringent than HIPAA. See 42 USC § 290dd–2; 42 CFR 2.11, et. seq.

Note 2: A parent also may not be a personal representative if there are safety concerns. A provider may decide not to treat the parent as the minor's personal representative if the provider believes that the minor has been or may be subject to violence, abuse, or neglect by the parent or the minor may be endangered by treating the parent as the personal representative; and the provider determines, in the exercise of professional judgment, that it is not in the best interests of the patient to treat the parent as the personal representative. See 45 CFR 164.502(g)(5).

At what age of a child is the parent no longer the personal representative of the child for HIPAA purposes?

HIPAA defers to state law to determine the age of majority and the rights of parents to act for a child in making health care decisions, and thus, the ability of the parent to act as the personal representative of the child for HIPAA purposes. See 45 CFR 164.502(g).

Does a parent have a right to receive a copy of psychotherapy notes about a child's mental health treatment?

No. The Privacy Rule distinguishes between mental health information in a mental health professional's private notes and that contained in the medical record. It does not provide a right of access to psychotherapy notes, which the Privacy Rule defines as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. See 45 CFR 164.501. Psychotherapy notes are primarily for personal use by the treating professional and generally are not disclosed for other purposes. Thus, the Privacy Rule includes an exception to an individual's (or personal representative's) right of access for psychotherapy notes. See 45 CFR 164.524(a)(1)(i).

However, parents generally are the personal representatives of their minor child and, as such, are able to receive a copy of their child's mental health information contained in the medical record, including information about diagnosis, symptoms, treatment plans, etc. Further, although the Privacy

Rule does not provide a right for a patient or personal representative to access psychotherapy notes regarding the patient, HIPAA generally gives providers discretion to disclose the individual's own protected health information (including psychotherapy notes) directly to the individual or the individual's personal representative. As any such disclosure is purely permissive under the Privacy Rule, mental health providers should consult applicable State law for any prohibitions or conditions before making such disclosures.

What options do family members of an adult patient with mental illness have if they are concerned about the patient's mental health and the patient refuses to agree to let a health care provider share information with the family?

The HIPAA Privacy Rule permits a health care provider to disclose information to the family members of an adult patient who has capacity and indicates that he or she does not want the disclosure made, only to the extent that the provider perceives a serious and imminent threat to the health or safety of the patient or others and the family members are in a position to lessen the threat. Otherwise, under HIPAA, the provider must respect the wishes of the adult patient who objects to the disclosure. However, HIPAA in no way prevents health care providers from listening to family members or other caregivers who may have concerns about the health and well-being of the patient, so the health care provider can factor that information into the patient's care.

In the event that the patient later requests access to the health record, any information disclosed to the provider by another person who is not a health care provider that was given under a promise of confidentiality (such as that shared by a concerned family member), may be withheld from the patient if the disclosure would be reasonably likely to reveal the source of the information. 45 CFR 164.524(a)(2)(v). This exception to the patient's right of access to protected health information gives family members the ability to disclose relevant safety information with health care providers without fear of disrupting the family's relationship with the patient.

Does HIPAA permit a doctor to contact a patient's family or law enforcement if the doctor believes that the patient might hurt herself or someone else?

Yes. The Privacy Rule permits a health care provider to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when the provider believes the patient presents a

serious and imminent threat to self or others. The scope of this permission is described in a letter to the nation's health care providers - PDF

Specifically, when a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat. These provisions may be found in the Privacy Rule at 45 CFR § 164.512(j).

Under these provisions, a health care provider may disclose patient information, including information from mental health records, if necessary, to law enforcement, family members of the patient, or any other persons who may reasonably be able to prevent or lessen the risk of harm. For example, if a mental health professional has a patient who has made a credible threat to inflict serious and imminent bodily harm on one or more persons, HIPAA permits the mental health professional to alert the police, a parent or other family member, school administrators or campus police, and others who may be able to intervene to avert harm from the threat.

In addition to professional ethical standards, most States have laws and/or court decisions which address, and in many instances require, disclosure of patient information to prevent or lessen the risk of harm. Providers should consult the laws applicable to their profession in the States where they practice, as well as 42 USC 290dd-2 and 42 CFR Part 2 under Federal law (governing the disclosure of alcohol and drug abuse treatment records) to understand their duties and authority in situations where they have information indicating a threat to public safety. Note that, where a provider is not subject to such State laws or other ethical standards, the HIPAA permission still would allow disclosures for these purposes to the extent the other conditions of the permission are met.

If a law enforcement officer brings a patient to a hospital or other mental health facility to be placed on a temporary psychiatric hold, and requests to be notified if or when the patient is released, can the facility make that notification?

The Privacy Rule permits a HIPAA covered entity, such as a hospital, to disclose certain protected health information, including the date and time of admission and discharge, in response to a law enforcement official's request, for the purpose of locating or identifying a suspect, fugitive, material witness, or missing person. See 45 CFR § 164.512(f)(2). Under this

provision, a covered entity may disclose the following information about an individual: name and address; date and place of birth; social security number; blood type and rh factor; type of injury; date and time of treatment (includes date and time of admission and discharge) or death; and a description of distinguishing physical characteristics (such as height and weight).

Other Privacy Rule provisions also may be relevant depending on the circumstances, such as where a law enforcement official is seeking information about a person who may not rise to the level of a suspect, fugitive, material witness, or missing person, or needs protected health information not permitted under the above provision. For example, the Privacy Rule's law enforcement provisions also permit a covered entity to respond to an administrative request from a law enforcement official, such as an investigative demand for a patient's protected health information, provided the administrative request includes or is accompanied by a written statement specifying that the information requested is relevant, specific and limited in scope, and that de- identified information would not suffice in that situation. The Rule also permits covered entities to respond to court orders and court-ordered warrants, and subpoenas and summonses issued by judicial officers. See 45 CFR § 164.512(f)(1). Further, to the extent that State law may require providers to make certain disclosures, the Privacy Rule would permit such disclosures of protected health information as "required-by-law" disclosures. See 45 CFR § 164.512(a).

Finally, the Privacy Rule permits a covered health care provider, such as a hospital, to disclose a patient's protected health information, consistent with applicable legal and ethical standards, to avert a serious and imminent threat to the health or safety of the patient or others. Such disclosures may be to law enforcement authorities or any other persons, such as family members, who are able to prevent or lessen the threat. See 45 CFR § 164.512(j).

If a doctor believes that a patient might hurt himself or herself or someone else, is it the duty of the provider to notify the family or law enforcement authorities?

A health care provider's "duty to warn" generally is derived from and defined by standards of ethical conduct and State laws and court decisions such as Tarasoff v. Regents of the University of California. HIPAA permits a covered health care provider to notify a patient's family members of a serious and imminent threat to the health or safety of the patient or others if those family members are in a position to lessen or avert the threat. Thus, to

the extent that a provider determines that there is a serious and imminent threat of a patient physically harming self or others, HIPAA would permit the provider to warn the appropriate person(s) of the threat, consistent with his or her professional ethical obligations and State law requirements. See 45 CFR 164.512(j). In addition, even where danger is not imminent, HIPAA permits a covered provider to communicate with a patient's family members, or others involved in the patient's care, to be on watch or ensure compliance with medication regimens, as long as the patient has been provided an opportunity to agree or object to the disclosure and no objection has been made. See 45 CFR 164.510(b)(2).

Does HIPAA prevent a school administrator, or a school doctor or nurse, from sharing concerns about a student's mental health with the student's parents or law enforcement authorities?

Student health information held by a school generally is subject to the Family Educational Rights and Privacy Act (FERPA), not HIPAA. HHS and the Department of Education have developed guidance clarifying the application of HIPAA and FERPA - PDF

In the limited circumstances where the HIPAA Privacy Rule, and not FERPA, may apply to health information in the school setting, the Rule allows disclosures to parents of a minor patient or to law enforcement in various situations. For example, parents generally are presumed to be the personal representatives of their unemancipated minor child for HIPAA privacy purposes, such that covered entities may disclose the minor's protected health information to a parent. See 45 CFR § 164.502 (g)(3). In addition, disclosures to prevent or lessen serious and imminent threats to the health or safety of the patient or others are permitted for notification to those who are able to lessen the threat, including law enforcement, parents or others, as relevant. See 45 CFR § 164.512(j).

Additional FAQs on Sharing Information Related to Treatment for Mental Health or Substance Use Disorder—Including Opioid Abuse

ADULT PATIENTS

Does having a health care power of attorney (POA) allow access to the patient's medical and mental health records under HIPAA?

Generally, yes. If a health care power of attorney is currently in effect, the named person would be the patient's personal representative (The period of effectiveness may depend on the type of power of attorney: Some health care power of attorney documents are effective immediately, while others are only triggered if and when the patient lacks the capacity to make health

care decisions and then cease to be effective if and when the patient regains such capacity).

"Personal representatives," as defined by HIPAA, are those persons who have authority, under applicable law, to make health care decisions for a patient. HIPAA provides a personal representative of a patient with the same rights to access health information as the patient, including the right to request a complete medical record containing mental health information. The patient's right of access has some exceptions, which would also apply to a personal representative. For example, with respect to mental health information, a psychotherapist's separate notes of counseling sessions, kept separately from the patient chart, are not included in the HIPAA right of access.

Additionally, a provider may decide not to treat someone as the patient's personal representative if the provider believes that the patient has been or may be subject to violence, abuse, or neglect by the designated person or the patient may be endangered by treating such person as the personal representative, and the provider determines, in the exercise of professional judgment, that it is not in the best interests of the patient to treat the person as the personal representative. See 45 CFR 164.502(g)(5).

Does HIPAA permit health care providers to share protected health information (PHI) about an individual who has mental illness with other health care providers who are treating the same individual for care coordination/continuity of care purposes?

HIPAA permits health care providers to disclose to other health providers any protected health information (PHI) contained in the medical record about an individual for treatment, case management, and coordination of care and, with few exceptions, treats mental health information the same as other health information. Some examples of the types of mental health information that may be found in the medical record and are subject to the same HIPAA standards as other protected health information include:

• medication prescription and monitoring

• counseling session start and stop times

• the modalities and frequencies of treatment furnished

• results of clinical tests

• summaries of: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to

date.

HIPAA generally does not limit disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes. Covered entities should determine whether other rules, such as state law or professional practice standards place additional limitations on disclosures of PHI related to mental health.

For more information see:

Does HIPAA provide extra protections for mental health information compared with other health information?

Does HIPAA permit health care providers to share protected health information (PHI) about an individual with mental illness with a third party that is not a health care provider for case management or continuity of care purposes? For example, can a health care provider refer a homeless patient to a social services agency, such as a housing provider, when doing so may reveal that the basis for eligibility is related to mental health?

HIPAA, with few exceptions, treats all health information, including mental health information, the same. HIPAA allows health care providers to disclose protected health information (PHI), including mental health information, to other public or private-sector entities providing social services (such as housing, income support, job training) in specified circumstances. For example:

- A health care provider may disclose a patient's PHI for treatment purposes without having to obtain the authorization of the individual. Treatment includes the coordination or management of health care by a health care provider with a third party. Health care means care, services, or supplies related to the health of an individual. Thus, health care providers who believe that disclosures to certain social service entities are a necessary component of, or may help further, the individual's health or mental health care may disclose the minimum necessary PHI to such entities without the individual's authorization. For example, a provider may disclose PHI about a patient needing mental health care supportive housing to a service agency that arranges such services for individuals.
- A covered entity may also disclose PHI to such entities pursuant to an authorization signed by the individual. HIPAA permits authorizations that refer to a class of persons who may receive or use the PHI. Thus, providers could in one authorization identify a broad range of social services entities that may receive the PHI if the individual agrees. For example, an

authorization could indicate that PHI will be disclosed to "social services providers" for purposes of "supportive housing, public benefits, counseling, and job readiness."

EMERGENCIES, EMERGENCY HOSPITALIZATION OR DANGEROUS SITUATIONS

When does HIPAA allow a doctor to notify an individual's family, friends, or caregivers that a patient has overdosed, e.g., because of opioid abuse?

As explained more thoroughly below, when a patient has overdosed, a health care professional, such as a doctor, generally may notify the patient's family, friends, or caregivers involved in the patient's health care or payment for care if:

(1) the patient has the capacity to make health care decisions at the time of the disclosure, is given the opportunity to object, and does not object;

(2) the family, friends, or caregivers have been involved in the patient's health care or payment for care and there has been no objection from the patient;

(3) the patient had the capacity to make health care decisions at the time the information is shared and the doctor can reasonably infer, based on the exercise of professional judgment, that the patient would not object;

(4) the patient is incapacitated and the health care professional determines, based on the exercise of professional judgment, that notification and disclosure of PHI is in the patient's best interests;

(5) the patient is unavailable due to some emergency and the health care professional determines, based on the exercise of professional judgment, that notification and disclosure of PHI is in the patient's best interests; or

(6) the notification is necessary to prevent a serious and imminent threat to the health or safety of the patient or others.

If the patient who has overdosed is incapacitated and unable to agree or object, a doctor may notify a family member, personal representative, or another person responsible for the individual's care of the patient's location, general condition, or death. See 45 CFR 164.510(b)(1)(ii). Similarly, HIPAA allows a doctor to share additional information with a patient's family member, friend, or caregiver as long as the information shared is directly related to the person's involvement in the patient's health care or payment for care. 45 CFR 164.510(b)(1)(i). Decision-making incapacity may be temporary or long-term. If a patient who has overdosed regains decision-making capacity, health providers must offer the patient the opportunity to

agree or object to sharing their health information with involved family, friends, or caregivers before making any further disclosures. If a patient becomes unavailable due to some emergency, a health care professional may determine, based on the exercise of professional judgment, that notification and disclosure of PHI to someone previously involved in their care is in the patient's best interests. For example, if a patient who is addicted to opioids misses important medical appointments without any explanation, a primary health care provider at a general practice may believe that there is an emergency related to the opioid addiction and under the circumstances, may use professional judgment to determine that it is in the patient's best interests to reach out to emergency contacts, such as parents or family, and inform them of the situation. See 45 CFR 164.510(b)(3).

If the patient is deceased, a doctor may disclose information related to the family member's, friend's, or caregiver's involvement with the patient's care, unless doing so is inconsistent with any prior expressed preference of the patient that is known to the doctor. If the person who will receive notification is the patient's personal representative, that person has a right to request and obtain any information about the patient that the patient could obtain, including a complete medical record, under the HIPAA right of access. See 45 CFR 164.524.

When a patient poses a serious and imminent threat to his own or someone else's health or safety, HIPAA permits a health care professional to share the necessary information about the patient with anyone who is in a position to prevent or lessen the threatened harm--including family, friends, and caregivers--without the patient's permission. See 45 CFR 164.512(j). HIPAA expressly defers to the professional judgment of health care professionals when they make determinations about the nature and severity of the threat to health or safety. See 45 CFR 164.512(j)(4). Specifically, HIPAA presumes the health care professional is acting in good faith in making this determination, if the professional relies on his or her actual knowledge or on credible information from another person who has knowledge or authority. For example, a doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if, based on talking with or observing the patient, the doctor determines that the patient poses a serious and imminent threat to his or her own health. Even when HIPAA permits this disclosure, however, the disclosure must be consistent with applicable state law and standards of ethical conduct. HIPAA does not preempt any state law or professional ethics standards that would prevent a health care professional from sharing protected health information in the circumstances described

here. For example, the doctor in this situation still may be subject to a state law that prohibits sharing information related to mental health or a substance use disorder without the patient's consent in all circumstances, even if HIPAA would permit the disclosure.

For more information see OCR's guidance, How HIPAA Allows Doctors to Respond to the Opioid Crisis, https://www.hhs.gov/sites/default/files/hipaa-opioid-crisis.pdf

When does HIPAA allow a hospital to notify an individual's family, friends, or caregivers that a patient who has been hospitalized for a psychiatric hold has been admitted or discharged?

Hospitals may notify family, friends, or caregivers of a patient in several circumstances:

- When the patient has a personal representative

A hospital may notify a patient's personal representative about their admission or discharge and share other PHI with the personal representative without limitation. However, a hospital is permitted to refuse to treat a person as a personal representative if there are safety concerns associated with providing the information to the person, or if a health care professional determines that disclosure is not in the patient's best interest.

- When the patient agrees or does not object to family involvement

A hospital may notify a patient's family, friends, or caregivers if the patient agrees, or doesn't object, or if a health care professional is able to infer from the surrounding circumstances, using professional judgment that the patient does not object. This includes when a patient's family, friends, or caregivers have been involved in the patient's health care in the past, and the individual did not object.

- When the patient becomes unable to agree or object and there has already been family involvement

When a patient is not present or cannot agree or object because of some incapacity or emergency, a health care provider may share relevant information about the patient with family, friends, or others involved in the patient's care or payment for care if the health care provider determines, based on professional judgment, that doing so is in the best interest of the patient.

For example, a psychiatric hospital may determine that it is in the best interests of an incapacitated patient to initially notify a member of their household, such as a parent, roommate, sibling, partner, or spouse, and

inform them about the patient's location and general condition. This may include, for example, notifying a patient's spouse that the patient has been admitted to the hospital.

If the health care provider determines that it is in the patient's interest, the provider may share additional information that is directly related to the family member's or friend's involvement with the patient's care or payment for care, after they clarify the person's level of involvement. For example, a nurse treating a patient may determine that it is in the patient's best interest to discuss with the patient's adult child, who is the patient's primary caregiver, the medications found in a patient's backpack and ask about any other medications the patient may have at home.

Decision-making incapacity may be temporary or long-term. Upon a patient's regaining decision-making capacity, health providers should offer the patient the opportunity to agree or object to sharing their health information with involved family, friends, or caregivers.

- When notification is needed to lessen a serious and imminent threat of harm to the health or safety of the patient or others

A hospital may disclose the necessary protected health information to anyone who is in a position to prevent or lessen the threatened harm, including family, friends, and caregivers, without a patient's agreement. HIPAA expressly defers to the professional judgment of health professionals in making determinations about the nature and severity of the threat to health or safety. For example, a health care provider may determine that a patient experiencing a mental health crisis has ingested an unidentified substance and that the provider needs to contact the patient's roommate to help identify the substance and provide the proper treatment, or the patient may have made a credible threat to harm a family member, who needs to be notified so he or she can take steps to avoid harm. OCR would not second guess a health care professional's judgment in determining that a patient presents a serious and imminent threat to their own, or others', health or safety.

What constitutes a "serious and imminent" threat that would permit a health care provider to disclose PHI to prevent harm to the patient, another person, or the public without the patient's authorization or permission?

HIPAA expressly defers to the professional judgment of health professionals in making determinations about the nature and severity of the threat to health or safety posed by a patient. OCR would not second guess a health professional's good faith belief that a patient poses a serious and imminent threat to the health or safety of the patient or others and that the situation

requires the disclosure of patient information to prevent or lessen the threat. Health care providers may disclose the necessary protected health information to anyone who is in a position to prevent or lessen the threatened harm, including family, friends, caregivers, and law enforcement, without a patient's permission.

See Guidance on Sharing Information Related to Mental Health, https:// www.hhs.gov/hipaa/for- professionals/special-topics/mental-health/ index.html

If an adult patient who may pose a danger to self stops coming to psychotherapy sessions and does not respond to attempts to make contact, does HIPAA permit the therapist to contact a family member to check on the patient's well-being even if the patient has told the therapist that they do not want information shared with that person?

Yes, under two possible circumstances:

1. Given that the patient is no longer present, if the therapist determines, based on professional judgment, that there may be an emergency situation and that contacting the family member of the absent patient is in the patient's best interests; or

2. If the disclosure is needed to lessen a serious and imminent threat and the family member is in a position to avert or lessen the threat.

In making the determination about the patient's best interests, the provider may take into account the patient's prior expressed preferences regarding disclosures of their information, if any, as well as the circumstances of the current situation. In either case, the health care provider may share or discuss only the information that the family member involved needs to know about the patient's care or payment for care or the minimum necessary for the purpose of preventing or lessening the threatened harm.

Additionally, if the family member is a personal representative of the patient, the therapist may contact that person. However, a provider may decide not to treat someone as a personal representative if the provider believes that the patient has been or may be subject to violence, abuse, or neglect by the personal representative, or the patient may be endangered by treating the person as the personal representative; and the provider determines, in the exercise of professional judgment, that it is not in the best interests of the patient to treat the person as the personal representative. See 45 CFR 164.502(g)(5).

See Guidance on Sharing Information Related to Mental Health, https://www.hhs.gov/hipaa/for- professionals/special-topics/mental-health/index.html

Guidance on Personal Representatives, https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html

Does HIPAA require a mental health provider to let a patient know that the provider is going to share information with others before disclosing PHI to prevent or lessen a serious and imminent threat?

Not at the time of disclosure; however, the Notice of Privacy Practices should contain an example of this type of disclosure so patients are informed in advance of that possibility. See 45 CFR 164.520(b). In situations that also involve reports to the appropriate government authority that the patient may be an adult victim of abuse, neglect, or domestic violence, the mental health provider must promptly inform the patient that a report has been or will be made, unless:

- informing the patient would create a danger to the patient; or
- the provider would be informing a personal representative, and the provider reasonably believes the

personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the patient is determined by the provider, in the exercise of professional judgment. See 45 CFR 164.512(c).

Other standards, such as clinical protocols, ethics rules, or state laws, may also be applicable to patient notification about disclosures in situations involving threats of imminent harm.

SUBSTANCE USE DISORDER TREATMENT

How does HIPAA interact with the federal confidentiality rules for information about substance use disorder treatment, including treatment for opioid abuse, in an emergency situation—which rules should be followed?

A health provider that provides treatment for substance use disorders, including opioid abuse, needs to determine whether it is subject to 42 CFR Part 2 (i.e., a "Part 2 program") and whether it is a covered entity under HIPAA. Generally, the Part 2 rules provide more stringent privacy protections than HIPAA, including in emergency situations. If an entity is subject to both Part 2 and HIPAA, it is responsible for complying with the more protective Part 2 rules, as well as with HIPAA. HIPAA is intended to be a set of minimum federal privacy standards, so it generally is possible to

comply with HIPAA and other laws, such as 42 CFR Part 2, that are more protective of individuals' privacy.

For example, HIPAA permits disclosure of protected health information (PHI) for treatment purposes (including in emergencies) without patient authorization, and allows PHI to be used or disclosed to lessen a threat of serious and imminent harm to the health or safety of the patient or others (which may occur as part of a health emergency) without patient authorization or permission. Because HIPAA permits, but does not require, disclosures for treatment or to prevent harm, if Part 2 restricts certain disclosures during an emergency, an entity subject to both sets of requirements could comply with Part 2's restrictions without violating HIPAA.

For more information about applying 42 CFR Part 2 in an emergency, see https://www.samhsa.gov/about- us/who-we-are/laws-regulations/confidentiality-regulations-faqs

5. Professional Ethics

5A. CAMFT CODE OF ETHICS UPDATED AND REVISED (2019)

The CAMFT Code of Ethics was updated in December of 2019. The following includes some of the highlighted revisions, additions, and adjustments along with relevant discussion. This is followed by the complete 2019 CAMFT Code of Ethics.

According to Michael Griffin, JD, LCSW, CAMFT Staff Attorney, "In revising the Code of Ethics, a fundamental goal of the Ethics Committee was to ensure that the resulting ethical guidelines provide a clear and practical source of guidance to members of the Association. Depending on the particular code section, the revisions may be limited in scope, such as minor changes to Section 1.5, which simply clarifies that termination (if conducted appropriately) is permissible for non-payment of fees. In other instances, the changes are substantial, such as the content of Section 3, which integrates multiple issues applicable to the broad topic of informed consent and disclosure that were previously located in several sections of the Code of Ethics, or the multi-faceted guidance that is now provided in section 4 concerning Dual/Multiple Relationships." (*Our New Ethical Standards A*

Closer Look at the Revised CAMFT Code of Ethics Part I, CAMFT, Michael Griffin, JD, LCSW, CAMFT Staff Attorney, May 5, 2020)

This section focuses on portions of the Code of Ethics that are significantly revised or new additions.

PART I - THE STANDARDS

The following preamble was added to the Code of Ethics:

ETHICAL DECISION-MAKING

Marriage and family therapists recognize that ethical decision-making principles may be based on higher standards for their conduct than legal requirements and that they must comply with the higher standard. Marriage and family therapists act with integrity and truthfulness, ensure fairness and non-discrimination, and promote the well-being of their clients/patients within the larger society. Marriage and family therapists avoid actions that cause harm and recognize that their clients/patients control their own life choices.

Marriage and family therapists should be familiar with models of ethical decision-making and continuously develop their skills to recognize when an ethical conflict exists. Marriage and family therapists utilize consultation and stay current with the relevant research and literature about these processes. Marriage and family therapists reflect on ethical issues that arise within their practice and within the context of their legal responsibilities, ethical standards, and personal values, and develop congruent plans for action and resolution.

The Need for a New Preamble to the Code of Ethics

The new preamble to the Code of Ethics, entitled "Ethical Decision Making," provides "an over-arching aspirational statement, encompassing the core values of the marriage and family therapy profession, as they are expressed throughout the Code of Ethics." (*Our New Ethical Standards A Closer Look at the Revised CAMFT Code of Ethics Part I*, CAMFT, Michael Griffin, JD, LCSW, CAMFT Staff Attorney, May 5, 2020)

1.1 NON-DISCRIMINATION:

Marriage and family therapists do not condone or engage in discrimination, or refuse professional service to anyone on the basis of race, ethnicity, national origin, indigenous heritage, immigration status, gender, gender identity, gender expression, religion, national origin, age, sexual orientation, disability, socioeconomic status, or marital/relationship status. Marriage and family therapists make reasonable efforts to accommodate clients/ patients who have physical disabilities. (See also sections 3.2 Therapist Disclosures, 3.7 Therapist Professional Background, and 5.11 Scope of Competence.)

Summary of Section 1.1 Changes:

The new Section 1.1 changes discusses discrimination at a more in depth and specific level. It discusses the fact that discrimination or the refusal of professional services may not be based upon a person's ethnicity, indigenous heritage, or immigration status. Section 1.1 also adds "See also," which directs the reader to other applicable sections of the Code: (3.2 Therapist Disclosures, 3.7 Therapist Professional Background, and 5.11 Scope of Competence). "See also," demonstrates that clinicians should be aware of other applicable sections of the Code of Ethics when they are contemplating termination or refusal of services.

New Section 1.4

1.4 TERMINATION:

Marriage and family therapists use sound clinical judgment when terminating therapeutic relationships. Reasons for termination may include, but are not limited to, the client/patient is not benefiting from treatment, continuing treatment is not clinically appropriate, the therapist is unable to provide treatment due to the therapist's incapacity or extended absence, or due to an otherwise unresolvable ethical conflict or issue. (See also sections 3.8 Client/Patient Benefit and 5.11 Scope of Competence.)

The Need for a New Section 1.4

The new section 1.4 uses some wording from Section 1.3.1 of the previous Code of Ethics which highlights that the manner and process when

terminating should be based upon the clinician's sound clinical judgment. According to Michael Griffin, JD, LCSW, CAMFT Staff Attorney, "Furthermore, in contrast to the language of former Section 1.3.1, which stated that termination may occur 'in order to avoid' an ethical conflict, the Committee believed that it was clearer, and more instructive, to state that termination may be appropriate 'due to an otherwise unresolvable ethical conflict.' Section 1.4 also utilizes 'See also,' which alerts the reader to other relevant sections of the Code: (3.8 Client/ Patient Benefit and 5.11 Scope of Competence.)"

New Section 1.5

1.5 NON-PAYMENT OF FEES:

When terminating client/patient relationships due to non-payment of fees, marriage and family therapists do so in a clinically appropriate manner.

The Need for a New Section 1.5

Section 1.5 now includes wording from Section 1.3.4 of the previous Code of Ethics and provides further clarification that a therapist may ethically terminate a therapeutic relationship for non-payment of fees, if done in a clinically and ethically appropriate manner.

New Section 1.10

1.10 TREATMENT PLANNING:

Marriage and family therapists work with clients/ patients to develop and review treatment plans that are consistent with client/patient goals and that offer a reasonable likelihood of client/ patient benefit.

The Need for a New Section 1.10

The new Section 1.10 uses wording from Section 1.4.1 of the previous Code of Ethics and now includes the use of "Treatment Planning" as the new title because this section focuses on the importance of developing treatment plans that are "reasonably likely to be beneficial to the client/ patient and which are consistent with the client's/ patient's goals." The adjustment is a result of the Ethics Committee wanting to emphasize the "importance of treatment

planning in general, and the need for the therapist and their client/patient to collaborate in creating treatment plans.The client's/patient's treatment record ought to reflect the therapist's assessment of the client's/patient's needs and concerns, and their effort to work with the client/patient in determining appropriate goals and objectives."

2.4 EMPLOYEES—CONFIDENTIALITY:

Marriage and family therapists take appropriate steps to ensure, insofar as possible, that the confidentiality of clients/patients is maintained by their employees, supervisees, assistants, volunteers, and business associates.

The Need for a New Section 2.4

Section 2.4 uses wording from Section 2.5 of the previous Code of Ethics and now includes the term "business associates." Under the Health Insurance and Portability Act of 1996 (HIPAA), therapists who engage in certain transactions with third-party payers are considered to be "covered entities." A "covered entity" may disclose confidential information to a business associate (a person or entity) that performs functions or activities that involve the use or disclosure of protected health information on behalf of that entity.

New Section 3 and Preamble

3. INFORMED CONSENT AND DISCLOSURE: (New Preamble)

Marriage and family therapists respect the fundamental autonomy of clients/patients and support their informed decision-making. Marriage and family therapists assess their client's/patient's competence, make appropriate disclosures, and provide comprehensive information so that their clients/patients understand treatment decisions.

The Need for a New Preamble to Section 3

The new preamble to Section 3 emphasizes the importance informing clients/patients of adequate and relevant information in order to contribute to their informed participation in therapy. This new preamble incorporates

information that was previously located in multiple sections of the prior Code of Ethics.

New Section 3.1

3.1 INFORMED DECISION-MAKING:

Marriage and family therapists respect the rights of clients/patients to choose whether to enter into, to remain in, or to leave the therapeutic relationship. When significant decisions need to be made, marriage and family therapists provide adequate information to clients/patients in clear and understandable language so that clients/patients can make meaningful decisions about their therapy.

The Need for a New Section 3.1

Section 3.1 uses wording from Section 1.5 of the previous Code of Ethics. The title of Section 3.1 was changed from "Therapist Disclosures," to "Informed Decision-Making," in order to emphasize the importance of a client's right to make decisions about their therapy.

New Section 3.2

3.2 THERAPIST DISCLOSURE:

When a marriage and family therapist's personal values, attitudes, and/or beliefs are a prejudicial factor in diagnosing or limiting treatment provided to a client/patient, the marriage and family therapist shall disclose such information to the client/patient or facilitate an appropriate referral in order to ensure continuity of care.

The Need for a New Section 3.2

Section 3.2 uses wording from Section 1.5.1 of the previous Code of Ethics. This section clarifies that a therapist is "only expected to provide disclosures to a client/patient regarding the therapist's personal values, attitudes and/or beliefs, (or to facilitate an appropriate referral), if the therapist believes that their values, attitudes and/or beliefs are a prejudicial factor in diagnosing or limiting treatment to the client/patient."

New Section 3.4

3.4 EMERGENCIES/CONTACT BETWEEN SESSIONS:

Marriage and family therapists inform clients/patients of the extent of their availability for emergency care between sessions.

The Need for a New Section 3.4

The new Section 3.4 emphasizes the importance of providing emergency services to clients/patients in-between sessions, and uses wording from Section 1.5.3 of the previous Code of Ethics. The previous Section 1.5.3 addressed circumstances when the therapist "is not located in the same geographic area as the patient," and this is now addressed in Section 6 of the Code of Ethics, which concerns the topic of Telehealth.

New Section 3.11

3.11 TREATMENT ALTERNATIVES:

Marriage and family therapists discuss appropriate treatment alternatives with clients/ patients. When appropriate, marriage and family therapists advocate for the mental health care they believe will benefit their clients/ patients. Marriage and family therapists do not limit their discussions of treatment alternatives to what is covered by third-party payers.

The Need for a New Section 3.11

Section 3.11 uses language from Sections 1.12 and 1.13 of the previous Code of Ethics, and now includes wording which addresses advocating for mental health care on behalf of client/patients. It clarifies that "therapists are not ethically obligated to advocate for mental health care on behalf of clients/patients, but may engage in such advocacy, as they are often in a position to determine whether such services may benefit the client.' This new section also highlights the importance of discussing treatment alternatives with clients.

New Section 3.12

3.12 DOCUMENTING TREATMENT RATIONALE/CHANGES:

Marriage and family therapists document treatment in their client/patient records, such as major changes to a treatment plan, changes in the unit being treated and/or other significant decisions affecting treatment.

The Need for a New Section 3.12

The new Section 3.12 emphasizes the importance that significant changes to a client's treatment plan, and decisions affecting a person's treatment (such as changes in the unit of treatment) needs to be documented. According to Michael Griffin, JD, Staff Attorney, "In light of the fact that documentation of treatment is a legal and an ethical duty, language that was located in Section 1.15 of the prior Code of Ethics ("Documenting Treatment Decisions"), which merely encouraged marriage and family therapists to carefully document treatment was not included in this new section. The Committee also decided not to carry over language from the prior Code of Ethics regarding the documentation of suspected child abuse, or elder or dependent abuse, in order to clarify that mandated reporters have discretion whether to document their decisions related to mandatory reporting. The Child Abuse and Neglect Reporting Act provides protection to mandated reporters by stating that the identity of the mandated reporter must be kept confidential and may only be disclosed as specified in the law, unless authorized by the mandated reporter or by a court order."

New Section 4 and Preamble

4. DUAL/MULTIPLE RELATIONSHIPS:

(Preamble) Marriage and family therapists establish and maintain professional relationship boundaries that prioritize therapeutic benefit and safeguard the best interest of their clients/patients against exploitation. Marriage and family therapists engage in ethical multiple relationships with caution and in a manner that is congruent with their therapeutic role.

Need for A New Section 4 and Preamble

The new preamble to Section 4 emphasizes the importance of therapists being mindful of the best interests of their clients, and to "exercise due care", when considering the possibility of dual/multiple relationships with clients/patients. This section addresses the general topic of dual/ multiple relationships. According to Michael Griffin, JD, Staff Attorney, "It was created to provide an expanded, and better integrated discussion of various issues that are relevant to this topic. This new section is also intended to provide ethical standards that are more specific and which offer improved guidance to therapists, compared to the prior Code of Ethics."

New Section 4.1

4.1 DUAL/MULTIPLE RELATIONSHIPS:

Dual /multiple relationships occur when a therapist and his/her client/patient concurrently engage in one or more separate and distinct relationships. Not all dual/ multiple relationships are unethical, and some need not be avoided, including those that are due to geographic proximity, diverse communities, recognized marriage and family therapy treatment models, community activities, or that fall within the context of culturally congruent relationships. Marriage and family therapists are aware of their influential position with respect to clients/ patients, and avoid relationships that are reasonably likely to exploit the trust and/or dependence of clients/patients, or which may impair the therapist's professional judgment.

The Need for A New Section 4.1

The new Section 4.1 provides further clarification about dual/multiple relationships, and addresses the misconception that all dual/ multiple relationships are unethical. The new Section 4.1 uses and expands upon language that was previously located in Sections 1.2 and 1.2.1 of the former Code of Ethics. According to Michael Griffin, JD, Staff Attorney, "As an example, Section 4.1 clarifies that, in some circumstances, a dual/ multiple relationship may be unavoidable, or permissible, including those that are based upon: Geographic proximity, (where engaging the client/patient in the community may be unavoidable by virtue of residing or working in the same

location); Diverse communities, (where therapists and clients/patients engage in close-knit activities based upon their mutual affiliation with a particular group or community); Recognized marriage and family therapy treatment models that require activities outside of the traditional therapist role (such as a therapist who assumes a supervisory role while working in a substance abuse treatment setting, or, who works in a community mental health treatment model which incorporates therapists into activities that are outside of the treatment setting. Examples of the latter may include, accompanying the client/patient to court, to seek health care or to secure social services); Community activities (where the therapist participates in an activity that the client/ patient happens to be involved in, such as a food drive, or a clean-up effort at a local beach), and, activities which fall within the context of culturally congruent relationships, (such as instances where the therapist's participation in an activity is important or meaningful to the client/patient, such as attending an adolescent's Quinceañera or similar event)."

New Section 4.2

4.2 ASSESSMENT REGARDING DUAL/ MULTIPLE RELATIONSHIPS:

Prior to engaging in a dual/multiple relationship, marriage and family therapists take appropriate professional precautions which may include, but are not limited to the following: obtaining the informed consent of the client/ patient, consultation or supervision, documentation of relevant factors, appraisal of the benefits and risks involved in the context of the specific situation, determination of the feasibility of alternatives, and the setting of clear and appropriate therapeutic boundaries to avoid exploitation or harm.

The Need for a New Section 4.2

- Therapist may be faced with many dual/multiple relationship possibilities.
- Therapists are expected to take appropriate professional precautions to avoid the possibility of exploitation or harm to the client/patient.

Section 4.2 provides guidance to therapists including examples of precautions for therapists to consider when assessing whether it may be appropriate to enter into a dual/multiple relationship with a client.

According to Michael Griffin, JD, Staff Attorney, "As an example, obtaining informed consent from the client/patient can help that person make an informed decision regarding their relationship with the therapist; Consultation or supervision may provide a therapist with objective input from a colleague or other professional regarding relevant clinical, legal or ethical issues; Thorough documentation by the therapist may help to clarify the therapist's rationale, justification and appraisal of risks, benefits, and alternatives, and illuminate their efforts to establish clear and appropriate boundaries in order to avoid exploitation or harm to the client/patient."

New Section 4.3

4.3 UNETHICAL DUAL/MULTIPLE RELATIONSHIPS:

Acts that could result in unethical dual relationships include, but are not limited to, borrowing money from a client/ patient, hiring a client/patient, or engaging in a business venture with a patient, or engaging in a close personal relationship with a client/ patient. Such acts with a client's/patient's spouse, partner or immediate family member are likely to be considered unethical dual relationships.

The Need for a New Section 4.3

Section 4.3 now includes wording from Section 1.2.1 of the previous CAMFT Code of Ethics. This section emphasizes that unethical dual/ multiple relationships between a therapist and a client's spouse, partner or immediate family member are likely to be considered unethical. According to Michael Griffin, JD, Staff Attorney, "The Committee believed that it was appropriate to clarify that the application of this standard to immediate family members was reasonable and that therapists should not be restricted from engaging in a relationship with a person merely because that individual is related to the client/patient."

New Section 4.4

4.4 NON-PROFESSIONAL RELATIONSHIPS WITH FORMER CLIENTS/PATIENTS:

Prior to engaging in a non-sexual relationship with former clients/ patients, marriage and family therapists take care to avoid engaging in interactions which may be exploitive or harmful to the former client/patient. Marriage and family therapists consider factors which include, but are not limited to, the potential continued emotional vulnerability of the former client/patient, the anticipated consequences of involvement with that person, and the elimination of the possibility that the former client/patient resumes therapy in the future with that therapist.

The Need for a New Section 4.4

The new Section 4.4 addresses issues which specifically apply to dual/ multiple relationships with former clients/patients. According to Michael Griffin, JD, Staff Attorney, “First of all, the Committee believed that it was necessary to provide clearer language and improved guidance on this topic than that which was provided by Section 1.2 of the prior Code of Ethics, which stated that a dual relationship was a separate or distinct relationship with the client/patient which was entered into ‘either simultaneously with the therapeutic relationship, or during a reasonable period of time following the termination of the therapeutic relationship.’ Because such language may have caused some confusion, due to the ambiguous meaning of what constitutes ‘a reasonable period of time,’ it was not included in the new Section 4.4. The Committee believed that a primary consideration for a therapist who is contemplating a relationship with a former client/patient, is whether the relationship may lead to exploitation or harm to the former client/patient. Section 4.4 therefore provides therapists with a number of factors to consider when making such a determination, including: The potential continued emotional vulnerability of the former client/patient and the anticipated consequences of entering into a post-therapy relationship with that individual, including, but not limited to, the possibility that a post-therapy relationship may preclude the resumption of therapy with that person in the future. The fact that it is not uncommon for former clients/

patients to request services from their therapist at some point in time after termination occurs, should be a significant consideration for therapists when deciding whether to enter into a post-therapy relationship with a former client/patient."

New Section 4.5

4.5 SEXUAL CONTACT:

Sexual contact includes, but is not limited to sexual intercourse, sexual intimacy, and sexually explicit communications without a sound clinical basis and rationale for treatment. Sexual contact with a client/patient, or a client's/patient's spouse or partner, or a client's/patient's immediate family member, during the therapeutic relationship, or during the two years following the termination of the therapeutic relationship, is unethical. Prior to engaging in sexual intimacy contact with a former client/patient or a client's/patient's spouse or partner, or a client's/patient's immediate family member, following the two years after termination or last professional contact, the therapist shall consider factors which include, but are not limited to, the potential harm to or exploitation of the former client/patient or to the client's/patient's family, the potential continued emotional vulnerability of the former client/patient, and the anticipated consequences of involvement with that person. (See also section 7.2 Sexual Contact with Supervisees and Students.)

The Need for a New Section 4.5

The new Section 4.5 addresses Section 1.2.2 of the previous Code of Ethics. The new Section 4.5 requires therapists to evaluate several considerations prior to engaging in a sexual relationship with a former client/patient, a client's/patient's spouse or partner, or a client's patient's immediate family member, as opposed to former Section 1.2.2, which stated: "Should a marriage and family therapist engage in sexual intimacy..." According to Michael Griffin, JD, Staff Attorney, "Also, Section 4.5 requires therapists to undertake the same professional precautions that are applicable to non-professional relationships with former clients/patients, (as expressed in Section 4.4), by requiring therapists to avoid the potential harm to, or

exploitation of, the former client/patient, or their spouse or immediate family member, by assessing the potential continued emotional vulnerability of the former client/patient, and the anticipated consequences of involvement with that person." In addition, a significant addition to Section 4.5, is language which clarifies that sexual contact includes, "sexually explicit communications without a sound clinical basis and rationale for treatment." This added language takes into consideration that sexual intimacy may include electronic communications with a person that convey sexually explicit content. However, this ethical standard is not meant to preclude the use of sexually explicit communications by a therapist when there is a sound clinical basis for such communications, such as circumstances where a therapist is discussing sexual behaviors with a client/patient, as an appropriate part of that person's treatment plan. Section 4.5 also utilizes "See also," which alerts the reader to other relevant sections of the Code: (7.2 Sexual Contact with Supervisees and Students.)"

New Section 4.6

4.6 PRIOR SEXUAL RELATIONSHIP:

A marriage and family therapist does not enter into a therapeutic relationship with a person with whom the therapist has had a sexual relationship or knowingly enter into a therapeutic relationship with a partner or immediate family member of a person with whom the therapist has had a sexual relationship.

The Need for A New Section 4.6

According to Michael Griffin, JD, Staff Attorney, "Section 4.6 recognizes that there may be circumstances where a therapist is not aware of the fact that they are treating the partner or immediate family member of someone with whom they have had a sexual relationship. This section therefore clarifies that a therapist is prohibited from knowingly entering into a therapeutic relationship with someone with whom the therapist has had a sexual relationship."

New Section 4.8

4.8 NON-THERAPIST ROLES:

Marriage and family therapists when engaged in professional roles other than treatment or supervision (including, but not limited to, managed care utilization review, consultation, coaching, adoption service, child custody evaluation, or behavior analysis), act solely within that role and clarify, as necessary in order to avoid confusion with consumers and employers, how that role is distinguished from the practice of marriage and family therapy.

The Need for a New Section 4.8

According to Michael Griffin, JD, Staff Attorney, "Section 4.8 contains language from Section 1.16 of the prior Code of Ethics, with the addition of "child custody evaluation" to the list of non-therapist roles. This change is in recognition of the fact that marriage and family therapists often assume the role of child custody evaluators."

New Section 5.1

5.1 CONVICTION OF A CRIME

Marriage and family therapists are in violation of this Code and subject to termination of membership, or other appropriate action, if they: are convicted of a crime substantially related to their professional qualifications or functions, are expelled from or disciplined by other professional organizations, or have licenses or certificates that are lapsed, suspended, or revoked, or are otherwise disciplined by regulatory bodies.

The Need for a New Section 5.1

The new Section 5.1 now contains wording from section 3.1 of the previous Code of Ethics. Practicing while impaired due to physical or mental causes and/or the abuse of alcohol and/or other substances is located in section 5.5 Practicing While Impaired.

New Section 5.3

5.3 CLIENT/PATIENT RECORDS

Marriage and family therapists create and maintain client/patient records consistent with sound clinical judgment, standards of the profession, and the nature of the services being rendered.

The Need for a New Section 5.3

The new Section 5.3 now contains wording formerly located in section 3.3 of the previous Code of Ethics. However, updated language is now added that addresses requirements for marriage and family therapists creating and maintaining client/patient records (Business & Professions Code, §4982v).

New Section 5.5

5.5 PRACTICING WHILE IMPAIRED

Marriage and family therapists do not practice when their competence is impaired because of physical or psychological causes or the use of alcohol or other substances.

Why Is There a New Section 5.5?

A distinct section has been created to address the topic of practicing while impaired in order to emphasize the importance of this problem**.**

New Section 5.7

5.7 SENSITIVITY TO DIVERSITY

Marriage and family therapists actively strive to identify and understand the diverse backgrounds of their clients/patients by obtaining knowledge, gaining personal awareness, and developing sensitivity and skills pertinent to working with a diverse client/patient population.

The Need for a New Section 5.7

The new Section 5.7 now includes wording previously located in section 3.6 of the previous Code of Ethics. According to Michael Grifin, JD, LCSW, CAMFT Staff Attorney, “A significant change is that the word “culture” in the title of the section has been changed to “diversity” to reflect a broader sensitivity to all forms of diversity. While “culture” may be viewed as

pertaining only to race or nationality, “diversity” includes factors that may be unique to the client/patient such as race, gender, sexual orientation, religious beliefs, disability, and socioeconomic status.” (*A Closer Look at the Revised CAMFT Code of Ethics: Part II*, The Therapist, September/October 2020.)

New Section 5.8

5.8 GIFTS

Marriage and family therapists carefully consider the clinical and cultural implications of giving and receiving gifts or tokens of appreciation. Marriage and family therapists take into account the value of the gift, the effect on the therapeutic relationship, and the motivations of the client/patient and the psychotherapist for giving, receiving, or declining the gift.

The Need for a New Section 5.8

The topic of gifts has become a common source or discussion and confusion within the mental health and social work community. According to Michael Grifin, JD, LCSW, CAMFT Staff Attorney, *“*While it is not unethical, per se, for a therapist to give a gift to a client/patient or to receive one, it is always important to consider the relevant clinical and cultural implications. For example, an individual may offer a gift to the therapist as part of a cultural tradition, or the therapist’s refusal of a gift from a client/patient may be experienced as a personal rejection and prove harmful to the therapeutic relationship.” (*A Closer Look at the Revised CAMFT Code of Ethics: Part II*, The Therapist, September/October 2020.)

New Section 5.12

5.12 DUPLICATION OF THERAPY

Marriage and family therapists do not generally duplicate professional services to a prospective client/patient who is already receiving treatment from another psychotherapist. When making a determination to provide services, marriage and family therapists carefully consider the needs, presenting treatment issues, and welfare of the client/patient to minimize potential confusion and/or conflict. Prior to rendering services to the

prospective client/patient, marriage and family therapists address these issues, including the nature of the client's/ patient's relationship with the other treating psychotherapist and whether consultation with the other psychotherapist is appropriate.

The Need for a New Section 5.12

The new Section 5.12 addresses the issue of a client having more than one therapist. The newly outlined standards are more flexible than in the former section 3.10 of the previous Code of Ethics. For the most part, it prohibited more than one therapist seeing the same client without an agreement between the therapists. According to Michael Grifin, JD, LCSW, CAMFT Staff Attorney, "A significant change is that section 5.12 provides that consultation with the other therapist in these circumstances in now elective rather than required. This section also requires the therapist to consider the prospective client's/ patient's needs and input, as well as their relationship with the other therapist, when deciding whether to provide services."(*A Closer Look at the Revised CAMFT Code of Ethics: Part II*, The Therapist, September/October 2020.)

New Section 5.13

5.13 PUBLIC STATEMENTS

Because of their ability to influence and alter the lives of others, marriage and family therapists exercise caution when making public their professional recommendations or opinions through testimony, social media, Internet content, or other public statements.

The Need for a New Section 5.13

The new Section 5.13 retains the wording of the former section 3.10 of the previous Code of Ethics with the addition of more current wording such as "social media" and "Internet content."

New Section 5.14

5.14 LIMITS OF PROFESSIONAL OPINIONS

Marriage and family therapists do not express professional opinions about an individual's psychological condition unless they have treated or conducted an examination and assessment of the individual, or unless they reveal the limits of the information upon which their professional opinions are based with appropriate cautions as to the effects of such limited information on their opinions. (See also section 10.7 Professional Opinions in Court-Involved Cases.)

The Need for a New Section 5.14

The new Section 5.14 contains wording from the former section 3.14 of the previous Code of Ethics. However, it now contains the wording "psychological conditions" instead of "mental and emotional disorders" in order to update the wording thereby making it more applicable to mental, emotional, and behavioral disorders. The new Section 5.14 also now indicates that section 10.7 should additionally also be evaluated when the issue involves the professional opinions related to court cases**.**

New Section 6

6. TELEHEALTH (NEW PREAMBLE)

Marriage and family therapists recognize that ongoing technological developments promote availability and access to healthcare and expand opportunities to provide their services outside of the therapy office. When utilizing telehealth to provide services to clients/ patients, marriage and family therapists consider the welfare of the client/patient and the appropriateness and suitability of the modality in meeting the client's/ patient's needs. They make appropriate disclosures to the client/patient regarding the use of telehealth, exercise reasonable care when utilizing technolo**g**y, and remain current with the relevant laws and regulations.

The Need for a New Section 6 and Preamble

The new Section 6 became necessary in order to expand important guidelines on the growing field of telehealth. It includes wording from several former sections of the previous Code of Ethics. The new preamble for section 6 now addresses considerations for therapists to consider when

contemplating the use of telehealth while emphasizing actions that therapists should take.

New Section 6.1

6.1 TELEHEALTH

Marriage and family therapists take precautions to meet their responsibilities to clients/patients who are not physically present during the provision of therapy. Prior to utilizing telehealth, marriage and family therapists consider the appropriateness and suitability of this therapeutic modality in meeting the client's/patient's needs. This includes consideration of factors such as the client's/patient's familiarity with the modality, the issues to be addressed, and the therapeutic orientation. Marriage and family therapists then employ telehealth competently.

The Need for a New Section 6.1

The new Section 6.1 includes wording from the former section 1.4.2 of the previous Code of Ethics. However, it no contains more specific language regarding the therapist's fundamental considerations when evaluating the benefit of telehealth for clients. The new wording is consistent with the requirements contained in regulations 6 C.C.R. §1815.5, California's Standards of Practice for Telehealth.

New Section 6.2

6.2 COMPLIANCE WITH TELEHEALTH LAWS

Marriage and family therapists are familiar with the state and federal laws governing telehealth and ensure compliance with all relevant laws prior to engaging in telehealth

The Need for a New Section 6.2

The new Section 6.2 addresses the fact that therapists must be fluent in the applicable federal and state laws when practicing telehealth. In addition to the California regulations (16 C.C.R. §1815.5), the Health Insurance and Portability Accountability Act (HIPAA) addresses legal requirements related

to the security and privacy of electronically transmitted private health information.

New Section 6.3

6.3 DISCLOSURES

Marriage and family therapists inform clients/patients of the potential risks, consequences, and benefits of the telehealth modality, including but not limited to issues of confidentiality, clinical limitations, and transmission/ technical difficulties.

The Need for a a New Section 6.3

The new Section 6.3 uses wording from the former section 1.4.2 of the previous Code of Ethics. However, this new section eliminates the wording "ability to respond to emergencies,". This issue now is categorized under clinical limitations.

New Section 7.1

7.1 MAINTAINING PROFESSIONAL BOUNDARIES WITH SUPERVISEES AND STUDENTS

Marriage and family therapists are aware of their influential position with respect to their students and supervisees, and they avoid exploiting the trust and dependency of such persons. Marriage and family therapists, therefore, avoid engaging in relationships with supervisees and students (over whom they exercise professional authority) that are likely to impair professional judgment or lead to exploitation. It is unethical for a supervisor or educator to provide therapy to students or supervisees over whom they exercise professional authority, and it is unethical to provide marriage and family therapy supervision to clients/patients. Other acts that are likely to be unethical include, but are not limited to, borrowing money from a supervisee, engaging in a business venture with a supervisee, and engaging in a close personal relationship with a supervisee or student. Such acts with a supervisee's spouse, partner, or immediate family member may also be considered unethical dual relationships.

The Need for a New Section 7.1

The new Section 7.1 uses language from the former section 4.1 of the previous Code of Ethics. The new wording now emphasizes the importance of maintaining professional boundaries with supervisees and students. According to Michael Grifin, JD, LCSW, CAMFT Staff Attorney, "Although this section does not express a blanket prohibition of dual/multiple relationships between supervisors/educators and supervisees/students, it clarifies that supervisors and educators should avoid engaging in dual relationships with supervisees and students over whom they exercise professional authority where such relationships are likely to impair the professional judgment of the supervisor/ educator or lead to exploitation of the supervisee/student. As in the former CAMFT Code of Ethics, this section also cautions supervisors against engaging in certain relationships (such as a close personal friendship or a business venture) with a supervisee's spouse or close family member." (*A Closer Look at the Revised CAMFT Code of Ethics: Part II*, The Therapist, September/October 2020.)

New Section 7.2

7.2 SEXUAL CONTACT WITH SUPERVISEES AND STUDENTS

Marriage and family therapists do not engage in sexual contact with supervisees or students over whom they exercise professional authority. Prohibited sexual contact includes, but is not limited to, sexual intercourse, sexual intimacy, and sexually explicit communications that have no sound clinical, supervisory, or educational basis. Such acts with the spouse, partner, or immediate family member of a supervisee or student are likely to be unethical and exploitive. (See also section 4.5 Sexual Contact.)

The Need for a New Section 7.2

The new Section 7.2 uses wording from the former section 4.1 of the previous Code of Ethics which prohibits supervisors from engaging in any sexual activity/contact with supervises or students. It additionally defines sexual contact as including "sexually explicit communications that have no sound clinical, supervisory, or educational basis". This section also alerts the reader to the fact that section 4.5 Sexual Contact is relevant to this topic. (*A*

Closer Look at the Revised CAMFT Code of Ethics: Part II, The Therapist, September/October 2020.)

New Section 7.4

7.4 COMPETENCE OF SUPERVISEES

Marriage and family therapists ensure that the extent, quality, and kind of supervision provided is consistent with the education, training, and experience level of the supervisee. Marriage and family therapists do not permit their students, employees, or supervisees to perform or hold themselves out beyond their pre-licensed status or to perform professional services beyond their scope of competence.

The Need for a New Section 7.4

The new Section 7.4 uses wording from the former section 4.2 of the previous Code of Ethics. It now additionally, includes the wording "education, training, and experience level" to further clarify the scope of competence.

New Section 7.6

7.6 KNOWLEDGE OF LAWS AND REGULATIONS

Supervisors and supervisees have a responsibility to be knowledgeable about relevant laws and regulations pertaining to the practice of marriage and family therapy.

The Need for a New Section 7.6

The new Section 7.6 includes wording from former sections 4.4 and 4.1 of the previous Code of Ethics. Additionally, there are now revisions that specify that supervisors are expected to be knowledgeable about laws and regulations that pertain to the practice of marriage and family therapy.

New Section 7.7

7.7 CHANGES IN LEGAL REQUIREMENTS AND ETHICAL STANDARDS

Supervisors maintain awareness of and stay current with changes in professional and ethical standards and legal requirements. Supervisors ensure that their supervisees are aware of professional and ethical standards and legal responsibilities.

The Need for a New Section 7.7

The new Section 7.7 includes wording from the former section 4.5 of the previous Code of Ethics. However, there is now more specific wording that supervisors need to stay current with changing legal and ethical standards.

New Section 7.11

7.11 BUSINESS PRACTICES

When acting as employers and/or supervisors, marriage and family therapists follow lawful business practices.

The Need for a New Section 7.11

The new Section 7.11 includes wording from the former section 4.9 of the previous Code of Ethics. Specifically, in indicates that therapists must follow lawful business practices when in the role of an employer and/or supervisor. The therapist's ethical duties that may conflict with the Code of Ethics is discussed in section 9.1.

New Section 7.12

7.12 BARTERING WITH SUPERVISEES

Marriage and family therapists ordinarily refrain from accepting goods or services from supervisees in return for services rendered because of the potential for conflict, exploitation, and/or distortion of the professional relationship. Bartering should only be considered and conducted if the supervisee requests it, the bartering is not otherwise exploitive or detrimental to the supervisory relationship, and it is negotiated without coercion. Marriage and family therapists are responsible for ensuring that such arrangements are not exploitive and that a clear written agreement is created. Marriage and family therapists are encouraged to consider the relevant social and/or cultural implications of bartering, including whether it is an accepted

practice among professionals within the community. (For bartering with clients/patients, see also section 12.5 Bartering.)

The Need for a New Section 7.12

The new Section 7.12 is a new addition but shares similarities with the wording from section 12.5. Section 12.5 contains updated wording on bartering with clients and specifies that bartering should only be considered if "the supervisee requests it; if the agreement is clear, fairly negotiated, and nonexploitive; and, perhaps most importantly, if it is not detrimental to the supervisory relationship." (*A Closer Look at the Revised CAMFT Code of Ethics: Part II*, The Therapist, September/October 2020.)

New Section 7.13

7.13 PERFORMANCE ASSISTANCE

Supervisors guide supervisees in securing assistance, such as personal psychotherapy, education, training, or consultation, when needed for the supervisee to maintain or improve performance. Supervisees have the responsibility to seek information and to ask for supervisorial guidance when necessary.

The Need for a New Section 7.13

The New Section 7.13 uses wording from the former section 4.10 of the previous Code of Ethics. Additionally, there are revisions which include wording expressing that supervisees are expected to seek out information and supervisorial guidance when needed.

New Section 7.17

7.17 SUPERVISOR QUALIFICATIONS

Supervisors maintain licensure and meet/ satisfy the qualifications, laws, and regulations that pertain to supervision.

The Need for a New Section 7.17

The new Section 7.17 underscores the need for supervisors to meet all necessary requirements.

New Section 7.18

7.18 SUPERVISEE REGISTRATION AND LIMITED ROLE

Supervisees maintain registrations when required by law and/or regulation and function within this limited role as permitted by licensing laws and/or regulations.

The Need for a New Section 7.18

The new Section 7.18 became necessary in order to emphasize the supervisees responsibilities in meeting all applicable requirements.

New Section 8.3

8.3 ETHICAL COMPLAINTS AGAINST COLLEAGUES

Marriage and family therapists are encouraged to take reasonable actions to resolve disputes with colleagues before filing an ethics complaint. Reasonable measures may include addressing the matter with the colleague, consultation, and/or mediation. Marriage and family therapists do not file or encourage the filing of ethics or other complaints that they know, or reasonably should know, are frivolous.

The Need for a New Section 8.3

The new Section 8.3 is intended to encourage therapists, whenever possible, to "pursue reasonable measures to resolve disputes with colleagues prior to filing an ethics complaint." (*A Closer Look at the Revised CAMFT Code of Ethics: Part II*, The Therapist, September/October 2020.)

New Section 8.4

8.4 SOLICITING OTHER CLIENTS/PATIENTS

Marriage and family therapists neither solicit clients/patients nor encourage clients/patients to leave other therapists when the client/ patient, because of circumstances, may be vulnerable to undue influence.

The Need for a New Section 8.4

The new Section 8.4 uses wording from the former section 5.4 of the previous Code of Ethics. However, wording has been added in order to "comply with the Federal Trade Commission (FTC) ruling against ethical standards that are overbroad and anti-competitive, or that restrict a licensee's ability to practice. The prohibition of soliciting clients/patients to leave other therapists must be limited to patients or other persons who because of their particular circumstances are vulnerable to undue influence." (*A Closer Look at the Revised CAMFT Code of Ethics: Part II*, The Therapist, Michael Griffin, JD, LCSW, Staff Attorney at CAMFT, September/October 2020.)

CAMFT Code of Ethics (*Revised by CAMFT 2019*)

Part I—The Standards

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Part I—The Standards

INTRODUCTION

The Board of Directors of CAMFT hereby publishes pursuant to the Association Bylaws, a revised CAMFT Code of Ethics. The CAMFT Code of Ethics is binding on all Members, Membership classes and Membership categories.

Members of CAMFT are expected to abide by these standards and by applicable California laws and regulations governing the conduct of licensed marriage and family therapists, supervisors, educators, registered associate marriage and family therapists, applicants, students, and trainees. Members are expected to be familiar with the Code of Ethics. A lack of understanding or knowledge of the Code of Ethics does not justify or excuse a violation. The effective date of these revised standards is December 7, 2019.

These standards are to be read, understood, and utilized as a guide for ethical behavior. The general principles contained in this code of conduct are also used as a basis for the adjudication of ethical issues and/or complaints (both within and outside of CAMFT) that may arise. Ethical behavior must satisfy not only the judgment of the individual marriage and family therapist, but also the judgment of one’s peers, based upon a set of recognized norms.

We recognize that the development of standards is an ongoing process, and that every conceivable situation that may occur cannot be expressly covered by any set of standards. The absence of a specific prohibition against a particular kind of conduct does not mean that such conduct is either ethical or unethical. While the specific wording of these standards is important, the spirit and intent of the principles should be taken into consideration by those utilizing or interpreting this code. The titles to the various sections of these standards are not considered a part of the actual standard. Violations of these standards may be brought to the attention of the CAMFT Ethics Committee,

in writing, at CAMFT's administrative office, 7901 Raytheon Road, San Diego, CA 92111-1606, or at such other address as may be necessary because of a change in location of the administrative office.

ETHICAL DECISION-MAKING

- Marriage and family therapists recognize that ethical decision-making principles may be based on higher standards for their conduct than legal requirements and that they must comply with the higher standard.
- Marriage and family therapists act with integrity and truthfulness, ensure fairness and non-discrimination, and promote the well-being of their clients/patients within the larger society.
- Marriage and family therapists avoid actions that cause harm and recognize that their clients/patients control their own life choices.
- Marriage and family therapists should be familiar with models of ethical decision-making and continuously develop their skills to recognize when an ethical conflict exists.
- Marriage and family therapists utilize consultation and stay current with the relevant research and literature about these processes.
- Marriage and family therapists reflect on ethical issues that arise within their practice and within the context of their legal responsibilities, ethical standards, and personal values, and develop congruent plans for action and resolution.

1. RESPONSIBILITY TO CLIENTS/PATIENTS

Marriage and family therapists advance the welfare of families and individuals, respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately.

1.1 NON-DISCRIMINATION:

- Marriage and family therapists do not condone or engage in discrimination, or refuse professional service to anyone on the basis of race, ethnicity, national origin, indigenous heritage, immigration status, gender, gender

identity, gender expression, sexual orientation, religion, age, disability, socioeconomic status, or marital/relationship status.

- Marriage and family therapists make reasonable efforts to accommodate clients/patients who have physical disabilities. (See also sections 3.2 Therapist Disclosures, 3.7 Therapist Professional Background, and 5.11 Scope of Competence.)

1.2 HISTORICAL AND SOCIAL PREJUDICE:

Marriage and family therapists are aware of and do not perpetuate historical and/or social prejudices when diagnosing and treating clients/patients because such conduct may lead to misdiagnosing and pathologizing clients/patients.

1.3 TREATMENT DISRUPTION:

Marriage and family therapists are aware of their professional and clinical responsibilities to provide consistent care to clients/patients and to maintain practices and procedures that are intended to provide undisrupted care. Such practices and procedures may include, but are not limited to, providing contact information and specified procedures in case of emergency or therapist absence, conducting appropriate terminations, and providing for a professional will.

1.4 TERMINATION:

Marriage and family therapists use sound clinical judgment when terminating therapeutic relationships. Reasons for termination may include, but are not limited to, the client/patient is not benefiting from treatment, continuing treatment is not clinically appropriate, the therapist is unable to provide treatment due to the therapist's incapacity or extended absence, or due to an otherwise unresolvable ethical conflict or issue. (See also sections 3.8 Client/Patient Benefit and 5.11 Scope of Competence.)

1.5 NON-PAYMENT OF FEES:

When terminating client/patient relationships due to non-payment of fees, marriage and family therapists do so in a clinically appropriate manner.

1.6 EMPLOYMENT AND CONTRACTUAL TERMINATIONS:

When terminating employment or contractual relationships, marriage and family therapists primarily consider the best interests of the client/patient when resolving issues of continued responsibility for client/patient care.

1.7 ABANDONMENT:

Marriage and family therapists do not abandon or neglect clients/patients in treatment. If a therapist is unable or unwilling to continue to provide professional services, the therapist will assist the client/patient in making clinically appropriate arrangements for continuation of treatment.

1.8 FINANCIAL GAIN:

Marriage and family therapists do not maintain therapeutic relationships solely for financial gain.

1.9 CLIENT/PATIENT AUTONOMY:

Marriage and family therapists respect client/patient choices, the right of the client/patient to make decisions, and help them to understand the consequences of their decisions. When clinically appropriate, marriage and family therapists advise their client/patient that decisions on the status of their personal relationships, including separation and/or divorce, are the responsibilities of the client/patient.

1.10 TREATMENT PLANNING:

Marriage and family therapists work with clients/patients to develop and review treatment plans that are consistent with client/patient goals and that offer a reasonable likelihood of client/ patient benefit.

2. CONFIDENTIALITY

Marriage and family therapists respect the confidences of their client(s)/ patient(s). Marriage and family therapists have unique confidentiality responsibilities because the client/patient in a therapeutic relationship may include more than one person.

2.1 DISCLOSURES OF CONFIDENTIAL INFORMATION:

Marriage and family therapists do not disclose client/patient confidences, (including the names or identities of their clients/patients), to anyone except as mandated by law, as permitted by law, when the marriage and family therapist is a defendant in a civil, criminal, or disciplinary action arising from the therapy (in which case client/patient confidences may only be disclosed in the course of that action), or if there is an authorization previously obtained in writing. Such information may only then be revealed in accordance with the terms of the authorization.

2.2 SIGNED AUTHORIZATIONS— RELEASE OF INFORMATION:

When there is a request for information related to any aspect of psychotherapy or treatment, each member of the unit receiving such therapeutic treatment must sign an authorization before a marriage and family therapist will disclose information received from any member of the treatment unit.

2.3 MAINTENANCE OF CLIENT/PATIENT RECORDS— CONFIDENTIALITY:

Marriage and family therapists store, transfer, transmit, and/or dispose of client/patient records in ways that protect confidentiality.

2.4 EMPLOYEES—CONFIDENTIALITY:

Marriage and family therapists take appropriate steps to ensure, insofar as possible, that the confidentiality of clients/patients is maintained by their employees, supervisees, assistants, volunteers, and business associates.

2.5 USE OF CLINICAL MATERIALS—CONFIDENTIALITY:

Marriage and family therapists use clinical materials in teaching, writing, and public presentations only if a written authorization has been previously obtained in accordance with 2.1, or when appropriate steps have been taken to protect patient identity.

2.6 GROUPS—CONFIDENTIALITY:

Marriage and family therapists, when working with a group, educate the group regarding the importance of maintaining confidentiality, and are encouraged to obtain written agreement from group participants to respect the confidentiality of other members of the group.

2.7 THIRD-PARTY PAYER DISCLOSURES:

Marriage and family therapists advise clients/patients of the information that will likely be disclosed (such as dates of treatment, diagnosis, prognosis, progress, and treatment plans) when submitting claims to managed care companies, insurers, or other third-party payers.

3. INFORMED CONSENT AND DISCLOSURE

Marriage and family therapists respect the fundamental autonomy of clients/patients and support their informed decision-making. Marriage and family therapists assess their client's/patient's competence, make appropriate disclosures, and provide comprehensive information so that their clients/patients understand treatment decisions.

3.1 INFORMED DECISION-MAKING:

Marriage and family therapists respect the rights of clients/patients to choose whether to enter into, to remain in, or to leave the therapeutic relationship. When significant decisions need to be made, marriage and family therapists provide adequate information to clients/patients in clear and understandable language so that clients/patients can make meaningful decisions about their therapy.

3.2 THERAPIST DISCLOSURE:

When a marriage and family therapist's personal values, attitudes, and/or beliefs are a prejudicial factor in diagnosing or limiting treatment provided to a client/patient, the marriage and family therapist shall disclose such information to the client/patient or facilitate an appropriate referral in order to ensure continuity of care.

3.3 RISKS AND BENEFITS:

Marriage and family therapists inform clients/patients of the potential risks and benefits of therapy when utilizing novel or experimental techniques or when there is a risk of harm that could result from the utilization of any technique.

3.4 EMERGENCIES/CONTACT BETWEEN SESSIONS:

Marriage and family therapists inform clients/patients of the extent of their availability for emergency care between sessions.

3.5 CONSENT FOR RECORDING/OBSERVATION:

Marriage and family therapists obtain written informed consent from clients/patients before recording, or permitting third party observation of treatment.

3.6 LIMITS OF CONFIDENTIALITY:

Marriage and family therapists are encouraged to inform clients/patients of significant exceptions to confidentiality such as child abuse reporting, elder and dependent adult abuse reporting, and clients/patients dangerous to themselves or others.

3.7 THERAPIST PROFESSIONAL BACKGROUND:

Marriage and family therapists are encouraged to disclose to clients/patients, at an appropriate time and within the context of the psychotherapeutic relationship, their experience, education, specialties, and theoretical orientation.

3.8 CLIENT/PATIENT BENEFIT:

Marriage and family therapists continually monitor their effectiveness when working with clients/patients and continue therapeutic relationships only so long as it is reasonably clear that clients/patients are benefiting from treatment.

3.9 FAMILY UNIT/CONFLICTS:

When treating a family unit(s), marriage and family therapists carefully consider the potential conflict that may arise between the family unit and each individual member. At the commencement of treatment and throughout treatment, marriage and family therapists clarify, which person or persons are clients/patients and the nature of the relationship(s) the therapist will have with each person participating in the treatment.

3.10 POTENTIAL CONFLICTS:

Marriage and family therapists carefully consider potential conflicts when providing concurrent or sequential individual, couple, family, and group treatment, and take reasonable care to avoid or minimize such conflicts.

3.11 TREATMENT ALTERNATIVES:

Marriage and family therapists discuss appropriate treatment alternatives with clients/patients. When appropriate, marriage and family therapists advocate for the mental health care they believe will benefit their clients/patients. Marriage and family therapists do not limit their discussions of treatment alternatives to what is covered by third-party payers**.**

3.12 DOCUMENTING TREATMENT RATIONALE/CHANGES:

Marriage and family therapists document treatment in their client/patient records, such as major changes to a treatment plan, changes in the unit being treated and/or other significant decisions affecting treatment.

4. DUAL/MULTIPLE RELATIONSHIPS

Marriage and family therapists establish and maintain professional relationship boundaries that prioritize therapeutic benefit and safeguard the best interest of their clients/patients against exploitation. Marriage and family therapists engage in ethical multiple relationships with caution and in a manner that is congruent with their therapeutic role.

4.1 DUAL/MULTIPLE RELATIONSHIPS:

Dual /multiple relationships occur when a therapist and his/her client/patient concurrently engage in one or more separate and distinct relationships. Not all dual/multiple relationships are unethical, and some need not be avoided, including those that are due to geographic proximity, diverse communities, recognized marriage and family therapy treatment models, community activities, or that fall within the context of culturally congruent relationships. Marriage and family therapists are aware of their influential position with respect to clients/patients, and avoid relationships that are reasonably likely to exploit the trust and/or dependence of clients/patients, or which may impair the therapist's professional judgment.

4.2 ASSESSMENT REGARDING DUAL/MULTIPLE RELATIONSHIPS:

Prior to engaging in a dual/multiple relationship, marriage and family therapists take appropriate professional precautions which may include, but are not limited to the following: obtaining the informed consent of the client/ patient, consultation or supervision, documentation of relevant factors, appraisal of the benefits and risks involved in the context of the specific situation, determination of the feasibility of alternatives, and the setting of clear and appropriate therapeutic boundaries to avoid exploitation or harm.

4.3 UNETHICAL DUAL/MULTIPLE RELATIONSHIPS:

Acts that could result in unethical dual relationships include, but are not limited to, borrowing money from a client/patient, hiring a client/patient, or engaging in a business venture with a patient, or engaging in a close personal relationship with a client/patient. Such acts with a client's/patient's spouse, partner or immediate family member are likely to be considered unethical dual relationships.

4.4 NON-PROFESSIONAL RELATIONSHIPS WITH FORMER CLIENTS/PATIENTS:

Prior to engaging in a non-sexual relationship with former clients/patients, marriage and family therapists take care to avoid engaging in interactions

which may be exploitive or harmful to the former client/patient. Marriage and family therapists consider factors which include, but are not limited to, the potential continued emotional vulnerability of the former client/patient, the anticipated consequences of involvement with that person, and the elimination of the possibility that the former client/patient resumes therapy in the future with that therapist.

4.5 SEXUAL CONTACT:

Sexual contact includes, but is not limited to sexual intercourse, sexual intimacy, and sexually explicit communications without a sound clinical basis and rationale for treatment. Sexual contact with a client/patient, or a client's/patient's spouse or partner, or a client's/patient's immediate family member, during the therapeutic relationship, or during the two years following the termination of the therapeutic relationship, is unethical. Prior to engaging in sexual contact with a former client/patient or a client's/patient's spouse or partner, or a client's/patient's immediate family member, following the two years after termination or last professional contact, the therapist shall consider factors which include, but are not limited to, the potential harm to or exploitation of the former client/patient or to the client's/patient's family, the potential continued emotional vulnerability of the former client/patient, and the anticipated consequences of involvement with that person. (See also section 7.2 Sexual Contact with Supervisees and Students.)

4.6 PRIOR SEXUAL RELATIONSHIP:

A marriage and family therapist does not enter into a therapeutic relationship with a person with whom the therapist has had a sexual relationship or knowingly enter into a therapeutic relationship with a partner or immediate family member of a person with whom the therapist has had a sexual relationship.

4.7 EXPLOITATION:

Marriage and family therapists do not use their professional relationships with clients/patients to further their own interests and do not exert undue influence on patients.

4.8 NON-THERAPIST ROLES:

Marriage and family therapists when engaged in professional roles other than treatment or supervision (including, but not limited to, managed care utilization review, consultation, coaching, adoption service, child custody evaluation, or behavior analysis), act solely within that role and clarify as necessary, in order to avoid confusion with consumers and employers, how that role is distinguished from the practice of marriage and family therapy.

5. PROFESSIONAL COMPETENCE AND INTEGRITY

Marriage and family therapists maintain high standards of professional competence and integrity.

5.1 CONVICTION OF CRIME:

Marriage and family therapists are in violation of this Code and subject to termination of membership, or other appropriate action, if they: are convicted of a crime substantially related to their professional qualifications or functions, are expelled from or disciplined by other professional organizations, or have licenses or certificates that are lapsed, suspended, or revoked or are otherwise disciplined by regulatory bodies.

5.2 FINANCIAL INCENTIVES:

Marriage and family therapists avoid contractual arrangements that provide financial incentives to withhold or limit medically/psychologically necessary care.

5.3 CLIENT/PATIENT RECORDS:

Marriage and family therapists create and maintain client/patient records consistent with sound clinical judgment, standards of the profession, and the nature of the services being rendered.

5.4 PROFESSIONAL ASSISTANCE:

Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that impair work performance or clinical judgment.

5.5 PRACTICING WHILE IMPAIRED:

Marriage and family therapists do not practice when their competence is impaired due to physical or psychological causes or to the use of alcohol or other substances.

5.6 STAYING CURRENT:

Marriage and family therapists remain current with developments in their field through educational activities or clinical experiences. Marriage and family therapists, when acting as teachers, supervisors, and researchers, stay informed about changes in the field, maintain relevant standards of scholarship, and present accurate information.

5.7 SENSITIVITY TO DIVERSITY:

Marriage and family therapists actively strive to identify and understand the diverse backgrounds of their clients/patients by obtaining knowledge, gaining personal awareness, and developing sensitivity and skills pertinent to working with a diverse client/patient population.

5.8 GIFTS:

Marriage and family therapists carefully consider the clinical and cultural implications of giving and receiving gifts or tokens of appreciation. Marriage and family therapists take into account the value of the gift, the effect on the therapeutic relationship, and the client/patient and the psychotherapist's motivation for giving, receiving, or declining, the gift.

5.9 IMPACT OF THERAPIST VALUES ON TREATMENT:

Marriage and family therapists make continuous efforts to be aware of how their cultural/racial/ethnic identities, values, and beliefs affect the process of therapy. Marriage and family therapists do not exert undue influence on the choice of treatment or outcomes based on such identities, values, and beliefs.

5.10 HARASSMENT OR EXPLOITATION:

Marriage and family therapists do not engage in sexual harassment or other forms of harassment or exploitation of clients/patients, students, supervisees, employees, or colleagues.

5.11 SCOPE OF COMPETENCE:

Marriage and family therapists take care to provide proper diagnoses of

psychological disorders or conditions and do not assess, test, diagnose, treat, or advise on issues beyond the level of their competence as determined by their education, training, and experience. While developing new areas of practice, marriage and family therapists take steps to ensure the competence of their work through education, training, consultation, and/or supervision.

5.12 DUPLICATION OF THERAPY:

Marriage and family therapists do not generally duplicate professional services to a prospective client/patient receiving treatment from another psychotherapist. When making a determination to provide services, marriage and family therapists carefully consider the client's/patient's needs, presenting treatment issues, and the welfare of the client/patient to minimize potential confusion and/or conflict. Prior to rendering services, marriage and family therapists discuss these issues with the prospective client/patient, including the nature of the client's/patient's current relationship with the other treating psychotherapist and whether consultation with the other psychotherapist is appropriate.

5.13 PUBLIC STATEMENTS:

Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise caution when making public their professional recommendations or their professional opinions through testimony, social media and Internet content, or other public statements.

5.14 LIMITS OF PROFESSIONAL OPINIONS:

Marriage and family therapists do not express professional opinions about an individual's psychological condition unless they have treated or conducted

an examination and code of ethics, assessment of the individual, or unless they reveal the limits of the information upon which their professional opinions are based, with appropriate cautions as to the effects of such limited information upon their opinions (See also section 10.7 Professional Opinions in Court-Involved Cases.)

5.15 CONSULTATION:

When appropriate, marriage and family therapists consult, collaborate with, and refer to physicians, other health care professionals, and community resources in order to improve and protect the health and welfare of the client/patient.

6. TELEHEALTH

Marriage and family therapists recognize that ongoing technological developments promote availability and access to healthcare and expand opportunities to provide their services outside of the therapy office. When utilizing Telehealth to provide services to clients/patients, marriage and family therapists consider the welfare of the client/patient, the appropriateness and suitability of the modality in meeting the client's/ patient's needs, make appropriate disclosures to the client/patient regarding its use, exercise reasonable care when utilizing technology, and remain current with the relevant laws and regulations.

6.1 TELEHEALTH:

Marriage and family therapists take precautions to meet their responsibilities to clients/patients who are not physically present during the provision of therapy. Prior to utilizing Telehealth, marriage and family therapists consider the appropriateness and suitability of this therapeutic modality in meeting the client's/patient's needs and do so competently. The suitability and appropriateness of Telehealth includes consideration of multiple factors such as the client's/patient's familiarity with the modality, the issues to be addressed, the therapeutic orientation, and other pertinent factors.

6.2 COMPLIANCE WITH TELEHEALTH LAWS:

Marriage and family therapists, prior to engaging in Telehealth, are familiar with the state and federal laws governing Telehealth and ensure compliance with all relevant laws.

6.3 DISCLOSURES:

Marriage and family therapists inform clients/patients of the potential risks, consequences, and benefits of the Telehealth modality, including but not limited to issues of confidentiality, clinical limitations, and transmission/ technical difficulties.

6.4 ELECTRONIC MEDIA:

Marriage and family therapists are aware of the possible adverse effects of technological changes with respect to the dissemination of client/patient information, and take care when disclosing such information. Marriage and family therapists are also aware of the limitations regarding confidential transmission by Internet or electronic media and take care when transmitting or receiving such information via these mediums.

7. SUPERVISOR, SUPERVISEE, EDUCATOR, AND STUDENT RESPONSIBILITIES

Marriage and family therapists, supervisees and students employ effective and respectful communication when fulfilling their professional responsibilities. Marriage and family therapists, when acting as supervisors and educators, are cognizant of their impact on the professional development of supervisees and students; they do not exploit the trust and dependence of students and supervisees and whenever possible they appropriately safeguard the best interests of the clients/patients of supervisees.

7.1 MAINTAINING PROFESSIONAL BOUNDARIES WITH SUPERVISEES AND STUDENTS:

Marriage and family therapists are aware of their influential position with respect to their students and supervisees, and they avoid exploiting the trust and dependency of such persons. Marriage and family therapists therefore

avoid engaging in relationships with supervisees and students (over whom they exercise professional authority) that are reasonably likely to impair professional judgment or lead to exploitation. Provision of therapy to students or supervisees over whom the supervisor or educator exercise professional authority is unethical and provision of marriage and family therapy supervision to clients/patients is also unethical. Other acts which are likely to be unethical include, but are not limited to, borrowing money from a supervisee, engaging in a business venture with a supervisee, or engaging in a close personal relationship with a supervisee or student. Such acts with a supervisee's spouse, partner or immediate family member may also be considered unethical dual relationships.

7.2 SEXUAL CONTACT WITH SUPERVISEES AND STUDENTS:

Marriage and family therapists do not engage in sexual contact with supervisees or students with whom they exercise professional authority. Sexual contact includes, but is not limited to, sexual intercourse, sexual intimacy, and sexually explicit communications without a sound clinical, supervisory, or educational basis. Such acts with the spouse, partner, or immediate family member of a supervisee or student are likely to be unethical and exploitive. (See also section 4.5 Sexual Contact.)

7.3 SEXUAL HARASSMENT OF SUPERVISEES OR STUDENTS:

Marriage and family therapists do not engage in sexual harassment of supervisees or students.

7.4 COMPETENCE OF SUPERVISEES:

Marriage and family therapists assure that the extent, quality and kind of supervision provided is consistent with the education, training, and experience level of the supervisee. Marriage and family therapists do not permit their students, employees, or supervisees to perform or to hold themselves out beyond their pre-licensed status or to perform professional services beyond their scope of competence.

7.5 MAINTAINING SUPERVISION SKILLS:

Marriage and family therapists who act as supervisors are responsible for maintaining the quality of their supervision skills and for obtaining consultation or supervision for their work as supervisors whenever appropriate.

7.6 KNOWLEDGE OF LAWS AND REGULATIONS:

Supervisors and supervisees have a responsibility to be knowledgeable about relevant laws and regulations pertaining to the practice of marriage and family therapy.

7.7 CHANGES IN LEGAL REQUIREMENTS AND ETHICAL STANDARDS:

Supervisors maintain awareness of and stay current with changes in professional and ethical standards and legal requirements. Supervisors ensure that their supervisees are aware of professional and ethical standards and legal responsibilities.

7.8 CULTURE AND DIVERSITY:

Supervisors and educators are aware of and address the role that culture and diversity issues play in their supervisory and educational relationships, including, but not limited to, evaluating, terminating, disciplining, or making decisions regarding supervisees or students.

7.9 POLICIES AND PROCEDURES:

Supervisors and educators create and implement policies and procedures that are clear and that are disclosed to supervisees and students at the commencement of and throughout supervision or education**.**

7.10 PERFORMANCE APPRAISALS:

Supervisors provide supervisees with periodic performance appraisals and evaluative feedback throughout the supervisory relationship and identify and address the limitations of supervisees that might impede performance.

7.11 BUSINESS PRACTICES:

When acting as employers and/or supervisors, marriage and family therapists follow lawful business practices.

7.12 BARTERING WITH SUPERVISEES:

Marriage and family therapists ordinarily refrain from accepting goods or services from supervisees in return for services rendered due to the potential for conflicts, exploitation, and/ or distortion of the professional relationship. Bartering should only be considered and conducted if the supervisee requests it, the bartering is not otherwise exploitive or detrimental to the supervisory relationship, and it is negotiated without coercion. Marriage and family therapists are responsible to ensure that such arrangements are not exploitive and that a clear written agreement is created. Marriage and family therapists are encouraged to consider relevant social and/or cultural implications of bartering including whether it is an accepted practice among professionals within the community. (For bartering with clients/patients, see also section 12.5 Bartering.)

7.13 PERFORMANCE ASSISTANCE:

Supervisors guide supervisees in securing assistance when needed for the supervisee to maintain or improve performance, such as personal psychotherapy, additional education, training, or consultation. Supervisees have the responsibility to seek information and to ask for supervisorial guidance when necessary.

7.14 DISMISSAL:

Supervisors shall document their decisions to dismiss supervisees.

7.15 REVIEW OF TRAINEE AGREEMENTS:

Supervisors are aware of and review any trainee agreements with qualified educational institutions.

7.16 CLIENTS/PATIENTS ARE PATIENTS OF EMPLOYER:

Supervisees understand that the clients/patients seen by them are the clients/patients of their employers.

7.17 SUPERVISOR QUALIFICATIONS:

Supervisors maintain licensure and meet/satisfy the qualifications, laws and regulations pertaining to supervision.

7.18 SUPERVISEE REGISTRATION AND LIMITED ROLE:

Supervisees maintain registrations when required by law and/or regulation and function within this limited role as permitted by the licensing law and/or regulations.

8. RESPONSIBILITY TO COLLEAGUES

To promote the welfare and best interest of clients/patients, marriage and family therapists collaborate with other professionals, communicate with and about colleagues in a respectful manner, and strive to maintain constructive working relationships with colleagues.

8.1 RESPECT CONFIDENCE OF COLLEAGUES:

Marriage and family therapists respect the confidences of colleagues that are shared in the course of their professional relationships.

8.2 IMPAIRED COLLEAGUES:

Marriage and family therapists are encouraged to provide consultation or assistance to colleagues who are impaired due to substance use or mental disorders.

8.3 ETHICAL COMPLAINTS AGAINST COLLEAGUES:

Marriage and family therapists are encouraged to take reasonable actions to resolve disputes with colleagues before filing an ethics complaint against a colleague. Reasonable measures may include, addressing the matter with the colleague, consultation, and/or mediation. Marriage and family therapists do

not file or encourage the filing of ethics or other complaints that they know, or reasonably should know, are frivolous.

8.4 SOLICITING OTHER CLIENTS/PATIENTS:

Marriage and family therapists do not solicit or encourage clients/patients to leave other therapists, where the client/patient, because of their circumstances, may be vulnerable due to undue influence.

9. RESPONSIBILITY TO THE PROFESSION

Marriage and family therapists respect the rights and responsibilities of colleagues. Marriage and family therapists cooperate with colleagues to act in the best interest of the profession. Marriage and family therapists participate in activities that advance the goals of the profession.

9.1 ACCOUNTABILITY TO THE STANDARDS OF THE PROFESSION:

Marriage and family therapists remain accountable to the standards of the profession when acting as members or employees of organizations. If an organization with whom a marriage and family therapist is employed or affiliated has policies, procedures, or demands that conflict with the CAMFT Code of Ethics, the marriage and family therapist shall make known their ethical obligations as set forth in the Code of Ethics and take reasonable steps to resolve such conflicts.

9.2 PUBLICATION CREDIT:

Marriage and family therapists assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with the customary standards of professional publication.

9.3 AUTHORS—CITING OTHERS:

Marriage and family therapists who are the authors of books or other materials that are published or distributed appropriately cite persons to whom credit for any original ideas are due.

9.4 AUTHORS—ADVERTISING BY OTHERS:

Marriage and family therapists who are the authors of books or other materials published or distributed by an organization take reasonable steps to ensure that the organization promotes and advertises the materials accurately.

9.5 PRO BONO SERVICES:

Marriage and family therapists are encouraged to participate in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return.

9.6 EMERGING PUBLIC POLICY:

Marriage and family therapists are encouraged to be aware of current and emerging laws and regulations pertaining to marriage and family therapy that serve the public interest, and with the revisions of such laws and regulations that are not in the public interest.

9.7 FAILURE TO COOPERATE WITH THE ETHICS COMMITTEE:

Marriage and family therapists cooperate with the Ethics Committee or its designee and truthfully represent facts to the Ethics Committee or its designee at any point from the inception of an ethical complaint through the completion of proceedings regarding a complaint. Failure to cooperate with the Ethics Committee is itself a violation of these standards.

10. RESPONSIBILITY TO THE LEGAL SYSTEM

Marriage and family therapists recognize their duty to remain objective and truthful. Marriage and family therapists recognize that court cases involving therapeutic services introduce factors and dynamics into the delivery of treatment services that are likely to impact their working alliance with the clients/patients; they are cognizant of the tendency of clients/patients to equate their own best interests with prevailing in a legal dispute. Marriage and family therapists understand that their role is not to produce a pre-determined outcome in the legal process; they should not align with the

client's/patient's legal position as this might distort information received, or impair their ability to support the client/patient in dealing with the stresses of the process and potential outcomes.

10.1 TESTIMONY:

Marriage and family therapists who give testimony in legal proceedings testify truthfully and avoid making misleading statements. Marriage and family therapists inform the court of any conflicts between the expectations of the court and their ethical obligations or role limitations. Marriage and family therapists should anticipate that clients, attorneys, or the court, might ask them to offer opinions or information beyond the limits of their knowledge base or expert role. In such circumstances, marriage and family therapists safeguard their professional objectivity by clarifying these issues with the court and respectfully declining to offer such testimony.

10.2 EXPERT WITNESSES:

Marriage and family therapists who act as expert or who provide expert opinions in any context, orally or in writing, clarify their expert role to their clients/patients, fellow professionals, attorneys, and the court as necessary. Marriage and family therapists base their opinions and conclusions on appropriate data and are careful to acknowledge the limits of their training, data, recommendations or conclusions, in order to avoid providing unsubstantiated, misleading, distorted, or biased testimony or reports. Marriage and family therapists carefully distinguish between the roles of "treating therapist" and "forensic expert." Treating therapists primarily provide opinions on the assessment, diagnosis, treatment progress and recommendations, and prognosis of their clients/patients. A treating expert's testimony should be limited to the therapist's particular area of expertise and issues directly relevant to the treatment role. They understand that their role is to facilitate successful psychological functioning, and not to promote a predetermined legal outcome. Forensic experts are retained to offer opinions and make recommendations in a variety of legal contexts, including specific parenting and custody plans or decision-making authority in legal proceedings.

10.3 CONFLICTING ROLES:

Whenever possible, marriage and family therapists avoid performing conflicting roles in legal proceedings and disclose any potential conflicts to prospective clients/patients, to the courts, or to others as appropriate. At the outset of the service to be provided and as changes occur, marriage and family therapists clarify role expectations, limitations, conflicts, and the extent of confidentiality to pre-existing or prospective clients, to the courts, or to others as appropriate.

10.4 DUAL ROLES:

Marriage and family therapists avoid providing both court evaluations and treatment concurrently or sequentially for the same clients/patients or treatment units in legal proceedings such as child custody, visitation, dependency, or guardianship proceedings, unless otherwise required by law or initially appointed pursuant to court order. When pre-existing clients/patients become involved in a legal proceeding and the marriage and family therapist continues to provide treatment, they should discuss the potential effects of legal involvement with their clients/patients, including clarifying the potential role conflicts, clients'/patients' expectations, and possible requests to release treatment information.

10.5 IMPARTIALITY:

Marriage and family therapists, regardless of their role in a legal proceeding, remain impartial and do not compromise their professional judgment or integrity. Marriage and family therapists understand that their testimony and opinions are impactful on legal outcomes. Marriage and family therapists use particular caution when drawing conclusions or forming or expressing opinions from limited observations or sources of information.

10.6 MINORS AND PRIVILEGE:

Marriage and family therapists determine who holds the psychotherapist-patient privilege on behalf of minor clients/patients prior to releasing information or testifying. Marriage and family therapists determine who are the legal recipients of privileged information and the extent of the

information to be released. When legally permitted, Marriage and family therapists are encouraged to inform parents/legal guardians about whether, how, and what they will communicate to the court.

10.7 PROFESSIONAL OPINIONS IN COURT-INVOLVED CASES:

Marriage and family therapists shall only express professional opinions about clients/patients they have treated or examined. Marriage and family therapists, when expressing professional opinions, specify the limits of the information upon which their professional opinions are based. Such professional opinions include, but are not limited to, mental conditions, emotional conditions, or parenting abilities. (See also section 5.14 Limits of Professional Opinions.)

10.8 CUSTODY EVALUATORS:

Marriage and family therapists who are custody evaluators (private or court-based) or special masters provide such services only if they meet the requirements established by relevant ethical standards, guidelines, laws, regulations, and rules of court.

10.9 CONSEQUENCES OF CHANGES IN THERAPIST ROLES:

Marriage and family therapists inform the client/patient orthe treatment unit of any potential consequences of therapist-client/patient role changes. Such role changes include, but are not limited to: child's therapist, family's therapist, couple's therapist, individual's therapist, mediator, and special master. Marriage and family therapists are encouraged to obtain consultation before changing roles to consider how the role change might create a conflict of interest or affect the therapeutic alliance, and to explore whether appropriate alternatives exist that would reduce such risks.

10.10FAMILIARITY WITH JUDICIAL AND ADMINISTRATIVE RULES:

Marriage and family therapists, when assuming treatment or forensic expert roles, are or become familiar with the judicial, jurisdictional, and administrative rules governing their roles.

10.11CUSTODY DISPUTES:

When treating families and minors who are involved in a custody determination or dispute, marriage and family therapists obtain information about how the decision to enter therapy was made, who was involved in the decision, and the outcomes expected by the parents, other parties, or the court. Marriage and family therapists take care to clarify and determine who has the legal authority to provide consent and treatment for the minor and avoid initiating treatment of the minor until such determination is made. Marriage and family therapists are encouraged to request copies of any court judgements or orders and determine who has the legal authority to make decisions about entering or continuing treatment, or access to or release of confidential information.

When providing legally permitted disclosures of confidential information or professional opinions about minor clients/patients in court-involved cases, marriage and family therapists generally limit the scope of such information to issues which concern the minor's psychotherapeutic treatment. In order to avoid an inaccurate or incomplete assessment of the minor's needs, marriage and family therapists use caution in the interpretation of a minor's pictures, writings, or other materials produced in the course of treatment as well as behaviors or statements when the minor expresses a position on disputed adult issues.

10.12PROFESSIONAL COMMUNICATIONS:

Marriage and family therapists are aware of the potential impact of the adversarial nature of legal disputes on their actions, observations, and opinions. When communicating with clients/patients, parents, counsel, the court, or other parties, marriage and family therapists ensure that their communications are properly authorized, unbiased, and accurate. Marriage and family therapists decline to communicate when there is insufficient data to form a reliable opinion or where the opinion is inconsistent with their role.

11. RESPONSIBILITY TO RESEARCH PARTICIPANTS

Researchers respect the dignity and welfare of participants in research and are aware of federal and state laws and regulations and professional standards governing the conduct of research.

11.1 SAFEGUARDS:

Researchers are responsible for making careful examinations of ethical acceptability in planning studies. To the extent that services to research participants may be compromised by participation in research, researchers seek the ethical advice of qualified professionals not directly involved in the research and observe safeguards to protect the rights of research participants.

11.2 CLIENT/PATIENT PARTICIPATION IN RESEARCH:

Researchers requesting participants' involvement in research inform them of all aspects of the research that might reasonably be expected to influence willingness to participate. Researchers are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, have impairments which limit understanding and/or communication, or when participants are children.

11.3 RESEARCH PARTICIPANTS:

Researchers respect participants' freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when researchers or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid dual/ multiple relationships with research participants that could impair professional judgment or increase the risk of exploitation.

11.4 CONFIDENTIALITY:

Information obtained about a research participant during the course of a research project is confidential unless there is an authorization previously obtained in writing. When the possibility exists that others, including family

members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained.

11.5 RESEARCH FINDINGS:

Marriage and family therapists take reasonable steps to prevent the distortion or misuse of their clinical and research findings.

12. FINANCIAL ARRANGEMENTS

Marriage and family therapists make financial arrangements with clients/ patients and supervisees that are understandable, and conform to accepted professional practices and legal requirements.

12.1 PAYMENT FOR REFERRALS:

Marriage and family therapists do not offer or accept payment for referrals, whether in the form of money or otherwise.

12.2 FINANCIAL EXPLOITATION:

Marriage and family therapists do not financially exploit their clients/ patients.

12.3 DISCLOSURE OF FEES:

Prior to the commencement of treatment, marriage and family therapists disclose their fees and the basis upon which they are computed, including, but not limited to, charges for canceled or missed appointments and any interest to be charged on unpaid balances, and give reasonable notice of any changes in fees or other charges.

12.4 COLLECTING ON UNPAID BALANCES:

Marriage and family therapists give reasonable notice to patients with unpaid balances of their intent to sue or to refer for collection. Whenever legal action is taken, marriage and family therapists will avoid disclosure of clinical information. Whenever unpaid balances are referred to collection agencies, marriage and family therapists will exercise care in selecting collection agencies and will avoid disclosure of clinical information.

12.5 BARTERING:

Marriage and family therapists ordinarily refrain from accepting goods or services from clients/ patients in return for services rendered due to the potential for conflicts, exploitation, and/or distortion of the professional relationship. Bartering should only be considered and conducted if the client/ patient requests it, the bartering is not otherwise exploitive or detrimental to the therapeutic relationship, and it is negotiated without coercion. Marriage and family therapists are responsible to ensure that such arrangements are not exploitive and that a clear written agreement is created. Marriage and family therapists are encouraged to consider relevant social and/or cultural implications of bartering including whether it is an accepted practice among professionals within the community. (For bartering with supervisees, see also section 7.12 Bartering with Supervisees.)

12.6 THIRD-PARTY PAYERS:

Marriage and family therapists represent facts regarding services rendered and payment for services fully and truthfully to third-party payers and/or guarantors of payment. When appropriate, marriage and family therapists make reasonable efforts to assist their clients/patients in obtaining reimbursement for services rendered.

12.7 WITHHOLDING RECORDS FOR NON-PAYMENT:

Marriage and family therapists do not withhold patient records or information solely because the therapist has not been paid for prior professional services.

13. ADVERTISING

Marriage and family therapists who advertise do so appropriately and recognize that advertising in all of its forms, enables consumers to choose professional services based upon accurate information.

13.1 ACCURACY REGARDING QUALIFICATIONS:

Marriage and family therapists accurately represent their education, training, and experience relevant to their professional practice to clients/patients and others.

13.2 ASSURING ACCURACY:

Marriage and family therapists take reasonable steps to assure that advertisements and publications, whether in directories, business cards, newspapers, radio, television, websites, email, social media, or any other media, are formulated to convey accurate information to the public.

13.3 FICTITIOUS/OTHER NAMES:

Marriage and family therapists do not use a name that could mislead the public concerning the identity, responsibility, source, and status of those practicing under that name, and do not hold themselves out as being partners or associates of a firm if they are not.

13.4 FALSE, MISLEADING, OR DECEPTIVE ADVERTISING:

Marriage and family therapists do not use any means of professional identification, including but not limited to: a business card, office sign, letterhead, telephone, email address, association directory listing, Internet, social media or any other media, if it includes a statement

or claim that is false, fraudulent, misleading, or deceptive. A statement is false, fraudulent, misleading, or deceptive if it contains a material misrepresentation of fact, omits any material fact necessary to make the statement, in light of all circumstances, not misleading, or is intended to or is likely to create an unjustified expectation.

13.5 CORRECTIONS:

Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist’s qualifications, services, or products.

13.6 SOLICITATION OF TESTIMONIALS:

Marriage and family therapists do not solicit testimonials from those clients/ patients who, due to their particular circumstances, are vulnerable to undue influence.

13.7 EMPLOYEE—ACCURACY:

Marriage and family therapists make certain that the qualifications of persons in their employ are represented in a manner that is not false, misleading, or deceptive.

13.8 SPECIALIZATIONS:

Marriage and family therapists may represent themselves as either specializing in or having expertise within a limited area of marriage and family therapy, but only if they have the education, training, and experience that meets recognized professional standards to practice in that specialty area.

13.9 ADVERTISING OF CAMFT MEMBERSHIP:

CAMFT members may identify their membership in CAMFT in public information or advertising materials, but they must clearly and accurately represent their membership status. Marriage and family therapists may use the CAMFT logo only after receiving written permission from the Association. Violations of these standards may be brought to the attention of the CAMFT Ethics Committee, in writing, mailed to CAMFT's administrative office at 7901 Raytheon Road, San Diego, CA 92111-1606, or at such other address as may be necessary because of a change in location of the administrative office.

Endnotes

1

The terms "psychotherapy," "therapy" and "counseling" are used interchangeably throughout the Code of Ethics.

2

The term “marriage and family therapist,” as used herein, is synonymous with the term “licensed marriage, family and child counselor,” and is intended to cover registered associate marriage and family therapists and trainees performing marriage and family therapy services under supervision and is meant to apply to all other mental health providers in all membership categories of the Association

3

The term “client/patient,” as used herein, is synonymous with such words as “consumer,” and “counselee.”

4

The term “supervisee,” as used herein, includes registrants, trainees, and applicants for the license.

All known dates of ethical standards revisions: 12/19, 6/11, 1/11, 9/09, 7/08, 5/02, 4/97, 4/92, 10/87, 9/78, and 3/66.

CAMFT Code of Ethics PART I (THE STANDARDS) AND PART II (THE PROCEDURES) is a publication of the California Association of Marriage and Family Therapists, headquartered in San Diego, California.

5B. ACA Code of Ethics

Preamble

The American Counseling Association (ACA) is an educational, scientific, and professional organization whose members work in a variety of settings and serve in multiple capacities. Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.

Professional values are an important way of living out an ethical commitment. The following are core professional values of the counseling profession:

1. enhancing human development throughout the life span;

2. honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts;

3. promoting social justice;

4. safeguarding the integrity of the counselor–client relationship; and

5. practicing in a competent and ethical manner.

These professional values provide a conceptual basis for the ethical principles enumerated below. These principles are the foundation for ethical behavior and decision making. The fundamental principles of professional ethical behavior are

• autonomy, or fostering the right to control the direction of one's life;

• nonmaleficence, or avoiding actions that cause harm;

• beneficence, or working for the good of the individual and society by promoting mental health and well-being;

• justice, or treating individuals equitably and fostering fairness and equality;

• fidelity, or honoring commitments and keeping promises, including fulfilling one's responsibilities of trust in

professional relationships; and

- veracity, or dealing truthfully with individuals with whom counselors come into professional contact.

(The American Counseling Association ACA Code of Ethics, 2014)

ACA Code of Ethics Purpose

The ACA Code of Ethics serves six main purposes:

1. The Code sets forth the ethical obligations of ACA members and provides guidance intended to inform the ethical practice of professional counselors.

2. The Code identifies ethical considerations relevant to professional counselors and counselors-in-training.

3. The Code enables the association to clarify for current and prospective members, and for those served by members, the nature of the ethical responsibilities held in common by its members.

4. The Code serves as an ethical guide designed to assist members in constructing a course of action that best serves those utilizing counseling services and establishes expectations of conduct with a primary emphasis on the role of the professional counselor.

5. The Code helps to support the mission of ACA.

6. The standards contained in this Code serve as the basis for processing inquiries and ethics complaints concerning ACA members.

7. The ACA Code of Ethics contains nine main sections that address the following areas:

- Section A: The Counseling Relationship
- Section B: Confidentiality and Privacy
- Section C: Professional Responsibility
- Section D: Relationships With Other Professionals
- Section E: Evaluation, Assessment, and Interpretation
- Section F: Supervision, Training, and Teaching
- Section G: Research and Publication
- Section H: Distance Counseling, Technology, and
- Social Media
- Section I: Resolving Ethical Issues

5C. NASW Code of Ethics

Approved by the 1996 NASW Delegate Assembly and revised by the 2017 NASW Delegate Assembly, the NASW Code of Ethics provides a guide to professional conduct of social workers. This Code includes four sections including:

1. The first Section, "Preamble," summarizes the social work profession's mission and core values.
2. The second section, "Purpose of the NASW Code of Ethics," provides an overview of the Code's main functions and a brief guide for dealing with ethical issues or dilemmas in social work practice.
3. The third section, "Ethical Principles," presents broad ethical principles, based on social work's core values, that inform social work practice.
4. The final section, "Ethical Standards," includes specific ethical standards to guide social workers' conduct and to provide a basis for adjudication.

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers

also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- ✓ service
- ✓ social justice
- ✓ dignity and worth of the person
- ✓ importance of human relationships
- ✓ integrity
- ✓ competence.

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: Service

Ethical Principle: Social workers' primary goal is to help people in need and to address social problems.

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: Social Justice

Ethical Principle: Social workers challenge social injustice.

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment,discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: Dignity and Worth of the Person

Ethical Principle: Social workers respect the inherent dignity and worth of the person.

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: Importance of Human Relationships

Ethical Principle: Social workers recognize the central importance of human relationships.

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Value: Integrity

Ethical Principle: Social workers behave in a trustworthy manner.

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: Competence

Ethical Principle: Social workers practice within their areas of competence and develop and enhance their professional expertise.

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

(NASW Delegate Assembly, the NASW Code of Ethics, Revised 2017)

6. Updated BBS Requirements

6A. Required Coursework or Supervised Experience: Suicide Risk

Assessment and Intervention

(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 or associateship that meets the requirement of this chapter, formal postdoctoral placement that meets the requirements of Section 2911, or other qualifying supervised 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) As a one-time requirement, a licensee prior to the time of his or her first renewal after January 1, 2021, or an applicant for reactivation or reinstatement to an active license status on or after January 1, 2021, shall have completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention, using one of the methods 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.

6B. Required Notice to Clients

On and after July 1, 2020, a licensee shall provide a client with a notice written in at least 12-point type prior to initiating psychological services that reads as follows:

Notice to Clients

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of licensed

educational psychologists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

According to the BBS, “There are several law changes that became effective in 2021 that will affect Board of Behavioral Sciences’ (Board’s) licensees, registrants, and applicants. It is important that you take some time to review these changes, which will help ensure compliance with the law. The Board recommends reading the bills referenced in their entirety for greater clarity, available by clicking on the bill number links below, or by visitinghttps:// leginfo.legislature.ca.gov.

The law changes listed below became effective on January 1, 2021.

✶ ***Update effective 2022:***

2022 Update AB 690 and SB 801: Updated Notices to Patients Overview

Effective January 1, 2022, AB 690 and SB 801 have amended the above stated requirement:

1) **Therapists must provide patients with the above notice prior to starting treatment or as soon as practicably possible thereafter.**
2) **Therapists must document their delivery of these notices in the patients' records.**

CAMFT provides Sample AB 630 Notices for private practice clinicians and agencies.

The BBS update states that practitioners are not required to provide updated notices to current patients. The Board only requires practitioners to provide the updated notices to new patients they begin treating on or after January 1, 2022. Access the full BBS 2022 update here.

2022 Update AB 690 and SB 801: Updated Notices to Patients Full BBS Update:

Updated Requirement to Provide Notice to Psychotherapy Clients

Beginning July 1, 2020, all mental health counselors, whether licensed or unlicensed, were required to provide a notice to each of their clients stating where they can file a complaint. (AB 630, Chapter 229, Statutes of 2019)

Effective January 1, 2022, there are some changes to the timing of when you must provide the notice and to documentation requirements. In addition, if you are not licensed or registered with the Board and are providing mental health counseling in an exempt setting, there are some changes you need to make to the wording of the notice moving forward.

When do I Provide This Notice?

For new clients, you are required to provide this notice prior to initiating psychotherapy services, or as soon as practicably possible thereafter. The "as soon as practicably possible thereafter" allowance is new, and is intended to allow a provider to provide services first in an emergency, and then provide the notice once the emergency has passed and it is appropriate to do so.

Am I Required to Document Delivery of the Notice?

Yes- for new clients that you see as of January 1, 2022 on, you are required to document in the client's record that you delivered the notice.

If I am not Licensed or Registered with the Board of Behavioral Sciences (Board), but Providing Mental Health Counseling in an Exempt Setting, What Does the Notice Need to Say?

If you are unlicensed or unregistered with the Board but providing services within the scope of practice of Board licensees in an exempt setting (a governmental entity, a school, college, or university, or an institution that is both nonprofit and charitable), the wording of the notice has changed. You are required to provide your clients with a notice about how to file a complaint with your agency. The fact that your setting is considered exempt is conditional upon you doing this.

The notice must be in at least 12-point font, and must be in substantially the following form:

NOTICE TO CLIENTS
The (Name of office or unit) of the (Name of agency) receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered

practitioner providing services at (Name of agency). To file a complaint, contact (Telephone number, email address, internet website, or mailing address of agency).

The Board of Behavioral Sciences receives and responds to complaints regarding services provided by individuals licensed and registered by the board. If you have a complaint and are unsure if your practitioner is licensed or registered, please contact the Board of Behavioral Sciences at 916-574-7830 for assistance or utilize the board's online license verification feature by visiting www.bbs.ca.gov.

If I am Licensed or Registered with the Board of Behavioral Sciences (Board), What Does the Notice Need to Say?

If you are a Board licensee or registrant, the wording of the notice has not changed. You must provide your new clients with a notice in at least 12-point font, that reads as follows:

NOTICE TO CLIENTS
The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of ([include your profession: marriage and family therapists/licensed educational psychologists/clinical social workers/professional clinical counselors]). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Do I Need to Provide this New Version of the Notice to Existing Clients?
No. You do not need to distribute the new version of the notice to existing clients. You
only need to distribute the new version, as listed above, to new clients you begin seeing on or after January 1, 2022.

6C. Changes to Elder and Dependent Adult Abuse Reporting, including Financial Abuse Reporting

Overview

Effective January 1, 2022 the definition of "elder" changes from age 65 or older to "means any person residing in this State 60 years of age or older" and the definition of "dependent adult" changes to "any person between 18

and 59 years of age." This new law also revises the definition of dependent adult in that a dependent adult has a combination of a disability and the inability to protect their own interest; or has an inability to carry out normal activities to protect their rights; or who is admitted as an inpatient to a 24-hour facility.

AB 636: Effective January 1, 2022, information relevant to an elder or dependent adult financial abuse *may* be provided to federal law enforcement agency, if the incident may be within the agency's jurisdiction, for the sole purpose of investigating a financial crime committed against the elder or dependent adult.

6D. Changes to Definition of Support Dog

AB 468: Changes to Definition of Support Dog Overview

Effective January 1, 2022, health care practitioners may not provide documentation in support of their patients' need for emotional support dogs unless they meet the following criteria:

1. The practitioner must possess a valid active license or associate registration;
   Note: The BBS interprets this provision to allow pre-licensees with valid, active associate registrations to provide ESD documentation so long as their supervisors review and approve the documentation.
2. The practitioner must be licensed or registered to provide therapy services in the jurisdiction in which the documentation is provided (i.e. where the patient is located);
   - ✳ The practitioner must:
     - ➡ Establish a therapeutic relationship with the patient at least 30 days prior to providing the ESD documentation; and
     - ➡ Complete a clinical evaluation regarding the individual's need for an ESD;
   - ✳ The practitioner must notify the patient seeking ED documentation, verbally or in writing, that:
     •"Knowingly and fraudulently representing oneself to be the owner or trainer of any canine licensed as, to be qualified as, or identified as, a guide, signal, or service dog is a misdemeanor violation of Section 365.7 of the Penal Code."
3. The practitioner must include their:
   - ✓ license/registration number;
   - ✓ effective date of licensure/registration;

- ✓ jurisdiction of licensure/registration (e.g. California); and
- ✓ license/registration type in the ESD documentation.
- ✓ Associates must also include their supervisors' information.

Click here for more information on the BBS website

AB 468: Changes to Definition of Support Dog BBS Full Update

Law Change Regarding Emotional Support Animals: What BBS Licensees Need to Know

AB 468 was recently signed by the Governor and becomes effective on January 1, 2022. This bill requires all health care practitioners (including Board licensees and registrants) to comply with all of the following if they are providing documentation relating to an individual's need for an emotional support dog:

1. They must have a valid, active license, and include their license effective date, license number, jurisdiction, and type of professional license in the documentation.

2. They must be licensed in the jurisdiction where the documentation is provided (i.e. where the client is located).

3. They must establish a client-provider relationship with the individual for at least 30 days prior to providing the documentation.

4. They must complete a clinical evaluation of the individual regarding the need for an emotional support dog.

5. They must provide a verbal or written notice to the individual that knowingly or fraudulently representing oneself as the owner or trainer of any dog licensed, qualified, or identified as a guide, signal or service dog is a misdemeanor violation of Section 365.7 of the Penal Code.

Any violation of the above subjects a health care practitioner to discipline from their licensing board.

What is an emotional support dog?
The bill defines and emotional support dog as a dog that provides emotional, cognitive, or other similar support to an individual with a disability, and that does not need to be trained or certified.

Are associates also permitted to issue this documentation?
Yes. Although the bill uses the term "licensed", Business and Professions Code (BPC) Section 23.8 states that when a "licensee" is referred to in the BPC, the term also includes registrants (associates). Therefore, the law as stated above applies to associates as well.

How many times must I meet with my client before issuing the documentation?
The new law states that the health care practitioner must not provide the documentation until a client-provider relationship has been established for at least 30 days. It does not prescribe a specified number of meetings.

6E. Supervisors in Private Practice and Professional Corporations

Hiring Supervisors in a Private Practice or Professional Corporations Laws and Regulations Overview

The requirements for a supervisor of an associate working in a private practice or a professional corporation has been updated. The supervisor must:

- Be employed or contracted by the associate's employer, or
- Be an owner.
- Also provide psychotherapeutic services to clients for the associate's employer; or have a written contract in place that provides the supervisor access to the associate's clinical records and the associate's clients must also authorize the release of their clinical records to the supervisor.

Increase in Number of Supervisees in Nonexempt Settings

Supervisors of supervisees in any nonexempt setting are limited to six supervisees per supervisor. This applies to all nonexempt settings, not just private practice and professional corporations. Click here for more information on the BBS's AB 690

Hiring Supervisors in a Private Practice or Professional Corporation
BBS Full Update

AB 690: Practice Setting Definitions and Supervision Law Changes

AB 690 becomes effective on January 1, 2022. Highlights of the changes it makes are as follows. The complete text of AB 690 can be found here.

Practice Setting Definitions

Practice settings are now defined as follows:

- Exempt Setting: A governmental entity, a school, a college, a university, or an institution that is both nonprofit and charitable.
- Nonexempt Setting: Any type of setting that does not qualify as an exempt setting.
- Private Practice: A type of nonexempt setting that meets all of the following:

  (A) The practice is owned by a health professional who is licensed under this division either independently or jointly with one or more other health professionals who are licensed under this division.

  (B) The practice provides clinical mental health services, including psychotherapy, to clients.

  (C) One or more licensed health professionals are responsible for the practice and for the services provided and set conditions of client payment or reimbursement for the provision of services.
- Professional Corporation: A type of nonexempt setting and private practice that has been formed pursuant to Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code.

Law Changes or Clarifications Related to Practice Settings

- An individual working or volunteering in an exempt setting who is licensed or registered by the Board of Behavioral Sciences (Board) is still under the jurisdiction of the Board and subject to its laws.
- An entity that is licensed or certified by a government regulatory agency to provide health care services is not an exempt setting just because it has government certification. It must still directly meet the definition of an exempt setting (i.e. the entity itself must be a governmental entity, a

school, a college, a university, or an institution that is both nonprofit and charitable) in order to be considered exempt.

- In nonexempt settings, an active license or registration number is always required to engage in the practice of the professions the Board regulates, with two exceptions:

**MFT trainees, PCC trainees, and social work interns may practice in nonexempt settings that are not private practices or professional corporations, if they are gaining supervised experience in their graduate degree program under the jurisdiction and supervision of their school.

**Applicants for registration as associates may practice in nonexempt settings that are not private practices or professional corporations, if they are in compliance with the 90-day rule and are gaining supervised experience toward licensure.

- A trainee, associate, or applicant for licensure who provides voluntary services in any lawful work setting who only receives reimbursement for expenses actually incurred shall be considered an employee. (Previously, this allowance was not available to individuals who were volunteering in a private practice.)

Law Changes or Clarifications Related to Supervision

• Changes were made to the law regarding where the supervisor of an associate working in a private practice or professional corporation must be employed and practice. The new law requires the following of supervisors of associates in a private practice or professional corporation:

✓ The supervisor must be employed by or contracted by the associate's employer, or be an owner.

✓ The supervisor must also meet one of the following:

1. The supervisor provides psychotherapeutic services to clients for the associate's employer; OR

2. The supervisor and the associate's employer must have a written contract in place that provides the supervisor the same access to the associate's clinical records as is provided to employees of that employer. The associate's clients must also authorize the release of their clinical records to the supervisor.

- A written oversight agreement between the supervisor and the employer is now required for all supervisor-supervisee relationships where the

supervisor is not employed by the supervisee's employer or is a volunteer. (Previously, this was not required for private practices, because supervisors in private practices were previously required to have the same employer as the supervisee.)

- Supervisors of supervisees in any nonexempt setting are limited to six supervisees per supervisor. (Please note that this limit applies to all nonexempt settings, not just private practices and professional corporations.)
- Supervisees working in exempt settings may obtain their required weekly direct supervisor contact via two-way, real-time videoconferencing. (Previously, the law had only stated that associates in exempt settings could obtain supervision via videoconferencing, leaving it unclear whether or not trainees (who are also supervisees) could do so as well.)

AB 690: Practice Setting Definitions and Supervision Law Changes
AB 690 becomes effective on January 1, 2022. Highlights of the changes it makes are as follows. The complete text of AB 690 can be found here.
Practice Setting Definitions
Practice settings are now defined as follows:

Exempt Setting: A governmental entity, a school, a college, a university, or an institution that is both nonprofit and charitable.
Nonexempt Setting: Any type of setting that does not qualify as an exempt setting.
Private Practice: A type of nonexempt setting that meets all of the following:

(A) The practice is owned by a health professional who is licensed under this division either independently or jointly with one or more other health professionals who are licensed under this division.
(B) The practice provides clinical mental health services, including psychotherapy, to clients.
(C) One or more licensed health professionals are responsible for the practice and for the services provided and set conditions of client payment or reimbursement for the provision of services.

Professional Corporation: A type of nonexempt setting and private practice that has been formed pursuant to Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code.

Law Changes or Clarifications Related to Practice Settings

- ➡ An individual working or volunteering in an exempt setting who is licensed or registered by the Board of Behavioral Sciences (Board) is still under the jurisdiction of the Board and subject to its laws.
- ➡ An entity that is licensed or certified by a government regulatory agency to provide health care services is not an exempt setting just because it has government certification. It must still directly meet the definition of an exempt setting (i.e. the entity itself must be a governmental entity, a school, a college, a university, or an institution that is both nonprofit and charitable) in order to be considered exempt.
- ➡ In nonexempt settings, an active license or registration number is always required to engage in the practice of the professions the Board regulates, with two exceptions:

    1. MFT trainees, PCC trainees, and social work interns may practice in nonexempt settings that are not private practices or professional corporations, if they are gaining supervised experience in their graduate degree program under the jurisdiction and supervision of their school.
    2. Applicants for registration as associates may practice in nonexempt settings that are not private practices or professional corporations, if they are in compliance with the 90-day rule and are gaining supervised experience toward licensure.

- ➡ A trainee, associate, or applicant for licensure who provides voluntary services in any lawful work setting who only receives reimbursement for expenses actually incurred shall be considered an employee. (Previously, this allowance was not available to individuals who were volunteering in a private practice.)

Law Changes or Clarifications Related to Supervision

- ➡ Changes were made to the law regarding where the supervisor of an associate working in a private practice or professional corporation must be employed and practice. The new law requires the following of supervisors of associates in a private practice or professional corporation:
    - ✓ The supervisor must be employed by or contracted by the associate's employer, or be an owner.
    - ✓ The supervisor must also meet one of the following:

- The supervisor provides psychotherapeutic services to clients for the associate's employer; OR
- The supervisor and the associate's employer must have a written contract in place that provides the supervisor the same access to the associate's clinical records as is provided to employees of that employer. The associate's clients must also authorize the release of their clinical records to the supervisor.

➡ A written oversight agreement between the supervisor and the employer is now required for all supervisor-supervisee relationships where the supervisor is not employed by the supervisee's employer or is a volunteer. (Previously, this was not required for private practices, because supervisors in private practices were previously required to have the same employer as the supervisee.)
➡ Supervisors of supervisees **in any nonexempt setting** are limited to six supervisees per supervisor. (Please note that this limit applies to all nonexempt settings, not just private practices and professional corporations.)
➡ Supervisees working in exempt settings may obtain their required weekly direct supervisor contact via two-way, real-time videoconferencing. (Previously, the law had only stated that associates in exempt settings could obtain supervision via videoconferencing, leaving it unclear whether or not trainees (who are also supervisees) could do so as well.)

6F. Additional Updated 2022 Supervision Requirements

2022 Supervision Requirements Overview

Effective January 1, 2022, the BBS has issued new supervision regulations which:

1. Increase consistency in supervisor requirements and responsibilities between the LMFT, LCSW and LPCC professions.
2. Highlight new supervisor responsibilities.
3. Require supervisors to submit a Self-Assessment Report in order to inform the Board that they are supervising, and to self-certify that they meet all qualifications to supervise.

- Require supervisors and supervisees to complete and sign a Supervision Agreement (replaces the Supervisor Responsibility Statement and Supervisory Plan for NEW supervisory relationships).

- Update the contents of the written oversight agreement (for NEW supervisory relationships)
- Set standards in regards to temporary substitute supervisors.
- Set standards for documentation when a supervisor is deceased or becomes incapacitated prior to signing off on an applicant's supervised experience.
- Set standards in regards to supervisees who have been placed in an agency by a temporary staffing agency.
- Modify supervisor training requirements, including the following:
    - Requires new supervisors to take 15 hours of supervision training that contains specified content within 60 days of commencing supervision.
    - Requires existing supervisors to take 6 hours of continuing professional development every two years, which may include continuing education courses or other specified professional development activities.

2022 Supervision Requirements BBS Full Update

Supervision-Related Regulation Changes for Individuals Pursuing LMFT, LCSW or LPCC Licensure and Supervisors

Effective January 1, 2022 The Board of Behavioral Sciences (board) has recently obtained approval of changes to its supervision-related regulations. Supervision-related laws are contained in both statutes (Business and Professions Code or BPC) and in Title 16, Division 18 of the California Code of Regulations (16 CCR).

This document provides a summary of the recent regulation changes, but we recommend you click here to read the full legal text of the updated regulations. Also, be sure to read the board's informational document pertaining to Assembly Bill (AB) 690, which makes some changes to the statutes (BPC) pertaining to supervision and work settings.

The board continues to discuss supervision-related topics and possible future law changes at various committee meetings, which you can find on the board's website and by signing up for our email subscriber's list.

Who do the new supervision-related regulations apply to?
The new regulations apply to anyone gaining hours of supervised experience toward licensure as any of the following:
• Licensed Marriage and Family Therapist (LMFT)
• Licensed Clinical Social Worker (LCSW)
• Licensed Professional Clinical Counselor (LPCC)

This includes Associates, applicants for Associate registration, and MFT Trainees, but does not include students pursuing LCSW or LPCC licensure. The regulations also apply to licensees who are supervising the above individuals, and include LMFTs, LCSWs, LPCCs, Licensed Educational Psychologists (LEPs), Psychologists licensed by the Board of Psychology (Licensed Psychologists), and Physicians certified in Psychiatry by the American Board of Psychiatry and Neurology (Board-Certified Psychiatrists). However, as in the past, the supervisor training and coursework requirements do not apply to Licensed Psychologists or Board-Certified Psychiatrists.

Why were changes made to supervision requirements?
The regulatory changes came about as a result of the board's Supervision Committee, which began its work in 2014. The Committee surveyed supervisors and supervisees to identify possible changes needed, and conducted public meetings where proposed changes were discussed with students, associates, educators, supervisors, agencies and others. These changes were originally noticed to the public on March 23, 2020.
The changes are designed to strengthen supervised experience requirements in ways that benefit and provide clarity to supervisors, agencies, and supervisees; to address issues that may arise during supervised experience; and, to reduce the problems sometimes encountered by supervisees in the process of applying for licensure.

What are the changes I need to be aware of and when do they take effect?
The regulation changes, with one exception, take effect on January 1, 2022 (the *Supervisor Self-Assessment Report* component is phased in later). The changes are detailed below:

I. DECEASED OR INCAPACITATED SUPERVISORS: DOCUMENTATION REQUIRED

16 CCR Section 1815.8

This new section specifies the documentation required should a supervisor pass away or become incapacitated prior to signing off on a supervisee's experience hours.

The required proof includes, but is not limited to evidence that the supervisor is deceased or incapacitated, all supervision documentation which had previously been signed by the supervisor, and documentation from the supervisee's employer or a *Written Oversight Agreement*.

What this means for Supervisees

When a supervisee applies for licensure and has gained experience under a supervisor who died or became incapacitated prior to signing off on the supervisee's experience, there is now a list of documents legally required to be provided to the board to substantiate that experience.

What this means for Supervisors

It is important that you sign all documentation required by law at the initiation of supervision, and sign experience logs weekly to ensure that the supervisee has the documentation needed to substantiate their experience on an ongoing basis in case something happens.

What this means for Employers

Should a supervisor of one of your employed supervisees pass away or become incapacitated prior to signing off on their supervisee's experience, the employer will need to provide the supervisee with documentation verifying the employment of the supervisor and supervisee (or, if the supervisor was not employed by the supervisee's employer, you will need to provide a copy of the *Written Oversight Agreement*).

What if my supervisor died or became incapacitated prior to the regulation's effective date and I have not applied for licensure yet?

If you already had this situation happen to you, the board will review the documentation you submit with your *Application for Licensure* on a case-by-case basis to make a determination. The board suggests that you include all of the documentation specified in the new regulation if possible.

II. REQUIRED DOCUMENTATION OF SUPERVISED EXPERIENCE

16 CCR Sections 1820 (LPCC), 1833 (LMFT), and 1869 (LCSW)

The regulation changes clarify and modify the required documentation for supervisees gaining experience toward licensure as follows:

A. Supervision Agreement

New requirements apply only to NEW supervisory relationships established on or after January 1, 2022.

Requires supervisors and supervisees to sign a *Supervision Agreement* within 60 days of the commencement of supervision. This form also includes a supervisory plan to be developed collaboratively by the supervisor and supervisee. The *Supervision Agreement* must be retained by the supervisee and submitted to the board upon application for licensure. This new form will be posted to the board's website prior to January 1, 2022.

The purpose of the agreement is to help ensure that supervisors and supervisees understand their requirements and responsibilities, and to help supervisees understand what is required for supervised experience to be accepted by the board. The *Supervision Agreement* replaces the *Supervisor Responsibility Statement* (formerly required for LCSW, LPCC and LMFT) and *Supervisory Plan* (formerly required for LCSW and LPCC).

B. Written Oversight Agreement

New requirements apply only to NEW supervisory relationships established on or after January 1, 2022.

The text required within the *Written Oversight Agreement*, required between the supervisor and employer prior to commencement of supervision when the supervisor is not employed by the supervisee's employer, has changed. A new sample agreement will be posted to the board's website prior to January 1, 2022.

The new content requires the employer to acknowledge their awareness that the supervisor will be providing clinical guidance and direction to the supervisee in order to ensure compliance with the standards of practice of the profession, which include legal requirements and professional codes of ethics, and to agree not to interfere with this process. This agreement must be provided to supervisees and submitted to the board upon application for licensure.

C. Weekly Log (Newly Required for LCSW Licensure Hours)
Applies only to hours gained toward LCSW licensure on or after January 1, 2022.
Requires a *Weekly Log* to record experience hours for those pursuing LCSW licensure (a weekly log is already required for those pursuing LPCC or LMFT licensure). The board currently publishes an optional weekly log for LCSWs even though it was not previously required by law. That form will not be changing – the only change is that the log is now required for hours gained on or after January 1, 2022. The log must be signed weekly by the supervisor and retained by the supervisee. The board may request to see portions of the log after the supervisee applies for licensure.
Note: Documentation of Completed Experience (Experience Verification)
The changes regarding documentation of completed experience simply clarify how completed hours of supervised experience shall be documented. There is no impact to supervisees, supervisors or employers as a result of the clarified regulation. The board will continue to provide an *Experience Verification* form for this purpose, which are not anticipated to change significantly. Old versions of these forms will continue to be accepted. The *Experience Verification* form will continue to be submitted to the board by the supervisee upon application for licensure as usual.

What these changes mean for Supervisees
A. Supervision Agreement
If you enter into a new supervisory relationship on or after January 1, 2022:
You and your new supervisor will both need to sign a *Supervision Agreement* within 60 days of commencing supervision, which you will retain and submit to the board upon application for licensure.

If you are already in a supervisory relationship prior to January 1, 2022:
A *Supervision Agreement* with your current supervisor is not required. Instead, you will retain the previously signed *Supervisor Responsibility Statement*, and if you are pursuing LCSW or LPCC licensure, the signed *Supervisory Plan,* for submission to the board upon application for licensure.

B. Written Oversight Agreement
If you enter into a new supervisory relationship that requires a *Written Oversight Agreement* on or after January 1, 2022:
Your supervisor and employer must sign a *Written Oversight Agreement* prior to the commencement of supervision that includes the new content

specified in regulation. You will need to submit this agreement to the board upon application for licensure.

If you are already in a supervisory relationship prior to January 1, 2022:
If there is a *Written Oversight Agreement* previously signed by your supervisor and employer, you do not need to ask them to sign a new one – retain the previously signed agreement for submission to the board upon application for licensure.

C. Weekly Log (Newly Required for LCSW Licensure Hours)
If you are pursuing LCSW licensure, you are now required to maintain a weekly log of your experience hours to be signed by your supervisor weekly for hours gained on and after January 1, 2022. If you are already maintaining a weekly log using the optional form currently published by the board, you just need to continue using that form and having it signed. If you are not currently keeping a weekly log, you must begin keeping one. We recommend that you use the current form provided on the board's website. The board may request to see portions of the log after you apply for licensure.

What these changes mean for Supervisors

A. Supervision Agreement
If you enter into a new supervisory relationship on or after January 1, 2022:
You and your new supervisee will both need to sign a *Supervision Agreement* within 60 days of commencing supervision, which the supervisee will retain for submission to the board upon application for licensure.
If you are already in a supervisory relationship prior to January 1, 2022:
A *Supervision Agreement* with your current supervisee(s) is not required. Instead, the supervisee will retain the previously signed *Supervisor Responsibility Statement*, and if the supervisee is pursuing LCSW or LPCC licensure, the signed *Supervisory Plan,* for submission to the board upon application for licensure.

B. Written Oversight Agreement
If you enter into a new supervisory relationship that requires a *Written Oversight Agreement* on or after January 1, 2022:
You and the employer must sign a *Written Oversight Agreement* prior to the commencement of supervision that includes the new content specified in

regulation. You must provide this agreement to the supervisee for submission to the board upon application for licensure.
If you are already in a supervisory relationship prior to January 1, 2022:
If there is a *Written Oversight Agreement* previously signed by you and your supervisee's employer, you do not need to sign a new one – your supervisee will retain the previously signed agreement for submission to the board upon application for licensure.

C. Weekly Log (Newly Required for LCSW Licensure Hours)
If you are supervising an individual pursuing LCSW licensure, you must now sign their weekly log of experience hours on a weekly basis, for hours gained on and after January 1, 2022. A weekly log form is currently available on the board's website for this purpose. The board may request to see portions of the log after your supervisee applies for licensure.

What these changes mean for Employers
A. Supervision Agreement
There are no new requirements for employers pertaining directly to the new *Supervision Agreement*.

B. Written Oversight Agreement
If you have an employee who enters into a new supervisory relationship that requires a *Written Oversight Agreement* on or after January 1, 2022:
You and the supervisor must sign a *Written Oversight Agreement* prior to the commencement of supervision that includes the new content specified in regulation.

If you have an employee who is already in a supervisory relationship prior to January 1, 2022: If there is a *Written Oversight Agreement* previously signed by you and the supervisor, you do not need to sign a new one.

C. Weekly Log (Newly Required for LCSW Licensure Hours)
There are no new requirements for employers pertaining directly to the new LCSW weekly log requirement.

III. PLACEMENT BY TEMPORARY STAFFING AGENCIES
16 CCR Sections 1820.3 (LPCC), 1833.05 (LMFT) and 1869.3 (LCSW)
This new section of law sets forth provisions that apply to a supervisee who has been placed by a temporary staffing agency (an agency that locates

positions and fills vacancies for agencies on a temporary basis). The new provisions include all of the following:

- Specifies that the supervisee shall only perform mental health and related services at the places where the contracting agency (the agency where a supervisee has been placed) permits business to be conducted.
- Clarifies that the *Written Oversight Agreement* (if required by statute) shall be between the contracting agency and the supervisor when the supervisor is not an employee of the contracting agency or is a volunteer. Also clarifies that, in cases where the supervisor is an employee of the contracting agency, no written oversight agreement shall be required.
- Clarifies that a supervisee placed by a temporary staffing agency is prohibited from being employed as an independent contractor.

What this means for Supervisees

A supervisee who has been placed by a temporary staffing agency should make sure that the contracting agency has authorized the location where they are performing mental health services. Those being supervised by a licensee who is not employed by the contracting agency should make sure that a *Written Oversight Agreement* has been signed. Lastly, supervisees should make sure they are not employed as an independent contractor.

What this means for Supervisors

If you are supervising an individual who has been placed by a temporary staffing agency, you should check to confirm that the contracting agency has authorized the location where the supervisee is performing mental health services. Supervisors who are not employed by the contracting agency must sign a *Written Oversight Agreement* with the contracting agency. Supervisors should also make sure their supervisee is not employed as an independent contractor (must be a W-2 employee).

What this means for Temporary Staffing Agencies

Temporary staffing agencies are no longer permitted to determine the location where the supervisee performs mental health and related services - this is now the contracting agency's decision. In addition, if your agency is the supervisee's employer, you may not employ them as an independent contractor (must be a W-2 employee).

What this means for Contracting Agencies
The contracting agency must now determine the location where the supervisee performs mental health and related services. If the supervisee's supervisor is not employed by your agency, a *Written Oversight Agreement* must be signed by your agency and the supervisee's supervisor. In addition, if you are the supervisee's employer, your agency may not employ them as an independent contractor (must be a W-2 employee).

What if a supervisee is in a position where they have been placed by a temporary staffing agency prior to January 1, 2022?
The board's statutes already prohibit supervisees being employed as an independent contractor, and already require a *Written Oversight Agreement* when the supervisor is not employed by the supervisee's employer. These provisions were only included in the regulation for clarity due to the unique circumstances of this employment situation, and therefore there is no actual change in requirements.

However, if a supervisee is in a position where the temporary agency has specified the location of where the mental health and related services are being provided, be aware that the service location is now solely the decision of the contracting agency.

IV. REQUIREMENTS FOR SUPERVISORS
Supervision Agreement, Supervisor Responsibilities, Supervisor Self-Assessment
16 CCR Sections 1821 (LPCC), 1833.1 (LMFT) and 1870 (LCSW)

1. Technical Changes:
Updates wording for consistency with the Business and Professions Code (BPC), and strikes requirements that duplicate BPC provisions.

2. Supervision Agreement:
Requires a *Supervision Agreement* for **new** supervisory relationships that are established on or after January 1, 2022. This agreement replaces the *Supervisor Responsibility Statement,* and for those pursuing LCSW or LPCC licensure, the *Supervisory Plan*. For more information on the *Supervision Agreement* see section II of this document.

3. Supervisor Responsibilities:
Adds the following supervisor responsibilities that apply **regardless of when** a supervisory relationship was established:

- ✓ Specifies that a supervisor shall be competent in the areas of clinical practice and techniques being supervised.
- ✓ Requires the supervisor to self-monitor for and address supervision dynamics such as, but not limited to, countertransference-, intrapsychic-, interpersonal-, or trauma-related issues that may affect supervision.
- ✓ Requires the supervisor to notify the supervisee of any licensure condition that affects the supervisor's ability to practice.
- ✓ Requires the supervisor to complete an assessment of the ongoing strengths and limitations of the supervisee at least once a year and at the completion or termination of supervision, and to provide the supervisee with a copy *(new for supervisees pursuing LPCC or LMFT licensure, previously required for LCSW)*.
- ✓ Requires a supervisor to establish written procedures for supervisees to contact the supervisor or, in the supervisor's absence, procedures for contacting an alternative on-call supervisor to assist supervisees in handling crises and emergencies. The supervisor shall provide these procedures to the supervisee prior to the commencement of supervision.

4. Supervisor Self-Assessment Report:
Requires supervisors to complete and submit a *Supervisor Self-Assessment Report* to the board, which affirms the licensee's qualifications to be a supervisor. The board is developing a form for this purpose that will be released on or before January 1, 2022.

Requirements for submission of the new *Supervisor Self-Assessment Report* is **phased in** as follows:

Licensees currently supervising one or more supervisees as of January 1, 2022:

- ✓ Must submit a *Supervisor Self-Assessment Report* to the board **by January 1, 2023**.

Licensees NOT supervising as of January 1, 2022:

✓ Must submit a *Supervisor Self-Assessment Report* to the board within 60 days of commencing supervision.

What these changes mean for Supervisees
There are no new requirements in this section that pertain directly to supervisees EXCEPT that those who begin working under a new supervisor **on or after January 1, 2022** will need to sign a *Supervision Agreement,* which is described in further detail in section II of this document.
Supervisees should also be aware of the following:

✓ Your supervisor is now required to conduct assessments of your strengths and limitations and provide you with a copy.

✓ Your supervisor must provide you with written procedures for contacting a supervisor in the event of a crisis or emergency.

What these changes mean for Supervisors

- All supervisor responsibilities are now the same regardless of which license type your supervisees are pursuing (previously there was some variation between the LCSW, LMFT and LPCC regulations).
- You must ensure that you are meeting all of the responsibilities specified above for all supervisees.
- You must complete a *Supervision Agreement* for new supervisory relationships that are established on or after January 1, 2022, as described in further detail in section II of this document
- You must complete a *Supervisor Self-Assessment Report* and submit it to the board according to the timeline specified in above.

What these changes mean for Employers
There are no new requirements in this section that pertain directly to employers. However, employers should be aware that supervisors have some new responsibilities as specified in above.

V. SUBSTITUTE SUPERVISORS

16 CCR Sections 1821.1 (LPCC), 1833.1.5 (LMFT), and 1870.3 (LCSW)
When a supervisee obtains supervision temporarily from a substitute supervisor, the following are now required:

- The substitute supervisor shall:
  - Meet all supervisor qualifications required by law; and

- Sign the supervisee's weekly log.

- The substitute supervisor and the supervisee shall sign the *Supervision Agreement* specified in regulation.
- The substitute supervisor and supervisee's employer shall sign a *Written Oversight Agreement* if required by statute.
- If the substitute will be supervising for MORE than 30 consecutive calendar days:
  - A new supervisory plan is also required, and
  - The substitute supervisor shall also verify the supervisee's experience gained during that time (the substitute supervisor must sign the *Experience Verification* form for hours earned under the substitute).
- If the substitute will be supervising for 30 consecutive calendar days or LESS:
  - A new supervisory plan is not required. The substitute supervisor shall follow the supervisee's pre-existing supervisory plan.
  - The experience gained during this period may be verified by the regular supervisor (the regular supervisor may sign the *Experience Verification* form for hours earned under the substitute).

What this means for Supervisees

Just like with your regular supervisor, you should verify that your substitute supervisor meets all normal supervisor qualifications required by law. In addition, you and the substitute must sign a *Supervision Agreement*, and you must have the substitute sign your weekly log during that time. If a *Written Oversight Agreement* is required, this must also be in place.

If the substitute is supervising you for LESS than 30 consecutive calendar days: A new supervisory plan (within the *Supervision Agreement* form) is not required – you can just write "N/A – substitute supervisor" in the supervisory plan section. Your regular supervisor may sign the *Experience Verification* form for the hours you gained under the substitute.

If the substitute is supervising you for MORE than 30 consecutive calendar days: In addition to the above, you and the substitute must also develop a new supervisory plan, which is a part of the *Supervision Agreement* form. Your substitute supervisor must sign the *Experience Verification* form for the experience you gained under the substitute.

What this means for Supervisors
If you will be serving as a substitute supervisor, you will need to ensure that you meet all normal supervisor qualifications required by law. In addition, you will need to sign a *Supervision Agreement* with the supervisee, sign the supervisee's weekly log, and if required, sign a *Written Oversight Agreement*.

If you will be supervising the supervisee for LESS than 30 consecutive calendar days: A new supervisory plan (within the *Supervision Agreement* form) is not required – you can just write "N/A – substitute supervisor" in the supervisory plan section. The regular supervisor may sign the *Experience Verification* form for the hours the supervisee gained under your supervision. If you will be supervising the supervisee for MORE than 30 consecutive calendar days: In addition to the above, you and the supervisee must also develop a new supervisory plan, which is within the *Supervision Agreement* form. You will need to sign an *Experience Verification* form for the experience gained under your supervision.

What this means for Employers
There are no new requirements in this section pertaining to employers. However, employers may want to verify that substitute supervisors providing supervision to employees meet these qualifications and follow these procedures.

VI. SUPERVISOR TRAINING AND COURSEWORK
16 CCR Sections 1821.3 (LPCC), 1834 (LMFT), and 1871 (LCSW)

1. 15-Hour Training for New Supervisors:
Requires **persons licensed by the Board of Behavioral Sciences who commence supervision for the first time in California on or after January 1, 2022** to complete 15 hours of supervision training or coursework. This course must be taken from a government agency or board-accepted continuing education (CE) provider within 60 days after commencing supervision, as follows:

- **Course Content**: The 15-hour course must include, but is not limited to, current best practices and current industry standards, which include legal requirements, professional codes of ethics, and research focused on supervision regarding the following:
  - Competencies necessary for new supervisors;
  - Goal setting and evaluation;

- ✳ The supervisor-supervisee relationship;
- ✳ California law and ethics, including legal and ethical issues related to supervision;
- ✳ Cultural variables, including, but not limited to, race, gender, social class, and religious beliefs;
- ✳ Contextual variables, such as treatment modalities, work settings, and use of technology;
- ✳ Supervision theories and literature; and
- ✳ Documentation and record keeping of the supervisee's client files, as well as documentation of supervision.

➡ **Age of Course**: If the 15-hours of training or coursework is taken from a government agency or board-accepted CE provider, the course may be up two years old. If taken at the master's or higher level from an accredited or approved postsecondary institution, the course may be up to four years old. If the course has not yet been taken, it must be taken within 60 days after commencing supervision.

2. Two-Year Lapse in Supervising:
Requires persons licensed by the Board of Behavioral Sciences who take a break from supervising (have not supervised for two years or more) to take six (6) hours of supervision training or coursework from a government agency or board-accepted CE provider within 60 days of resuming supervision. This applies to supervisors who resume supervision on or after January 1, 2022.

3. Six Hours of Continuing Professional Development (CPD) Each Renewal:
Requires supervisors licensed by the Board of Behavioral Sciences to complete a minimum of six (6) hours of continuing professional development (CPD) in supervision during each renewal period that occurs on or after January 1, 2022.

CPD may consist of any of the following activities, with documentation to be retained by the licensee in the event of a board audit, as specified below:

- **Training or coursework** specific to the topic of supervision, obtained from a government agency or acceptable continuing education (CE) provider.
- **Teaching** a supervision course offered by one of the above providers.

- **Authoring research** directly focused on supervision that has been published professionally. This may include, but is not limited to, quantitative or qualitative research, literature reviews, peer reviewed journals or books, monographs, or other industry or academic published work. This shall not include personal opinion papers, editorials, or blogs.
- **Collaboration** with another licensee who also serves as a board-qualified supervisor through the use of **mentoring or consultation**. Documentation of attendance shall consist of a log signed by both parties.
- Attendance at **supervisor peer discussion groups** with other licensees who also serve as board-qualified supervisors. Documentation of attendance shall consist of a letter or certificate from the group leader or facilitator.

4. Training Waiver for Certified Supervisors:
All training/coursework requirements are waived for board-licensed supervisors who hold a valid and active approved supervisor certification from one of the following entities:
• The American Association for Marriage and Family Therapy (AAMFT)
• The American Board of Examiners in Clinical Social Work (ABECSW)
• The California Association of Marriage and Family Therapists (CAMFT)
• The Center for Credentialing and Education (CCE)

Note: The board shall accept an approved supervisor certification from another entity if the licensee can demonstrate that the certification requirements of that entity meet or exceed those of any one of the above entities.

What these changes mean for Supervisees
There are no new requirements in this section pertaining to supervisees.

What these changes mean for Supervisors
The new requirements in this section pertain only to supervisors licensed as a LMFT, LCSW, LPCC or LEP. As in the past, supervisors who are a Licensed Psychologist or a Board-Certified Psychiatrist are not mandated to take supervisor coursework or training, though it is recommended that they do so.

The 15 hours of supervisor training or coursework applies only to NEW supervisors (those who have never supervised in California) who begin

supervising on or after January 1, 2022. See above for the allowed age of the course. The 15 hours can be taken as a single course, or as multiple courses as long as they add up to at least 15 hours and contain all of the content specified in above. A course taken from a board-accepted CE provider will count toward the CE required for license renewal. Licensees who are currently supervising do not need to take a 15-hour course, even if they have never taken a 15-hour course in the past.

The six (6) hours of Continuing Professional Development (CPD) in supervision each renewal cycle (as explained above) is required of anyone who is currently supervising. If you have already taken a six-hour course in supervision to meet the CE requirements of an upcoming license renewal, it will count toward the CPD requirement. Please note that only CE courses will apply to your regular license CE requirements – the other types of CPD listed will not.

If you have taken a break of two or more years in supervising, and resume supervising on or after January 1, 2022, you will need to take six (6) hours of supervision training or coursework within 60 days of resuming supervision. A course taken from a board-accepted CE provider will count toward the CE you are required to take for license renewal.

If you hold a valid and active approved supervisor certification as specified in above, all board-required supervision training and coursework, as listed above, is waived.

All documentation of supervisor training, coursework, CPD and/or approved supervisor certification(s) must be retained for seven (7) years after the termination of supervision in the event of a board audit, as required by statute.

What these changes mean for Employers
There are no new requirements in this section pertaining to employers. However, employers may want to verify that anyone licensed by the Board of Behavioral Sciences who is providing supervision to employees gaining hours toward licensure meet these qualifications.

VII. LPCC ASSESSMENT OR TREATMENT OF COUPLES AND FAMILIES

16 CCR Sections 1820.5 and 1821(a)(11)

This package of regulation changes contained minor changes to the above listed sections pertaining to LPCC assessment or treatment of couples and families. However, section 1820.5 and section 1821(a)(11) are no longer applicable due to the recent passage of AB 462 (Chapter 440, Statutes of 2021), which eliminates the requirement for LPCCs treating couples or families to meet certain additional education and experience requirements. The board will be working on a regulation change to delete sections 1820.5 and 1821(a)(11) since AB 462 supersedes the regulations.

6G. MFT Scope of Practice

Scope of Practice: Marriage and Family Therapy

Effective January 1, 2022, amendments have been made to the marriage and family therapy scope of practice in order to modernize and clarify it. The marriage and family therapy scope of practice now reads as follows:

BPC §4980.02.

(a) For the purposes of this chapter, the practice of marriage and family therapy shall mean the application of psychotherapeutic and family systems theories, principles, and methods in the delivery of services to individuals, couples, or groups in order to assess, evaluate, and treat relational issues, emotional disorders, behavioral problems, mental illness, alcohol and substance use, and to modify intrapersonal and interpersonal behaviors.

(b) The application of marriage and family therapy principles and methods includes, but is not limited to, all of the following:

(1) Assessment, evaluation, and prognosis.

(2) Treatment, planning, and evaluation.

(3) Individual, relationship, family, or group therapeutic interventions.

(4) Relational therapy.

(5) Psychotherapy.

(6) Client education.

(7) Clinical case management.

(8) Consultation.

(9) Supervision.

(10) Use, application, and integration of the coursework and training required by Sections 4980.36, 4980.37, and 4980.41, as applicable.

(c) The amendments to this section made by the act adding this subdivision do not constitute a change in, but are declaratory of, existing law. It is the intent of the Legislature that these amendments shall not be construed to expand or constrict the existing scope of practice of a person licensed pursuant to this chapter.

Required LMFT and LPCC Coursework: Prognosis
In the 2019 Committee Bill (SB 786, which was signed into law and became effective January 1, 2020), the Board sponsored an amendment to Business and Professions Code (BPC) sections 4980.36, 4980.37, 4980.81, 4999.32, and 4999.33.

Previously those sections, which list required education and practicum for LMFT and LPCC licensure, required training in assessment, diagnosis, and prognosis.

The Board proposed an amendment replacing the term "prognosis" with the term "treatment planning," because it believed treatment planning is a more accurate representation of the course of psychotherapy. This became law via SB 786.

However, an unintended consequence of this change was that some other mental health professions began interpreting the Board's law change as meaning LMFTs and LPCCs are not permitted to perform prognosis. This was not Board's intent, and therefore the word "prognosis" has been added back into the above-listed sections.

6H. 2022 Federal Regulations: The No Surprises Act

The No Surprises Act Overview

The No Surprises Act became effective on January 1st, 2022. It includes new requirements for health care providers, facilities, health plans and insurers designed to prevent clients/patients from receiving surprise medical fees/ bills. It is designed to increase transparency and reduce the likelihood that clients/patients receive any "surprise" medical bills. This is partially achieved by requiring that providers inform patients/clients of any expected charges for a services before the service is provided.

Part 1 of the regulations is designed to protect clients/patients covered by a health plan from unanticipated fees/bills from out of network MFT providers.

Part 2 of the regulations requires includes a "good faith estimate" and requires "all health care providers and health care facilities licensed, certified or approved by the state to provide good faith estimates of expected charges for services and items offered to uninsured and self-pay patients/ clients". In summary, any health care provider or health care facility licensed by their respective state must provide a good faith estimate of expected charges for services to current and future clients/patients. Clients/patients also now have access to a process to dispute provider charges that "substantially exceed" the good faith estimate provided.

"Health care provider" is defined as "a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable state law". This definition applies to all behavioral health providers, including but not limited to LPC's, LPCC's, LEP's, LCSW's and MFTs. Health care providers and facilities must notify out of pocket and uninsured clients/patients (orally and in writing) of their right to receive a good faith estimate upon their request or at the time their service is scheduled.

The good faith estimate must include the following:

- ➡ Client/patient name and birthdate.
- ➡ Clear and understandable explanation of, as well as date(s) of intended service(s).
- ➡ Itemized list of services.
- ➡ Service and diagnostic codes when applicable.
- ➡ Estimated associated charges corresponding with each itemized service.
- ➡ The provider's full name, NPI (National Provider Identifier), and TIN (Tax Identification Number) of any providers or facilities represented in the good faith estimate.

- ➡ The state and office/facility locations where the services are expected to be provided.

- ➡ If applicable, any anticipated services that require separate and/or additional scheduling and are expected to take place before or after the expected period of care for the primary service.

- ➡ Disclaimers including the following:

  - ✓ Separate and/or additional services that require separate and/or additional scheduling.

  - ✓ Actual charges may be different than the good faith estimate.

  - ✓ The patient/client may utilize the dispute resolution process if billed services significantly exceed the anticipated charges outlined in the good faith estimate.

  - ✓ The good faith estimate is in no way a contract and the patient/client is no way obligated to access any services specified in the good faith estimate.

  - ➡ If the good faith estimate requires any changes, an updated good faith estimate must be provided to the patient/client no later than one business day before the scheduled service.

  - ➡ If there is a change in the provider(s) identified on the good faith estimate less than one business day prior to the scheduled service, any replacement provider(s) must accept the anticipated charges identified in the good faith estimate.

Behavioral health providers such as MFTs, LCSW's, LPC's, and LEP's are required to disclose fees to clients. Most behavioral health providers specify their fees in their informed consent (and other intake documents) in order to provide realistic expectations for the cleint. Effective January 1st, 2021 behavioral health providers must additionally include the following with current and future patients/clients:

- Determination of health insurance coverage status and if the patient/client will be submitting a claim for the service(s)

- Provide a written document for all uninsured and self-pay patients/clients indicating that a good faith estimate of expected charges is available.

- Provide oral notification about the availability of a good faith estimate when patients/clients schedule services and/or have questions about costs.

- Provide a written good faith estimate either on paper or electronically depending on the patient/client'd preferred method of delivery. If the good faith estimate is provided electronically, the format must enable the patient/client to save and print the document. HHS has provided a sample template Standard Form: "Good Faith Estimate for Health Care Items and Services Under the No Surprises Act

Timeframes for providing a good faith estimate must be adhered to by providers and facilities:

➡ Providers scheduling services at least ten business days in advance must provide a good faith estimate within three business days.

➡ Providers scheduling services at least three business days in advance must provide a good faith estimate within one business day.

➡ If a patient/client requests any information contained in a good faith estimate, then a good faith estimate must be provided within three business days.

➡ Providers scheduling services less than three business days in advance are not required to provide a good faith estimate.

Because many patients/clients utilize recurring services over time, their providers or facilities are permitted to provide a single good faith estimate. In these cases, the good faith estimate must contain the anticipated timeframe, frequency, and total number of services. The estimate should include anticipated services provided within one year. A new and separate estimate for services past one year as well as and updates/changes must be provided.

Good Faith Estimate Documentation

Good faith estimates are an official part of the patient's/client's medical record. Good faith estimate records are required to be available to the

patient/client for at least six years. Maintaining patient records is required for at least seven years.

Dispute Resolution Process

Disputes between patients/clients and providers require a dispute resolution process. If a sell-pay or uninsured patient/client is charged for an amount that exceeds the good faith estimate provided, the patient/client can determine payment amount via the new dispute resolution process. Patients/clients may utilize this new process if they:

- Have a good faith estimate
- A bill within the past 120 calendar days
- Can show that the difference between the good faith estimate and the bill is at least 400.00

Patients/clients may request a third party arbitrator to review:

✓ The good faith estimate

✓ Their bill

✓ Information from their provider/facility in order to evaluate if the excess charges are allowable or if the provider/facility must charge less than the billed amount

The HHS (U.S Dept of Health and Human Services) will be providing an online portal and offer documents for hard copy submissions for patients/clients who wish to begin the dispute resolution process.

Continuity of Care

Health plans are now required to notify their subscribers of provider's changes to in-network status in an effort to ensure continuity of care. If a provider's contract is terminated, the subscriber has the option to continue with the provider for 90 days following contract termination or the date when no longer a continuing patient/client, whichever is earliest. The provider must continue to offer services under the same terms and conditions as stated in the in-network contract. The only exception to this is if the

provider's contract was terminated by the health plan for cause. This allows patients/clients the opportunity to transition services to an in-network provider.

The No Surprises Act Background and Key Points

The No Surprises Act seeks to protect consumers from surprise medical bills arising out of certain out-of-network emergency care. Under Section 109 of the Act, the Secretary of Health and Human Services (HHS), in consultation with the FTC and the Attorney General, must conduct a study by January 1, 2023, and annually thereafter for each of the following 4 years, on the effects of the Act on any patterns of vertical or horizontal integration of health care facilities, providers, group health plans, or health insurance issuers; overall health care costs; and access to health care.

KEY POINTS

- On January 1, 2022, the surprise billing provisions of the Consolidated Appropriations Act, 2021 – commonly referred to as the No Surprises Act – will go into effect. These requirements address the problem of surprise billing, which occurs when a privately insured individual receives an unexpected balance bill either in an emergency situation or when a service in an in-network facility is provided by an out-of-network provider.
- Research over the past decade shows that surprise billing is relatively common among privately-insured patients. Studies show that, on average, 18 percent of emergency room visits by people with large employer coverage result in one or more out-of-network bills and nearly 20 percent of patients undergoing in-network elective surgeries or giving birth in a hospital received surprise bills. Surprise bills in these studies averaged more than $1,200 for anesthesia, $2,600 for surgical assistants, and $750 for childbirth. All told, more than half of U.S. consumers report having received an unexpectedly large bill.
- Key among the No Surprises Act's provisions is removing the patient from payment disputes between providers and payers in instances where surprise billing occurs and establishing how such disputes will be resolved. The law established the framework for a formal payment dispute resolution process that was set forth in an Interim Final Rule issued on October 7, 2021.
- State efforts regarding surprise billing dispute resolution indicate that some of the possible approaches may potentially lead to increased health care costs. This experience informed current federal rulemaking.

The No Surprises Act, signed into law on December 27, 2020 as part of the Consolidated Appropriations Act, 2021,1 was designed to address the challenges of surprise billing. A surprise bill is an unexpected bill an individual receives for services provided by an out-of-network provider and occurs when a patient receives a bill for the difference between the provider's charges and what their insurance pays an out-of-network provider plus the patient's cost sharing, which is known as balance billing. These bills may be both unexpected to consumers and expensive. Surprise billing can happen in emergency situations, such as when a person goes to or is taken to the nearest emergency department that may or may not be in their issuer's provider network. However, surprise billing can also occur in non-emergency situations, such as when individuals receive care in an in-network hospital without knowing that other providers critical to their needed care (such as ancillary providers like anesthesiologists or assistant surgeons) are not part of their insurer's network. The issue of surprise billing has primarily pertained to the private insurance market, since both Medicare and Medicaid have provisions addressing balance billing.

Background

Surprise billing is a relatively common experience among the nearly 200 million Americans with private health insurance. For instance, a 2018 survey found that 57 percent of U.S. adults had received a medical bill that came as a surprise to them and that they thought would be covered by their insurance, though the survey did not distinguish whether these were out-of-network charges or resulted from other circumstances.

In a 2017 national study, an estimated 18 percent of emergency room visits by individuals with large employer coverage resulted in one or more out-of-network bills. This percentage of emergency room visits with an out-of-network charge varied widely by state, with a high of 38 percent in Texas and a low of 3 percent in Minnesota (Figure 1).3 The same study found emergency visits in urban areas (18 percent) are somewhat more likely to result in at least one out-of-network charge than are visits in rural areas (14 percent). Overall, patients receiving a surprise bill for emergency care paid physicians more than 10 times as much as emergency department patients without a surprise bill.

A 2020 study of privately-insured patients receiving elective surgery at an in-network hospital found that approximately 20 percent of patients received such a bill, often from an anesthesiologist (with an average out-of-network bill of $1,219) or surgical assistant (with an average out-of-network bill of $2,633).5 A 2021 study of childbirth-related surprise billing found a similar percentage (18 percent) resulted in surprise bills (averaging $744), although for a third of families the surprise bill was over $2,000.

Air ambulance service surprise bills are especially concerning because air ambulance services can be very expensive. A 2021 study found that in 2017, the average base price (not including mileage fees) charged by air ambulance providers was approximately $24,507 for a helicopter transport and $30,466 for a fixed−wing transport, and these charges have increased substantially in the past few years.7 A report by the Government Accountability Office (GAO) using 2017 data found that 69 percent of air ambulance transports of privately insured patients were out−of−network.8 Medicare beneficiaries are more likely to need an air ambulance transport, but a previous ASPE analysis showed that Medicare allowed charges* for air ambulance services were significantly lower than mean billed charges for commercial air ambulance claims in 2017.

6I. New Email Requirement for all Licensees, Registrants, and Applicants

Effective July 1, 2022, all licensees, registrants, and applicants who have an email address must provide it to the Board. The Board must be notified of any changes to your email address within 30 calendar days of the change. The email address that you provide the Board is for communication related to your license, registration, or examination status only, and will not be disclosed to the public. The email address can be added or updated to your Breeze account by logging in and by accessing the 'change of address application' located within the drop-down menu under 'manage your license' on Breeze. To access your BBS record and ensure your email address is provided, use the BBB’s BreEZe system.

6J. Health Plans

AB 1184

Beginning July 1, 2022, health plans will be required to demonstrate additional protection for the confidentiality of medical information related to "sensitive services" provided to subscribers who qualify as "protected individuals." Providers may educate their patients/clients regarding these new requirements to better protect their confidentiality.

Civil Code 56.107(a)

A health care service plan shall not require a protected individual to obtain the policyholder, primary subscriber, or other enrollee's authorization to:

- Receive sensitive services; or
- Submit a claim for sensitive services if the protected individual has the right to consent to care.

Civil Code 56.107(a)(3)

A health care service plan shall direct all communications regarding a protected individual's receipt of sensitive services to an alternative:

- mailing address;
- email address; and/or
- phone number should the protect individual designate such alternative contact information.

Communications that health plans may direct to alternative mailing addresses, email addresses, and phone numbers include:

- Bills and attempts to collect payment;
- A notice of adverse benefits determinations;
- An explanation of benefits notice;
- A health care service plan's request for additional information regarding a claim;
- The name and address of a provider, description of services provided, and other information related to a visit;
- Any written, oral, or electronic communication from a health care service plan that contains protected health information.

AB 221: Timely Access to Care

Commencing July 1, 2022, health plans must ensure their enrollees receive non-urgent follow up appointments with non-physician mental health care or substance use disorder provider(s) within 10 business days of the prior appointment(s) for those undergoing…course(s) of treatment for…ongoing mental health or substance use disorder condition(s).

6K. Licensed Professional Clinical Counselors (LPCCs): Elimination of Additional Requirements

Licensed Professional Clinical Counselors (LPCCs): Elimination of Additional Requirements to Assess or Treat Couples and Families and Elimination of Requirement for 150 Hours of Clinical Experience in a Hospital or Community Mental Health Setting.

With the passage of AB 462 (Chapter 440, Statutes of 2021), the following LPCC-related requirements are removed:

- The requirement that applicants for LPCC licensure must gain at least 150 hours of clinical experience in a hospital or community mental health setting; and
- The requirement that LPCCs must complete additional specified education (6 semester or 9 quarter units, or a named specialization/ emphasis in marriage and family therapy), supervised experience (500 hours working directly with couples, families, or children), and continuing education (6 hours specific to marriage and family therapy each renewal cycle) in order to assess or treat couples or families.

This becomes effective on January 1, 2022.
Elimination of the Licensure Requirement for 150 Hours of Clinical Experience in a Hospital or Community Mental Health Setting
Applicants for LPCC licensure no longer need to complete these hours. Please note that if you have already completed these hours, they will still count generally as experience hours toward your required 3,000 hours.

- If you have already submitted your LPCC application to the Board and have completed the 150 hours in a hospital/community mental health setting, your application will continue to process in the order received.
- If you have already submitted your LPCC application to the Board but have not yet completed the 150 hours in a hospital/community mental health setting you are not required to. The 150 hours will be considered a deficiency until January 1, 2022. On that date, the Board will

automatically clear that deficiency. It is not necessary to re-submit your application. (Please note that if you have other deficiencies besides the 150 hospital/community mental health setting hours, you must still clear those deficiencies within the timeframe specified in your deficiency letter.)

- If you have not submitted your LPCC application yet, and you are ready to do so other than that you have not completed the 150 hospital/ community mental health setting hours, you may submit your application at any time. You will no longer need to complete those hours. The lack of completion of these hours will be treated as a deficiency until January 1, 2022, however on that date the Board will automatically clear that deficiency.
- Please note that the total number of experience hours required for licensure has not changed. Applicants for an LPCC license must still complete at least 3,000 total post degree experience hours, of which 1,750 must still be direct clinical counseling with individuals, groups, couples or families.

Elimination of the Requirement that LPCCs Must Complete Additional Specified Education, Supervised Experience, and Continuing Education in Order to Assess or Treat Couples or Families

The requirement that LPCCs must complete additional specified education (6 semester or 9 quarter units, or a named specialization/emphasis in marriage and family therapy), supervised experience (500 hours working directly with couples, families, or children), and continuing education (6 hours specific to marriage and family therapy each renewal cycle) in order to assess or treat couples or families is eliminated. As of January 1, 2022, LPCCs may assess or treat couples and families without completing these additional requirements.

Please note that although authorized to treat couples and families as of January 1,2022, when working in any specific practice area, Board licensees should always consider whether that practice are is within their scope of competence, as established by one’s education, training, or experience. If a specific practice area is outside of this scope of competence, then the client should be referred to another health care professional who is competent in that area.

What this means for LPCC Licensees:

- As of January 1, 2022, you may assess or treat couples and families without meeting the additional education and experience previously required by law to assess or treat couples and families. You also no longer need to complete the continuing education specific to marriage and family therapy each renewal cycle.
- You no longer need to obtain written confirmation from the Board that you meet the additional requirements to assess or treat couples and families. If you have already obtained this confirmation, you are no longer required to provide a copy of it to your couple and family clients prior to commencement of treatment, and you are no longer required to provide a copy of it to your Associate Marriage and Family Therapist (AMFT) and MFT Trainee supervisees prior to commencing supervision.
- LPCC licensees are now permitted to serve as child custody evaluators without meeting the additional education, experience, and continuing education requirements previously required by law to assess or treat couples or families. (There are still other specified requirements that must be met to serve as a child custody evaluator, see Family Code Section 3110.5 for more information.)

What this means for Employers of LPCCs

- As of January 1, 2022, LPCCs that you employ no longer need to meet the additional education, experience, and continuing education requirements previously required by law in order to assess or treat couples and families. They no longer need to obtain a verification letter from the Board stating that they have met the additional requirements to do so. If they already have obtained such a letter, they are no longer required to provide a copy of it to their couple and family clients prior to commencement of treatment.
- Any LPCCs you employ that serve as supervisors may now also supervise AMFTs and MFT Trainees without meeting the additional requirements to assess or treat couples and families. They are no longer required to obtain and provide a copy of a verification letter from the Board that they meet these requirements to their AMFT and MFT Trainee supervisees prior to commencing supervision.

What this means for Associate Professional Clinical Counselors

- If you are an APCC who wishes to assess or treat couples and families as a licensee, you no longer need to plan on completing the additional education and experience previously required by law in order to do so.

What this means for LPCCs who Supervise Associate Marriage and Family Therapists or MFT Trainees

- As of January 1, 2022, LPCCs who serve as supervisors are now permitted to supervise AMFTs and MFT Trainees without meeting the additional education, experience and continuing education previously required by law to assess or treat couples and families. This means you are no longer required to obtain and provide a copy of a verification letter from the Board that you meet these requirements to your AMFT and MFT Trainee supervisees prior to commencing supervision.

6L. Other Law Changes

Amendments listed in this document reflect changes made by SB 801 (Chapter 647, Statutes of 2021). All changes are effective January 1, 2022, unless otherwise noted

Telehealth Services
Associate Clinical Social Workers, Associate Professional Clinical Counselors

Clarifies that associate clinical social workers and associate professional clinical counselors may provide services via telehealth.

LCSW Continuing Education
An amendment was made to permit clinical social workers to obtain continuing education from a school accredited by the U.S. Department of Education (USDE) or approved by the Bureau for Private Postsecondary Education (BPPE). (Previously, the law did not permit clinical social workers to gain continuing education from a school accredited by the US Department of Education (USDE) or approved by the Bureau for Private Postsecondary Education (BPPE), unless it was from a school of social work accredited by the Commission on Accreditation of the Council on Social Work Education.)

Other

• Suicide Risk Assessment and Intervention Coursework or Experience: Under this requirement, effective January 1, 2021, both applicants for licensure and licensees are required to complete a minimum of six hours of

coursework or applied experience under supervision in suicide risk assessment and intervention.

• "Old" LMFT and LPCC Supervised Experience Categories (Option 2) Expired December 31, 2020

Individuals gaining hours of supervised experience toward LMFT or LPCC licensure need to be aware that an important deadline passed at the end of 2020. Senate Bill 620 (Chapter 262, Statutes of 2015) had streamlined the categories of experience hours that qualify for licensure. The legislation allowed the prior set of experience categories to remain available, but only until December 31, 2020.

In order to qualify under the "old" set of categories (Option 2), an Application for Licensure and Examination must have been postmarked no later than December 31, 2020. Moving forward, applicants must fully qualify under the new set of categories (Option 1).

OTHER BILLS RELEVANT TO THE PROFESSIONS
• **AB 465**: This bill requires a licensed mental health professional to supervise any program where mental health professionals respond to emergency calls related to mental health crises in collaboration with, or in place of, law enforcement.
• **AB 1145**: This bill makes some clarifications about what is reportable under the Child Abuse and Neglect Reporting Act (CANRA). It specifies that voluntary acts of sodomy, oral copulation, and sexual penetration are not considered acts of sexual assault that must be reported by a mandated reporter as child abuse if there are no indicators of abuse, unless it is between a person age 21 or older and a minor under age 16.
• **AB 2112:** This bill authorizes the establishment of the Office of Suicide Prevention within the State Department of Public Health.
• **AB 2253**: Various mental health professionals working in certain state settings are allowed a waiver from licensure requirements for a specified period of time if they are working toward gaining "qualifying experience" toward licensure. This bill clarifies the definition of "qualifying experience" toward licensure so that it is consistent across state agencies.
• **AB 2520**: This bill requires, among other provisions, health care providers to assist in the completion of forms, relevant to a patient receiving public benefits, at no extra charge to the patient. This bill also entitles a nonprofit legal services entity representing a patient to receive a copy of the relevant

portion of the patient's records that are needed to support a claim regarding eligibility for specified public benefit programs. Additionally, this bill expands the number of public benefit program applications that qualify for free medical records.

• **SB 803**: This bill provides a pathway to certification for peer support specialists. It requires the Department of Health Care Services (DHCS) to establish statewide requirements for counties to use in developing these certification programs, by July 1, 2022. It authorizes counties, or an agency that represents a county, to develop a peer support specialist certification program and certification fee schedule, both of which would be subject to DHCS approval.

• **SB 855**: This bill expands California's 1999 Mental Health Parity Act. That act required health plans and insurers to provide coverage for the diagnosis and medically necessary treatment of severe mental illness (for persons of any age), and for serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions. Instead, this bill requires health plans and insurers to cover medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions.

• **SB 1474**: This bill extended the Board's sunset date by one year (to January 1, 2022). This bill also prohibits licensees from including a provision in a contract that limits a consumer's ability to make complaints to a licensing board or from participating in an investigation of a licensee. Including such a clause is unprofessional conduct.

SB 855: Mental Health Parity

- Effective January 1, 2021, this bill clarifies in state statute that health plans are required to cover treatment for all behavioral conditions contained in the Diagnostic and Statistical Manual of Mental Disorders.

Pursuant to this law, health plans are permitted (and in some cases may be required) to reimburse for services rendered by:

- MFT associates and trainees;
- ACSWs; and
- APCCs and PCC trainees depending on whether their supervisors have individual or group contracts with the health plans.

6M. New Laws Directly Affecting the Board's Application and Renewal Process

• **AB 2113**: Expedited Licensure for Refugees, Asylees, and Special Immigrant Visa Holders. This bill requires boards under the Department of Consumer Affairs, including the Board of Behavioral Sciences, to expedite the initial licensure process for an applicant who can provide satisfactory evidence of being admitted to the United States by one of the following methods:

a. As a refugee under Section 1157 of Title 8 of the United States Code;

b. Granted political asylum by the Secretary of Homeland Security or U.S.Attorney General pursuant to Section 1158 of Title 8 of the United States Code; or

c. Granted a special immigrant visa with a status under Section 1244 of Public Law 110-181, Public Law 109-163, or Section 602(b) of Title VI of Division F of Public Law 111-8, as follows:

i. Provides a set of criteria for granting special immigrant status to certain individuals from Iraq. (Section 1244 of Public Law 110-181)

ii. Sets forth provisions for granting special immigrant status to certain qualifying individuals who have served as a translator for the U.S. Armed Forces. (Section 1059 of Public Law 109-163)

iii. Provides a set of criteria for granting special immigrant status to certain individuals from Afghanistan. (Section 602(b) of Title VI of Division F of Public Law 111-8)

This bill became effective on January 1, 2021. An expedite request form, as well as further instructions, will be available on the Board's website soon.

• **AB 3330**: **Increase to Board's Licensing Fees**

This bill, effective January 1, 2021, increases the Board's fees for each of its license types. In setting the new fee amounts, the Board ensured fees were equitable across license types. For example, all licensees will now pay the

same license renewal fee amount, regardless of whether they are an LMFT, LCSW, LPCC, or LEP. Similarly, all applicants will pay the same amount for associate registration, regardless of the type of associate registration they are applying for.

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