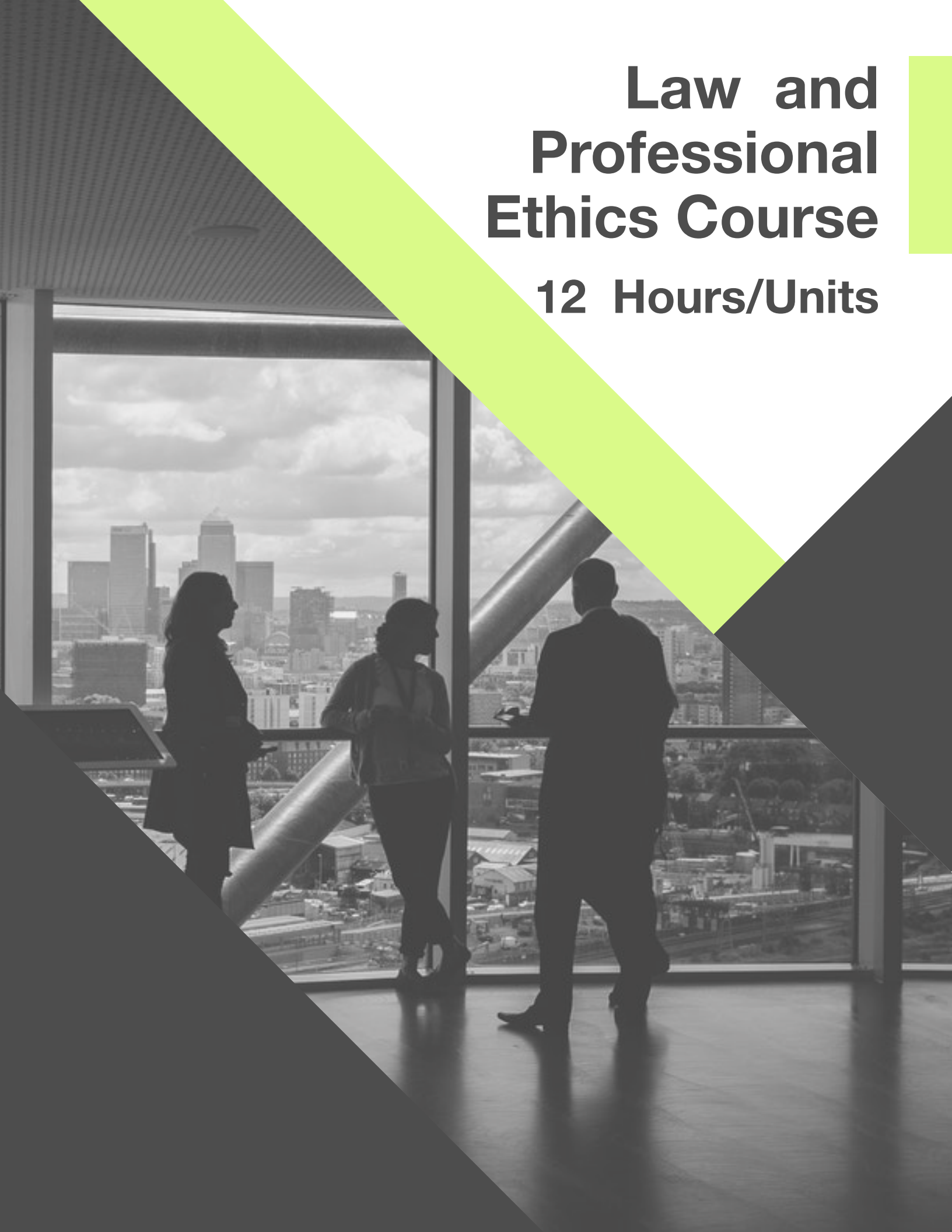
Law and Professional Ethics Course

12 Hours/Units



Law and Professional Ethics CE Course 12 CE Units/Hours

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Course Objectives: In addition to the course objectives listed below, this course addresses the following content areas related to law and professional ethics:

☑ Assessment
☑ Professional practice issues

1. Identify at least two legal and ethical issues in counseling including but not limited to professional ethical standards and significant legal considerations
2. Explain at least one key factor in the licensing law and process.
3. Describe at least one regulatory law that delineates the profession's scope of practice, counselor-client privilege, confidentiality, the client dangerous to self or others, treatment of minors with or without parental consent, relationship between practitioner's sense of self and human values, functions and relationships with other human service providers, strategies for collaboration, and advocacy processes needed to address institutional and social barriers that impeded access, equity, and success for clients
4. Describe at least two HIPAA requirements and standards.
5. Discuss at least one unprofessional conduct and negligence behaviors.
6. Define at least two best standards of practice.
7. Identify at least one continuing education requirement.
8. Discuss at least two professional ethics concepts.
9. Discuss at least two clinical supervision ethical considerations.
10. Describe at least two exceptions to confidentiality.
11. Discuss the most common standard of care liability facing clinicians today.
12. Describe at least one way in which clinicians can be active in maintaining the standard of care.

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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 naiveté 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, Januaury 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 section.

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:

1. 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.
2. 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.

3. 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.
4. Gross negligence or incompetence in the performance of marriage and family therapy.
5. Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.
6. 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.
7. 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.
8. Aiding or abetting any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.
9. Intentionally or recklessly causing physical or emotional harm to any client.
10. The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.
11. 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.

12. 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.
13. 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.
14. 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.
15. 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).
16. Advertising in a manner which is false, misleading, or deceptive.
17. 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.
18. 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
13. Cancellation policy
14. Telephone policy
15. 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 to 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

Abuse occurs when a victim has suffered physical injury inflicted other than by accidental means, has injuries, or is in a condition resulting from mistreatment, such as malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional abuse or cruelty. Neglect may be defined as abandonment, denial of proper care and attention physically, emotionally, or morally, or living under conditions, circumstances or associations injurious to well-being (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

Mandated Reporters

Mandated reporters are those who, in the course of their work and because they have regular contact with children, are required to make a suspected child abuse report whenever physical, sexual or other types of abuse has been observed or is suspected, or when there is evidence of neglect, knowledge of an incident, or an imminent risk of serious harm. Abuse occurs when a victim has suffered physical injury inflicted other than by accidental means, has injuries, or is in a condition resulting from mistreatment, such as malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional abuse or cruelty. Neglect may be defined as abandonment, denial of proper care and attention physically, emotionally, or morally, or living under conditions, circumstances or associations injurious to well-being *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Mandated reporters also include persons who have assumed full or intermittent responsibility for the care or custody of a child, dependent adult, or elder, whether or not they are compensated for their services. 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 Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

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. A client's self-report does not negate the therapist's mandate to report. The role of a mandated reporter is to report and not investigate the allegation(s). Any attempts to investigate may have a negative clinical impact on the child and family. If a mandated reporter 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 *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

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 *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

RAINN maintains a database of mandatory reporting regulations regarding children and the elderly by state, including who is required to report, standards of knowledge, definitions of a victim, to whom the report must be made, information required in the report, and regulations regarding timing and other procedures.

The criteria in identifying suspected child abuse and when a mandatory reporter should report varies among states. Typically, a report must be made when the

reporter, in his or her official capacity, *suspects* that a child has been abused. Another standard frequently used is when the reporter has knowledge of, or observes a child being subjected to, conditions that would reasonably result in harm to the child *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse')*

State Reporting Laws

All 50 States and the District of Columbia have statutes that protect children from abuse and neglect by their parents or others. There are criminal statutes prohibiting certain acts (or failures to act), violation of which may lead to imprisonment. There are also civil statutes that prohibit abuse and neglect. If these statutes are violated, the court may impose requirements that parents accept certain kinds of help (such as substance abuse treatment, parenting classes, or anger management training), that their children be removed from the home, or that their parental rights be terminated *(Source: SAMHSA)*

Most States define abuse as an act or failure to act that result in non-accidental physical injury or sexual abuse of a child. Neglect generally includes the denial of adequate food, shelter, supervision, clothing, or medical care when such resources or services are available. Each state defines abuse and neglect differently, and the conditions considered to be neglect or abuse in one state may not be the same in others. Because state law often requires that treatment providers report suspected abuse and neglect, treatment staff should become familiar with their state's definitions of abuse and neglect. Staff can contact the State's CPS agency for information on current laws. (If the abuse occurred in another state, or if the perpetrator is currently living in another state, it is wise to check on the laws in the other state to ensure compliance. At times, there may be a need to report in both states.) Readers can also find state statutory child abuse and neglect definitions on the Internet at http://www.calib.com/nccanch/services/statutes.htm. Federal definitions of these terms appear in the Child Abuse Prevention and Treatment Act, 42 U.S.C. §5106(g). In some cases, the CPS agency can be consulted regarding whether or not a report must be made in a particular situation without divulging confidential (i.e., identifying) information. Consultation with the CPS agency must be done with great care, and this communication can be noted in the client's chart *(Source: SAMHSA)*.

Although each state's laws are different, the following conditions are reportable in most states:

- The child has been seriously physically injured by a parent or other adult by other than accidental means.

- The child appears injured or ill to the point that a reasonable person would seek medical attention, but the parent has not sought medical attention, refuses to consider it, or fails to follow medical advice, putting the child at risk
- An adult has sexually touched (or made the child sexually touch the adult), abused, or exploited the child.
- The child is not registered for or attending school, and the parent refuses to remedy the situation (home schooling must be adequately documented).

Although the behaviors outlined above are the most blatant examples of child abuse or neglect, other parental behaviors or practices may put children at risk. For example, the following may also constitute child abuse or neglect:

- Leaving a young child alone and unsupervised
- Inappropriate punishment that puts a child at risk (e.g., locking a young child out of the house as a punishment)
- Depriving a young child of food for an extended period of time
- Treating one child, the "bad one," far more harshly than others

Whether behaviors like these are reportable depends, in part, on how State statutes define abuse and neglect, the seriousness of the behavior or incident, its impact on the child, and the counselor's perception of the client's overall behavior with the child and of the client's willingness to correct inappropriate behavior *(Source: SAMSHA)*.

RAINN maintains a database of mandatory reporting regulations regarding children and the elderly by state, including who is required to report, standards of knowledge, definitions of a victim, to whom the report must be made, information required in the report, and regulations regarding timing and other procedures.

California

Who is required to report?

- Teachers;
- Instructional aides;
- Teacher’s aides or teacher’s assistants employed by any public or private school; Classified employees of any public school;
- Administrative officers or supervisors of child welfare and attendance, or certificated pupil personnel employees of any public or private school;
- Administrators of a public or private day camp;

- Administrators or employees of a public or private youth center, youth recreation program, or youth organization;
- Administrators, board members, or employees of a public or private organization whose duties require direct contact and supervision of children, including a foster family agency;
- Any employee of a county office of education or the California Department of Education, whose duties bring the employee into contact with children on a regular basis;
- Licensees, administrators, or employees of a licensed community care or child day care facility;
- Head Start program teachers;
- Licensing workers or licensing evaluators employed by a licensing agency;
- Public assistance workers;
- Employees of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities;
- Social workers, probation officers, or parole officers;
- Employees of a school district police or security department;
- Any person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in any public or private school;
- District attorney investigators, inspectors, or local child support agency caseworkers (except in certain limited circumstances);
- Peace officers;
- Firefighters, except for volunteer firefighters;
- Physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, marriage and family therapists, clinical social workers, professional clinical counselors, and any other persons who are currently licensed under Division 2 of the Business and Professions Code;
- Any emergency medical technicians I or II, paramedics, or others certified under Division 2.5 of the Health and Safety Code;
- Psychological assistants registered under Section 2913 of the Business and Professions Code;
- Marriage and family therapist trainees;

- Marriage and family therapist interns registered under Section 4980.44 of the Business and Professions Code;
- State or county public health employees who treats a minor for venereal disease or any other condition;
- Coroners;
- Medical examiners, or any other persons who performs autopsies;
- Commercial film and photographic print processors (excluding a person who develops film or makes prints for a public agency);
- Child visitation monitors;
- Animal control officers or humane society officers;
- Clergy members, including priests, rabbis, ministers, religious practitioners or similar functionaries of a church, temple or recognized denomination or organization; Except when knowledge or reasonable suspicion is acquired during a penitential communication.
- Any custodian of records of a clergy member;
- Any employee of any police department, county sheriff's department, county probation department, or county welfare department;
- Employees or volunteers of a Court Appointed Special Advocate program;
- Custodial officers;
- Any person providing services to a minor child;
- Alcohol or drug counselors (i.e., persons providing counseling, therapy, or other clinical services for a state licensed or certified drug, alcohol, or drug and alcohol treatment program (except that alcohol or drug abuse, or both alcohol and drug abuse, is not in and of itself a sufficient basis for reporting child abuse or neglect))
- Clinical counselor trainees registered under the business and professions code;
- A clinical counselor intern registered under the business and professions code;
- An employee or administrator of a public or private postsecondary educational institution, whose duties bring the administrator or employee into contact with children on a regular basis or who supervises those whose duties bring the administrator or employee into contact with children on a regular basis, as to child abuse or neglect occurring on that institution's premises or at an official activity of, or program conducted by, the institution;

- An athletic coach, athletic administrator, or athletic director employed by any public or private school that provides any combination of instruction for kindergarten, or grades 1 to 12, inclusive;
- A commercial computer technician;
- Any athletic coach, including, but not limited to, an assistant coach or a graduate assistant involved in coaching, at public or private postsecondary educational institutions;
- An individual certified by a licensed foster family agency as a certified family home; and
- An individual approved as a resource family.

When is a report required and where does it go?

When is a report required?

When a mandated reporter who, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect.

Where does it go?

Reports must be made to any police department or sheriff's department (not including a school district police or security department), or the county probation department (if designated by the county to receive mandated reports), or the county welfare department.

The telephone numbers for the applicable hotlines in each county can be found at http://www.childsworld.ca.gov/res/pdf/

What definitions are important to know?

"Animal control officers or humane society officer" means any person employed by a city, county, or city and county for the purpose of enforcing animal control laws or regulations or any person appointed or employed by a public or private entity as a humane officer under applicable regulations.

"Child" means a person under the age of 18.

"Child Abuse or Neglect" includes physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse, neglect, the willful harming or injuring of a child or the endangering of the person or health of a child, and unlawful corporal punishment or injury. "Child abuse or neglect" does not include a mutual affray between minors.

"Child visitation monitor" means any person who, for financial compensation, acts as monitor of a visit between a child and any other person when the monitoring of that visit has been ordered by a court of law.

“Commercial computer technician” means a person who works for a company that is in the business of repairing, installing, or otherwise servicing a computer or computer component, including, but not limited to, a computer part, device, memory storage or recording mechanism, auxiliary storage recording or memory capacity, or any other material relating to the operation and maintenance of a computer or computer network system, for a fee.

"Commercial film and photographic print processor" means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for compensation, including any employee of such a person.

“Commercial sexual exploitation” refers to either:

The sexual trafficking of a child, or

The provision of food, shelter, or payment to a child in exchange for the performance of any sexual act.

“Neglect” means the negligent treatment or the maltreatment of a child by a person responsible for the child’s welfare under circumstances indicating harm or threatened harm to the child’s health or welfare. The term includes both acts and omissions on the part of the responsible person.

“Reasonable suspicion” means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. “Reasonable suspicion” does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any “reasonable suspicion” is sufficient.

"Sexual Assault” includes rape, statutory rape, rape in concert, incest, sodomy, lewd or lascivious acts upon a child, oral copulation, sexual penetration, or child molestation.

These acts can include, but are not limited to, the following:

- Penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen;
- Sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person;

- Intrusion by one person into the genitals or anal opening of another person, including the use of an object for this purpose, except that it does not include acts performed for a valid medical purpose;
- The intentional touching of the genitals or intimate parts of the child or the perpetrator by a child, for purposes of sexual arousal or gratification, except that it does not include acts which may be reasonably construed to be (i) normal caretaker responsibilities, (ii) interactions with, or demonstrations of affection for, the child, or (iii) acts performed for a valid medical purpose; and
- The intentional masturbation of the perpetrator's genitals in the presence of a child.

"Sexual Exploitation" means any of the following:

- Conduct involving matter depicting a minor engaged in obscene acts in violation of Section 311.2 (preparing, selling, or distributing obscene matter) or subdivision (a) of Section 311.4 (employment of minor to perform obscene acts);
- A person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or a person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assist others 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, painting, or other pictorial depiction, involving obscene sexual conduct. For the purpose of this section, "person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution; or
- A person who depicts a child in, or who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of Section 311.3 of the California Penal Code,

"The willful harming or injuring of a child or the endangering of the person or health of a child" means a situation in which any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation in which his or her person or health is endangered.

What timing and procedural requirements apply to reports?

An initial report must be made immediately or as soon as is practicably possible by telephone. The mandated reporter must also prepare and send, fax, or electronically transmit a written follow-up report within 36 hours of receiving the information concerning the incident.

If, after reasonable efforts, a mandated reporter is unable to submit an initial report by phone, he/she shall immediately or as soon as is practicably possible, by fax or electronic transmission, make a one-time automated written report on the form prescribed by the DOJ, and shall also be available to respond to a follow up call by the agency with which the report was filed.

Any mandated reporter who knows or reasonably suspects that the home or institution in which a child resides is unsuitable for the child because of abuse or neglect of the child shall bring the condition to the attention of the agency to which, and at the same time as, he or she makes a report of the abuse or neglect.

When two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and where there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

What information must a report include?

Reports must include the following:

- Name, business address, and telephone number of the mandated reporter;
- The capacity that makes the person a mandated reporter; and
- The information that gave rise to the reasonable suspicion of child abuse or neglect and the source or sources of that information.

The following information, if known, shall also be included in the report:

- The child's name, address, present location, and, if applicable, school, grade, and class;
- The names, addresses, and telephone numbers of the child's parents or guardians; and
- The name, address, telephone number, and other relevant personal information about the person or persons who might have abused or neglected the child.
- The mandated reporter may include with the report any non-privileged documentary evidence the mandated reporter possesses relating to the incident.

The form to be completed regarding suspected child abuse can be found at http://ag.ca.gov/childabuse/pdf/ss_8572.pdf.

Anything else I should know?

The requirements in the mandatory reporting section shall apply even if the victim of the known or suspected abuse has reached the age of majority by the time the required report is made.

Any mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect is guilty of a misdemeanor punishable by up to six months confinement in a county jail or by a fine of $1,000 or both.

Any mandated reporter who willfully fails to report abuse or neglect, or any person who impedes or inhibits a report of abuse or neglect, in violation of this article, where that abuse or neglect results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than $5,000, or by both that fine and imprisonment.

Reporting the information regarding a case of possible child abuse or neglect to an employer, supervisor, school principals, school counselor, coworker, or other person will not be a substitute for making a mandated report to the police department, sheriff's department, county probation department or county welfare department.

The pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse.

A commercial film, photographic print, or image processor who has knowledge of or observes, within the scope of his or her professional capacity or employment, any film, photograph, videotape, negative, slide, or any representation of information, data, or an image, including, but not limited to, any film, filmstrip, photograph, negative, slide, photocopy, videotape, video laser disc, computer hardware, computer software, computer floppy disk, data storage medium, CD–ROM, computer-generated equipment, or computer-generated image depicting a child under 16 years of age engaged in an act of sexual conduct, shall, immediately or as soon as practicably possible, telephonically report the instance of suspected abuse to the law enforcement agency located in the county in which the images are seen.

Within 36 hours of receiving the information concerning the incident, the reporter shall prepare and send, fax, or electronically transmit a written follow-up report of the incident with a copy of the image or material attached.

A commercial computer technician who has knowledge of or observes, within the scope of his or her professional capacity or employment, any representation of

information, data, or an image, including, but not limited to any computer hardware, computer software, computer file, computer floppy disk, data storage medium, CD–ROM, computer-generated equipment, or computer-generated image that is retrievable in perceivable form and that is intentionally saved, transmitted, or organized on an electronic medium, depicting a child under 16 years of age engaged in an act of sexual conduct, shall immediately, or as soon as practicably possible, telephonically report the instance of suspected abuse to the law enforcement agency located in the county in which the images or material are seen.

As soon as practicably possible after receiving the information concerning the incident, the reporter shall prepare and send, fax, or electronically transmit a written follow-up report of the incident with a brief description of the images or materials.

An employer of a commercial computer technician may implement internal procedures for facilitating reporting. These procedures may direct employees who are mandated reporters under this paragraph to report materials described in subdivision (e) of Section 11166 to an employee who is designated by the employer to receive the reports. An employee who is designated to receive reports under this subparagraph shall be a commercial computer technician for purposes of this article.

A commercial computer technician who makes a report to the designated employee pursuant to this subparagraph shall be deemed to have complied with the requirements of this article and shall be subject to the protections afforded to mandated reporters, including, but not limited to, those protections afforded by Section 11172.

Statutory citation(s)

Child Abuse and Neglect Reporting Act, Cal. Penal Code §§ 11164 et seq.

Abuse or neglect suspected at an institution or facility

Mandated reporters are required to file a report whenever there is reasonable cause to suspect or believe any resident of a care facility has been abused or neglected by a staff member of a public or private institution or facility that provides care. Whenever the results of an investigation leads to the conclusion that there is reasonable cause to believe that that there has been abuse or neglect perpetrated by staff, then the institution, school or facility must provide records concerning the investigation to the appropriate investigating agency and/or to the agency that licensed the facility. An institution may suspend employee(s) during an investigation, or, at the conclusion of an investigation, may impose penalties in addition to any separate penalties resulting from civil litigation or criminal

prosecution. Employers may not discharge, discriminate or retaliate against an employee for making a good faith report or for testifying at an abuse or neglect proceeding *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Anonymity and Immunity

Mandated reporters are usually required to identify themselves by name when making a report, but may request anonymity to protect their privacy. A mandated reporter who knowingly makes a false report will ordinarily have their identity disclosed to the appropriate law enforcement agency, and their identity may be disclosed to the alleged perpetrator of the reported abuse or neglect. A mandated reporter may be subject to penalties, though immunity from civil or criminal liability is granted to reporters who report in good faith. Immunity is also granted to reporters who, in good faith, have not reported. However, failure to report suspected abuse or neglect could result in fines or other sanctions, such as participation in a training program. Failure to act may result in even stiffer penalties, such as civil litigation or criminal prosecution with the prospect of potential imprisonment *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Conflicts

Conflicts between a mandated reporter's duties and privileged communication statutes are common. It has been argued that the category of "mandatory reporters" should be expanded to members of the clergy; however in some more traditional denominations the conflict this creates with the "confessional" makes this unworkable. When such conflicts arise, professionals often choose not to report; e.g., in a large number of cases involving clergy, numerous alleged child sexual assaults have gone unreported *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Informing family members and guardians

Mandated reporters typically are not obligated to inform parents, siblings or offspring that a report has been made. In many circumstances, however, it may be necessary and/or beneficial to do so. When a report is made at a care giving facility, the person in charge of a hospital, school or other institution is generally required to notify family members, or other caregiver(s) responsible for the (possible) victim, that a report has been made. Healthcare professionals or members of the clergy, however, often must to talk with family members or guardians to offer support and guidance, or to assess the cause of an injury. In cases of serious physical abuse or sexual abuse, it may be unwise to advise

caregivers before a case is reported, as it may put a victim at greater risk and/or interfere with a criminal investigation *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Investigation of reports

Law enforcement or public health agencies are responsible for immediately evaluating and classifying all reports of suspected abuse, neglect, or imminent risk. When reports contain sufficient information to warrant an investigation, authorities must make efforts within a reasonable time frame to begin an effective investigation, often within hours, particularly when there is an imminent risk of physical harm or another emergency; investigations must also be completed within a reasonable or specified time frame. The investigation also must also include a determination of whether the report was warranted or unfounded *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Agencies must coordinate activities to minimize impacts upon the (possible) victim. Consent to interview(s) of the (possible) victim often must be obtained from caregivers, family members or guardians, unless there is reason to believe such person is the alleged perpetrator. In cases where serious abuse or neglect is substantiated, local law enforcement, prosecutors or other public offices must be notified, and a copy of the investigation report must be sent *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Legal and Ethical Considerations

Subpoenas and Court Orders

Mental health professionals should be informed about the possibility of being served with a subpoena or court order to provide information about the nature of the treatment and the sequelae of traumatic stress following the child's abuse. They should share this potentiality with their clients. Mental health professionals should be aware of how information can be released upon receipt of a subpoena. A court order may be necessary in order to release specific types of mental health information.

The mental health professional should also communicate clearly to families which types of information must be shared without the client's consent such as suspected child abuse, adult and domestic abuse, and suicidal or homicidal threats. Certain

safety issues found in some families dealing with sexual abuse fall in this category including re-abuse and contact with the alleged perpetrator when such contact has been disallowed by CPS.

Implications of Mental Health Treatment for the Juvenile and Criminal Justice Systems

Traumatized children and their families are often involved with multiple service systems, including law enforcement, child welfare, the courts, schools, primary care, and mental health. When different systems have different and potentially competing priorities, there is a risk that children and their families will receive mixed or confusing messages—or simply fall through the cracks. The challenge faced by each type of court (whether juvenile, civil, family, or criminal) is to collaborate with mental health professionals in a manner that minimizes re-traumatizing the child or family. At the same time, the court must meet its obligations to remain objective and unbiased. Aside from the clinical benefits associated with traditional psychotherapy, mental health treatment/involvement has direct implications for child and family participation in the legal system.

Role Clarity

Whenever possible, the forensic interviewer should not be the treating mental health professional for a child he/she interviewed. Conversely, a mental health professional who has treated a child or who has a therapeutic relationship with a child should not conduct a forensic interview with that child.

Psychotherapy and Court Proceedings

Mental health professionals can help promote the child's safety, permanency, and well-being by alleviating symptoms, helping to improve psychosocial functioning, and working to prepare the child for periods of heightened distress in response to court activity. Treatment may bolster the child's capacity to participate meaningfully in the legal process and may make a profound contribution to the future well-being and development of victimized children.

In addition to direct interventions to ameliorate such symptoms as depression and PTSD, quality mental health care provides an opportunity for children to master effective techniques for coping with anticipatory anxiety related to legal proceedings and to address unwarranted feelings of guilt or responsibility for their abuse. Particularly for abused children contending with PTSD symptoms,

treatment may involve the development of a "trauma narrative" *(Deblinger & Runyon)*. The narrative allows them to recall and consider their experiences over time in a manner that is less overwhelming.

Some attorneys advise against children's participating in therapy prior to a court appearance, concerned that therapy may result in a child's testimony appearing too polished or rehearsed. Research indicates, however, that therapy is beneficial because it helps children learn effective coping strategies that tend to reduce anxiety and distress and improve their ability to participate in the legal process *(Cohen, et al.)*.

Prosecuting attorneys may need to be given information on the functions of therapy to help dissuade them from dispensing inappropriate advice to families. As cases extend for months and years, the legal system bears witness to despair, victimization, and family dysfunction—none of which it can effectively address. Since implementation of The Adoption and Safe Families Act in 1997, courts face an increased responsibility to ensure safety, permanency, and well-being for children in the child welfare system. The courts are unlikely to meet this mandate unless they develop close collaboration with mental health and prevention systems and providers *(Lederman & Osofsky)*.

Mental health providers may assist courts in developing recommendations for treatment and best practice models that draw upon available evidence for the effectiveness of particular interventions to help further the courts' efforts to act in the "best interests of the child"(Goldstein et al.). Clinicians may also serve as consultants to courts, providing an important developmental perspective on child trauma, maltreatment, and their potential manifestations in the legal context including recommendations regarding treatment, placement, permanency, and competence to provide testimony *(Office for Victims of Crime,; Osofsky et al.; Cohen & Youcha)*. Faced with decisions about custody, placement, parental rights, and culpability for abuse, courts are increasingly challenged to act "in the best interest of the child" while facing choices that may represent only a "least detrimental alternative."

Given the potential benefits to the child and family, as well as to the legal process, mental health treatment for child victims of abuse should be introduced as early as possible. Accurate and timely evaluation of the child sets the stage for recovery. Treatment that utilizes evidence-based interventions allows children a more complete return to the appropriate developmental tasks consistent with their age.

Client Confidentiality and Sharing of Information

Once an investigation is complete, law enforcement and CPS staff may have limited (or no) contact with the family. Mental health professionals, however, may work with the family for months after the investigation is complete, and typically will form strong, trusting relationships with families. The mental health professional is in a unique position to recognize the strengths of—and potential risks for—a family, and to learn what the family's greatest concerns are related to the investigation and its outcome. Thus, the sharing of information between the mental health provider and the team can be beneficial both to the family and to the team's effort to conduct a thorough investigation and successfully resolve the case.

Confidentiality laws, including Health Insurance Portability and Protection Act (HIPPA) regulations, also extend to clients' mental health records. Mental health professionals are legally and ethically bound to adhere to these laws. Confidentiality should be discussed as treatment begins and proceeds. For example, if the mental health professional is a participant in a weekly case review in which the status and progress of cases are discussed, he or she should explain to the family the purpose of the case review meeting. Therapy records should include documentation signed by clients indicating that they understand the protection of their private health information.

Elder Abuse Assessment and Reporting

Mandated Reporters

Who is required to report?

- Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults;
- Any elder or dependent adult care custodian;
- A health practitioner including a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, registered nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage and family, therapist, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or

person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage and family therapist intern, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage and family therapist intern registered under Section 4980.44 of the Business and Professions Code, a clinical counselor trainee (as defined in subdivision (g) of Section 4999.12 of the Business and Professions Code), a clinical counselor intern registered under Section 4999.42 of the Business and Professions Code, a state or county public health or social service employee who treats an elder or a dependent adult for any condition, a coroner, or a substance use disorder counselor.

- As used in this section, a "substance use disorder counselor" is a person providing counseling services in an alcoholism or drug abuse recovery and treatment program licensed, certified, or funded under Part 2 (commencing with Section 11760) of Division 10.5 of the Health and Safety Code.
- A clergy member including a priest, minister, rabbi, religious practitioner, or similar functionary of a church, synagogue, temple, mosque, or recognized religious denomination or organization, but excluding any unpaid volunteers whose principal occupation or vocation does not involve active or ordained ministry in a church, synagogue, temple, mosque, or recognized religious denomination or organization, and who periodically visit elder or dependent adults on behalf of that church, synagogue, temple, mosque, or recognized religious denomination or organization.
- An employee of a county adult protective services agency or a local law enforcement agency;
- All officers and employees of financial institutions are mandated reporters of suspected financial abuse; and
- Any notary public who, in connection with providing notary services, has observed or has knowledge of suspected financial abuse of an elder or dependent adult is a mandatory reporter of suspected financial abuse.

When is a report required and where does it go?

When is a report required?

When a mandated reporter, in his or her professional capacity, or within the scope of his or her employment:

- Has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect;
- Is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect; or reasonably suspects that abuse.
- When a mandated reporter of suspected financial abuse, who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records or transactions, and who within the scope of his or her employment or professional practice:
- Has observed or has knowledge of an incident that is directly related to the transaction or matter that is within the scope of employment and reasonably appears to be financial abuse; or reasonably suspects that abuse.

Where does it go?

If physical abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center,

1. If the suspected abuse results in serious bodily injury, an oral report by telephone shall be made to the local law enforcement agency immediately (and in no event later than 2 hours after the suspected abuse), and a written report shall be made to the local law enforcement agency, the local ombudsperson and the corresponding licensing agency within 2 hours after the suspected abuse;
2. If the suspected abuse does not result in serious bodily injury, then an oral report by telephone shall be made to the local law enforcement agency within 24 hours after the suspected abuse and a written report shall be made to the local law enforcement agency, the local ombudsperson and the corresponding licensing agency within 24 hours after the abuse; and
3. If the suspected abuse is caused by a resident with a physician's diagnosis of dementia and there is no serious bodily injury, the reporter shall report to the local ombudsperson or law enforcement agency by telephone immediately or as soon as reasonably practicable and by written report within 24 hours.

If other-than-physical abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center, the telephone and written report shall be made to the local ombudsman or the local law enforcement agency.

If the abuse occurred in a state mental hospital or a state developmental center and the alleged abuse or neglect resulted in death, sexual assault, an assault with a deadly weapon by a nonresident of a state mental hospital or a state developmental center, an assault with force likely to produce great bodily injury, an injury to the genitals where the cause is undetermined or a broken bone where the cause of the break is undetermined, then the report shall be made immediately (but in any event within 2 hours of the event) to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services and also to the local law enforcement agency.

Reports of all other suspected cases of abuse or neglect occurring in a state mental hospital or a state development center shall be made to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services or the local law enforcement agency.

Reports related to suspected abuse or neglect that occurred in any place other than a long-term care facility, a state mental hospital or a state developmental center shall be made to the adult protective services agency or the local law enforcement agency.

What definitions are important to know?

"Abandonment" means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

"Abduction" means the removal from the State of California and the restraint from returning to the State of California, or the restraint from returning to the State of California, of any elder or dependent adult who does not have the capacity to consent to the removal from the State of California and the restraint from returning to the State of California, or the restraint from returning to the State of California, as well as the removal from the State of California or the restraint from returning to the State of California, of any conservatee without the consent of the conservator or the court.

"Abuse of an elder or a dependent adult" means either of the following:

- Physical abuse, neglect, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.
- The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.
- Financial abuse.

“Dependent adult” means:

- A person, regardless of whether the person lives independently, between the ages of 18 and 64 years who resides in California and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age; and
- any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility.

“Elder” means any person residing in California, 65 years of age or older.

“Financial Abuse” of an elder or dependent adult occurs when a person or entity does any of the following:

- Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both;
- Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; or
- Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence.

A person or entity shall be deemed to have taken, secreted, appropriated, obtained, or retained property for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property and the person or entity knew or should have known that this conduct is likely to be harmful to the elder or dependent adult.

For purposes of this section, a person or entity takes, secretes, appropriates, obtains, or retains real or personal property when an elder or dependent adult is deprived of any property right, including by means of an agreement, donative transfer, or testamentary bequest, regardless of whether the property is held directly or by a representative of an elder or dependent adult.

For purposes of this section, “representative” means a person or entity that is either of the following:

A conservator, trustee, or other representative of the estate of an elder or dependent adult; or

An attorney-in-fact of an elder or dependent adult who acts within the authority of the power of attorney.

"Isolation" means any of the following:

- Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls;
- Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor, where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons;
- False imprisonment (as defined in the Penal Code); or
- Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors.

"Neglect" means either of the following:

- The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or
- The negligent failure of an elder or dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise.

"Neglect" includes, but is not limited to, all of the following:

- Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.
- Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.
- Failure to protect from health and safety hazards.
- Failure to prevent malnutrition or dehydration.
- Failure of an elder or dependent adult to satisfy the needs specified above for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.

"Physical abuse" means any of the following:

- Assault (as defined in the Penal Code);

- Battery (as defined in the Penal Code);
- Assault with a deadly weapon or force likely to produce great bodily injury (as defined in the Penal Code);
- Unreasonable physical constraint, or prolonged or continual deprivation of food or water;
- Sexual assault; or
- Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
    1. for punishment;
    2. for a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given; or
    3. for any purpose not authorized by the physician and surgeon.

"Reasonable suspicion" means an objectively reasonable suspicion that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing when appropriate upon his or her training and experience, to suspect abuse.

"Sexual Assault" means:

- Sexual battery (as defined in the Penal Code);
- Rape (as defined in the Penal Code);
- Rape in concert (as defined in the Penal Code);
- Spousal rape (as defined in the Penal Code);
- Incest (as defined in the Penal Code);
- Sodomy (as defined in the Penal Code);
- Oral copulation(as defined in the Penal Code);
- Sexual penetration(as defined in the Penal Code); or
- Lewd or lascivious acts (as defined in the Penal Code).

What timing and procedural requirements apply to reports?

- A telephone report or confidential Internet reporting tool report shall be made immediately or as soon as practicably possible.
- If the initial report was made by telephone, a written report must be sent, or an Internet report shall be made, within 2 working days.

- If physical abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center,
- If the suspected abuse results in serious bodily injury: An oral report by telephone shall be made to the local law enforcement agency immediately (and in no event later than 2 hours after the suspected abuse), and a written report shall be made to the local law enforcement agency, the local ombudsperson and the corresponding licensing agency within 2 hours after the suspected abuse;
- If the suspected abuse does not result in serious bodily injury: An oral report by telephone shall be made to the local law enforcement agency within 24 hours after the suspected abuse and a written report shall be made to the local law enforcement agency, the local ombudsperson and the corresponding licensing agency within 24 hours after the abuse; and
- If the suspected abuse is caused by a resident with a physician's diagnosis of dementia and there is no serious bodily injury, the reporter shall report to the local ombudsperson or law enforcement agency by telephone immediately or as soon as reasonably practicable and by written report within 24 hours.
- If the abuse occurred in a state mental hospital or a state developmental center and the alleged abuse or neglect resulted in death, sexual assault, an assault with a deadly weapon by a nonresident of a state mental hospital or a state developmental center, an assault with force likely to produce great bodily injury, an injury to the genitals where the cause is undetermined or a broken bone where the cause of the break is undetermined, then the report shall be made immediately (but in any event within 2 hours of the event) to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services and also to the local law enforcement agency.

What information must a report include?

Each county operates its own abuse reporting hotline.

The applicable telephone numbers can be found at: http://www.cdss.ca.gov/Adult-Protective-Services/County-APS-Offices

The written report shall be submitted on a form adopted by the State Department of Social Services (available at: https://www.cdss.ca.gov/Portals/9/FMUForms/Q-T/SOC341.pdf), which requires, among other things, the following:

✓ The name, e-mail address, telephone number, and occupation of the person reporting;

✓ The name, age, gender, sexual orientation, protected class, and address of the victim;

✓ The date, time, and place of the incident;

- ✓ Other details, including the reporter's observations and beliefs concerning the incident;
- ✓ Any statement relating to the incident made by the victim;
- ✓ The name of any individuals believed to have knowledge of the incident; and
- ✓ The name of the individuals believed to be responsible for the incident and their connection to the victim (suspected abuser).

A form has been prepared for use by financial institutions for reports of suspected dependent adult/elder financial abuse (http://www.cdss.ca.gov/cdssweb/entres/for

Anything else I should know?

- ✓ A clergy member who acquires knowledge or reasonable suspicion of elder or dependent adult abuse during a penitential communication is not a mandated reporter.
- ✓ "Penitential communication" means a communication that is intended to be in confidence, including, but not limited to, a sacramental confession made to a clergy member who, in the course of the discipline or practice of his or her church, denomination, or organization, is authorized or accustomed to hear those communications and under the discipline tenets, customs, or practices of his or her church, denomination, or organization, has a duty to keep those communications secret.
- ✓ Nothing shall limit a clergy member's duty to report known or suspected elder and dependent adult abuse when he or she is acting in the capacity of a care custodian, health practitioner, or employee of an adult protective services agency.
- ✓ When two or more mandated reporters are present and jointly have knowledge or reasonably suspect that types of abuse of an elder or a dependent adult for which a report is or is not mandated have occurred, and when there is agreement among them, the telephone report or internet report may be made by a member of the team selected by mutual agreement, and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

A mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist is not required to report an incident where all of the following conditions exist:

- ✓ The mandated reporter has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect.

- ✓ The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
- ✓ The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
- ✓ In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

In a long-term care facility, a mandated reporter is not required to report as a suspected incident of abuse, an incident where all of the following conditions exist:

- ✓ The mandated reporter is aware that there is a proper plan of care.
- ✓ The mandated reporter is aware that the plan of care was properly provided or executed.
- ✓ A physical, mental, or medical injury occurred as a result of care provided pursuant to the clauses above.
- ✓ The mandated reporter reasonably believes that the injury was not the result of abuse.

Any person who fails to make a required report, or impedes or inhibits a report, shall be guilty of a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than $1,000, or both. Any mandated reporter who willfully fails to report, or impedes or inhibits a report, and the abuse results in death or great bodily injury shall be punished by not more than one year in a county jail, a fine of not more than $5,000, or both.

Failure of a financial institution to report financial abuse shall be subject to a civil penalty not exceeding $1,000 or if the failure to report is willful, a civil penalty not exceeding $5,000, which shall be paid by the financial institution that is the employer of the mandated reporter to the party bringing the action.

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

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

A mandated reporter of suspected financial abuse of an elder or dependent adult is authorized to not honor a power of attorney as to an attorney-in-fact, if the mandated reporter of suspected financial abuse of an elder or dependent adult makes a report to an adult protective services agency or a local law enforcement agency of any state that the principal may be subject to financial abuse, as described in this chapter or as defined in similar laws of another state, by that attorney-in-fact or person acting for or with that attorney-in-fact.

In any court proceeding or administrative hearing, neither the physician-patient privilege nor the psychotherapist-patient privilege applies to the specific information reported pursuant to this chapter.

Statutory citation(s):

Elder Abuse and Dependent Adult Civil Protection Act, Ca. Welf. & Inst. §§ 15600 et seq.

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.

Social 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. 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;

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

4.0 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

6.0 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 technology, 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 or the 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.

10.11 CUSTODY 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.

10.12 PROFESSIONAL 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.

Part II—The Procedures

PREAMBLE

When accepting membership in the Association, each member agrees to abide by the CAMFT Code of Ethics. It is the ethical responsibility of each member to safeguard the standards of ethical practice and to see that violations of the CAMFT Code of Ethics are addressed. Members of the Association cooperate with duly constituted bodies of the California Association of Marriage and Family Therapists, and in particular, with the Ethics Committee, by responding to inquiries promptly, truthfully, and completely.

I. SCOPE OF AUTHORITY OF THE ETHICS COMMITTEE

A. The Bylaws of the Association (Article IV, Section A) provide for three categories of membership in CAMFT:

Clinical member

Pre-licensed member

Associate member

B. The Association has authority only over these members. This authority is derived from Article IV Section C of the Bylaws.

Except as otherwise provided in these Bylaws, membership in any category shall be upon a majority vote of the Board of Directors. The Board of Directors may refer an application for membership to the Ethics Committee when it has reasonable cause to believe that the applicant may have violated the CAMFT Code of Ethics. The Ethics Committee, after investigating the referral, shall make its recommendation to the Board of Directors. All members shall pay dues in accordance with the dues schedule of the Association and shall abide by the Bylaws and the CAMFT Code of Ethics of the Association.

The Executive Director shall make reports to licensing board(s) of membership denials, pursuant to Section 805(c) of the Business and Professions Code.

C. Article VII, Section B.3. of the Bylaws of the Association authorizes the various functions of the Ethics Committee. The Ethics Committee maintains and reviews the CAMFT Code of Ethics, interprets the Code of Ethics to the membership and the public, conducts investigations of alleged ethics violations, makes recommendations to the Board of Directors regarding members alleged to have violated the Code of Ethics, makes recommendations to the Board of Directors regarding acceptance or rejection of prospective members who may have violated the CAMFT Code of Ethics, and from time to time proposes revisions, deletions, and additions to the Code of Ethics to the Board of Directors for its approval.

D. The Bylaws of the Association, in Article IV, Section E3 provides for the expulsion or suspension of members. Expulsion or suspension: any member who violates the CAMFT Code of Ethics may be expelled or suspended from membership in the Association following an investigation and report by the Ethics Committee and a hearing before the Board of Directors. A two-thirds (2/3) majority vote of those Directors present at the hearing shall be necessary in order to expel or suspend a member. The member accused of the violation shall be given a reasonable opportunity to defend against the charge and shall be entitled to be represented at all stages of the proceedings. Any member to be expelled or suspended shall be entitled to at least fifteen (15) days prior notice of the expulsion or suspension and the reasons

therefore, and shall be entitled to be heard, orally or in writing, not less than five (5) days before the effective date of expulsion or suspension by the Board of Directors. Notice may be given by any method reasonably calculated to provide actual notice. Any notice given by mail shall be given by first-class, registered, or certified mail sent to the last address of the member as shown on the Association's records. The CAMFT Code of Ethics shall spell out further details of the procedures for investigation and hearing of alleged violations not inconsistent with these Bylaw provisions.

II. MEMBERSHIP AND MEETINGS OF THE COMMITTEE

A. Article VII, Section B3 of the Bylaws defines the composition and terms of office of the Ethics Committee. The Ethics Committee shall consist of not less than five (5) nor more than seven (7) members, all of whom shall be clinical members of the Association for at least two (2) years prior to appointment. The Committee shall not contain any directors as members. The term of office shall be two (2) years with a maximum of four terms. B. Article VII, Section E of the Bylaws, defines when the Ethics Committee may meet and the required notice for such meetings.

Meetings: Committees shall meet at such times as determined either by resolution of the Board of Directors, by resolution of the Committee with the approval of the President, or by a Committee Chair with the prior approval of the President. Meetings of Committees shall be held at the principal office of the Association or at any other place that is designated from time to time by the Board, the Committee, or the Committee Chair.

Notice: Meetings of the committees shall be held upon not less than ten (10) days written notice. Notice of a meeting need not be given to any committee member who signed a waiver of notice or a written consent to holding the meeting or an approval of the minutes thereof, whether before or after the meeting, or who attends the meeting without protesting, prior thereto or at its commencement, the lack of notice to such committee member.

Quorum: A majority of the committee members of each committee shall constitute a quorum of the committee for the transaction of business.

Minutes: Minutes shall be kept of each meeting of any committee and shall be filed with the corporate records. The Board of Directors may adopt rules for the governance of any committee consistent with the provisions of these Bylaws.

III. INITIATION OF COMPLAINTS

A. The Ethics Committee shall recognize and accept written complaints received from members of the Association or non-members, or the Ethics Committee may proceed on its own initiative, as specified in Section III. D.

B. All complaints must be in writing. Anonymous complaints shall neither be recognized nor accepted.

C. Complaints must be signed by the complainant and accompanied by the complainant's address and other contact information.

D. Notwithstanding the provisions specified, the Ethics Committee may proceed on its own initiative when it has been presented with sufficient information, which, if proven, would constitute a violation of the CAMFT Code of Ethics. For example, the Committee could proceed on information received from the CAMFT Board of Directors, another professional organization, a state licensing board, or a peer review committee. The Ethics Committee shall proceed with an investigation if directed to do so by the CAMFT Board of Directors.

E. The Ethics Committee may, in its discretion, determine that a complaint should not be acted upon because the events complained about occurred too far in the past.

IV. INITIAL ACTION BY EXECUTIVE DIRECTOR

Upon receipt of a complaint, the Executive Director, or his/her designee (hereafter "Executive Director"), shall determine whether the person who is the subject of the complaint is a member or applicant for membership in the Association.

A. If the person is not a member or an applicant for membership in the Association, the Executive Director shall so inform the complainant in writing and shall explain that the Association has no authority to proceed against the person.

B. If the person is a member of the Association or an applicant for membership in the Association, the Executive Director shall forward a copy of the complaint to the Chair of the Ethics Committee. A letter shall be sent by the Executive Director to the complainant acknowledging receipt of the complaint and informing the complainant that the person complained against is a member. A copy of the CAMFT Code of Ethics shall be included with the letter.

V. PRELIMINARY DETERMINATION BY CHAIR OF ETHICS COMMITTEE

A. The Chair of the Ethics Committee, or his/her designee (hereafter Chair), with the advice of Legal Counsel for the Association, shall review the complaint and determine whether it states allegations which, if proven, would constitute one or more violations of the CAMFT Code of Ethics. In the event the Chair determines that the complaint shall be closed without further action, the complainant shall be notified of such decision and the reason for such decision. When the Chair determines the complaint should not be closed, the complaint shall be referred to the full Ethics Committee. To aid in making such determinations, the Chair, with the advice of Legal Counsel for the Association, may request, in writing, clarification from the complainant.

B. When a complaint has been referred to the Ethics Committee, the Chair shall request the complainant's permission to disclose his/her name and/or to use any evidence provided by the complainant, for the purpose of the investigation. The Chair or his or her designee shall request that the complainant agree, in writing, to waive his/her rights of confidentiality and/or psychotherapist/patient privilege in order to permit the Ethics Committee to obtain information related to the investigation from the member and/or others.

C. If the complainant refuses permission for the use of his/her name in the investigation or refuses permission for the disclosure of his/her name or any of the written or other matter or evidence provided by the complainant, or if the complainant refuses to sign a waiver of confidentiality and/or psychotherapist/patient privilege, then the Chair of the Ethics Committee, with the advice of Legal Counsel, may close the matter and notify the complainant in writing or refer the matter to the full Ethics Committee for its action in accordance with III (D).

D. All correspondence to the complainant and to the member shall be marked “Confidential” or “Personal and Confidential.”

E. All actions of the Chair shall be reported to the full Ethics Committee at the next regularly scheduled meeting.

VI. INVESTIGATION BY ETHICS COMMITTEE

A. The Ethics Committee shall review complaints and supporting documentation/evidence to determine whether or not to investigate complaints. When the complaint warrants investigation, copies of the complaint and supporting documentation/evidence shall be sent to all members of the Ethics Committee. Investigations may be carried out by the Chair of the Committee in consultation with Legal Counsel, by the Chair’s designee(s), or by the Committee. The Chair, in consultation with Legal Counsel, may act on behalf of the Committee between meetings of the Committee, to pursue investigations, and shall report such actions to the full Committee.

B. The Chair of the Ethics Committee, in consultation with Legal Counsel, shall prepare and send a letter to the member, specifying those sections of the CAMFT Code of Ethics that may have been violated by the member. The letter shall inform the member of the ethical duty to cooperate with the Ethics Committee in its effort to investigate the circumstances that led to the allegations, and to provide on his/her behalf, a written statement in response to the allegations made in the complaint. The member shall be sent a copy of the CAMFT Code of Ethics.

C. Investigations may be pursued by corresponding with the member and other persons involved in the dispute, or by interviewing such persons, personally or by telephone, electronic transmissions, or by any other lawful means.

D. During the investigation stage of the proceedings, the member shall have the right to consult with his/her attorney and shall have the right to have his/her attorney present at any investigatory meeting with the member.

VII. ACTION BY THE ETHICS COMMITTEE

A. After reviewing the complaint, the response of the member, and any other pertinent information, the Ethics Committee may make findings of a violation of the CAMFT Code of Ethics, close the case without a finding of a violation of the CAMFT Code of Ethics, hold the case in abeyance pending other action, continue the investigation, attempt to settle the case by mutual agreement, send a letter with cautions or recommendations, or recommend to the Board of Directors that the individual's membership be terminated, suspended, placed on probation, that other action be taken. The Ethics Committee may appropriately impose more stringent requirements upon members previously found to have violated the CAMFT Code of Ethics, or any other relevant professional or state code of professional conduct. If additional evidence of unethical conduct is brought to the attention of the Committee after a matter has been closed, the case may be reopened and acted upon under these procedures.

B. If the Ethics Committee decides to attempt to settle the case by mutual agreement:

The Committee may recommend to the member that he/she agree to the terms of a Settlement by Mutual Agreement. The terms and conditions of the Settlement by Mutual Agreement may include requiring the member to: cease and desist from specified actions, accept censure, be placed on probation and/or rehabilitation, be under supervision or monitored practice, complete education or therapy or both, agree to suspension or termination of

membership in the Association, or any other terms and conditions that the Committee deems appropriate.

The Settlement by Mutual Agreement shall be in writing and shall detail the specific sections of the CAMFT Code of Ethics that have been violated and the manner in which the agreement is to be implemented.

The Committee shall supervise and oversee compliance with the Settlement by Mutual Agreement. The Committee has the final authority over the Settlement by Mutual Agreement and the meaning of the terms of the Settlement by Mutual Agreement. The Committee may alter such terms and conditions when requested by the member or as deemed necessary by the Committee with the written agreement of the member.

The Agreement shall become effective and is binding as soon as it is signed by the member and the Chair of the Ethics Committee or at any other time designated in the Agreement. The Agreement shall be maintained in the Association's records.

The Committee, in its sole discretion, may make a finding that the member has not complied with the terms or conditions of the Settlement by Mutual Agreement. In the event of the member's noncompliance with the Settlement by Mutual Agreement, the Committee may proceed in accordance with the provisions of the Settlement by Mutual Agreement that relate to non-compliance, or in accordance with Section D, or in any other manner not inconsistent with Section D.

If no Settlement by Mutual Agreement occurs, because a settlement is offered but ultimately rejected by the member, the Ethics Committee may recommend that action be taken against the member by theBoard of Directors as a result of one or more violations of the CAMFT Code of Ethics.

C. When the Ethics Committee recommends that action be taken by the Board of Directors, the Ethics Committee shall give the member written notice as specified below. Notice shall be given by personal delivery or certified mail sent to the last address of the member as shown on the Association's records. The written notice shall include, at a minimum, all of

the following information: 1) the findings of the Ethics Committee, 2) the final proposed action of the Ethics Committee, 3) whether such action, if adopted by the Board of Directors, would require a report pursuant to Section 805 of the Business and Professions Code, 4) that the member has a right to request a hearing on the final proposed action, and 5) that the time limit within which a hearing must be requested is thirty (30) days from receipt of notification of the final proposed action.

D. If a hearing is not requested within forty (40) days from mailing of notification of the final proposed action, then the Committee's final proposed action shall be adopted, and the Ethics Committee Chair shall thereafter forward the final determination to the Executive Director for such further action as may be appropriate.

E. If a hearing is requested on a timely basis, the Ethics Committee shall give the member written notice. Notice shall be given by personal delivery or certified mail sent to the last address of the member as shown on the Association's records. The written notice shall include, at a minimum, all of the following information: 1) the reasons for the final proposed action recommended, including the acts or omissions with which the member is charged, and 2) the place, time, and date of the hearing. The hearing shall be commenced within sixty (60) days after receipt of the request for a hearing.

VIII. PROCEDURES FOR HEARINGS BEFORE BOARD OF DIRECTORS

A. The hearing shall be conducted in accordance with the provisions of these Procedures. Should these Procedures be inconsistent with the Peer Review Fair Hearing Procedures commencing with Section 809 of the Business and Professions Code, the provisions of the Business and Profession Code shall prevail.

B. The hearing shall be held before the Board of Directors.

C. The Board of Directors may designate a hearing officer to preside at such hearing. If the charged member is a current member of the Board of Directors, or a Board of Directors member-elect, the Board of Directors shall designate a hearing officer who is not a current member of the Board of

Directors to preside at such hearing. The hearing officer shall be a person who will gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

D. The member shall have the option of being represented by counsel, and if counsel is desired, notice shall be expense.

E. All costs of attendance for the charged member at the hearing shall be borne by the charged member.

F. The charged member shall have the right to a reasonable opportunity to voir dire the Board of Directors and any hearing officer, if selected, and the right to challenge the impartiality of any Board Member or hearing officer.

G. The Ethics Committee, through its Chair or his/her designee, shall present the case against the member.

H. Continuances shall be granted upon agreement of the parties on a showing of good cause by the hearing officer or if there is no hearing officer, the President or his/her designee (hereafter President).

I. The charged member and the Ethics Committee shall have the right to inspect and copy documentary information relevant to the charges in each other's possession or under their control. Both parties shall provide access to this information at least thirty (30) days before the hearing.

J. The parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing at least thirty (30) days before the hearing.

K. The charged member and the Ethics Committee have the following rights:

To be provided with all of the information made available to the Board of Directors.

To have a record made of the proceedings at the Member's cost.

To make opening and closing statements.

To call, examine and cross-examine witnesses. Members of the Association have a duty to testify as to relevant information, if requested to do so by the Ethics Committee pursuant to Section 9.7 of the Code of Ethics.

To present and rebut evidence determined by the President.

To submit a written statement at the close of the hearing.

L. All evidence, which is relevant and reliable, as determined by the President shall be admissible. The formal rules of evidence shall not apply.

M. The Ethics Committee shall have the burden of proving the charges by a preponderance of the evidence.

N. The decision of the Board shall be by majority vote of the Board of Directors present. Pursuant to the Bylaws, if the decision is to expel or suspend, a two-thirds (2/3) majority vote of the Board of Directors present is required.

O. Upon completion of a hearing concerning a final proposed action, the member and the Ethics Committee shall receive a written decision of the Board of Directors within a reasonable time. Said decision shall include findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The written decision shall be delivered by personal delivery or certified mail sent to the last address of the member as shown on the Association's records.

P. If no violation of the CAMFT Code of Ethics is found, the Board of Directors shall order that the member be cleared of all charges.

Q. If a violation or violations of the CAMFT Code of Ethics is/are found, the Board shall either adopt the final proposed action recommended by the Ethics Committee or take any other action that the Board deems appropriate, including, but not limited to, requiring him/her to cease and desist from specific actions; accept censure; probation and/or rehabilitation; supervision or monitored practice; education, therapy, or both; and/or suspension or termination of membership.

R. There shall be no appeals from decisions of the Board of Directors, but the Board, in its discretion, may reconsider its decision upon the written request of the member.

S. Any terms or conditions ordered by the Board shall be monitored by the Ethics Committee. Any request by the member for modification of terms or conditions shall be directed to the Ethics Committee, which shall consider and act upon the requested modifications in a reasonable time.

IX. RESIGNATIONS AND NON-RENEWALS

If a member resigns from membership in the Association during the investigation of the complaint or at any other time during the consideration of the complaint, the Ethics Committee, at its discretion, may continue its investigation. The Executive Director shall make reports to licensing board(s) of resignations and withdrawal or abandonment of applications, pursuant to Section 805(c) of the Business and Professions Code.

X. RECORDS AND DISCLOSURE OF INFORMATION

A. The permanent files of the Ethics Committee shall be maintained in the principal office of the Association.

B. All information obtained by the Ethics Committee, including Settlements by Mutual Agreement, any investigating subcommittee or designee, and all proceedings of the Ethics Committee, shall be confidential except as follows:

Information may be disclosed by those investigating the complaint, or the investigating subcommittee or designee, as is necessary in order to pursue a thorough investigation.

The complainant may be informed of the status and progress of the complaint and shall be notified of the conclusion of the case.

The Ethics Committee may, in its discretion, authorize the Executive Director to publicize summaries of Settlements by Mutual Agreement without disclosing the name of the complainant or the charged member.

When an accused member resigns his/her CAMFT membership during the course of an Ethics Committee investigation, and where the Committee determines that there has been a violation of the CAMFT Code of Ethics, the Association may publish the fact and circumstances of the member's resignation.

Whenever the Board of Directors finds, after a hearing, that a member has not violated the CAMFT Code of Ethics, that fact shall be disclosed to the membership of the Association by publication in The Therapist only upon the written request of the cleared member.

If, after a hearing, the Board of Directors finds that a member has violated the CAMFT Code of Ethics, the Board of Directors may do any of the following:

a. Disclose the ethics violation and disciplinary action to the membership of the Association.

b. Inform state regulatory agencies and other professional organizations, including chapters of CAMFT.

The Board of Directors shall order the publication of a member's expulsion or suspension if, after a hearing by the Board of Directors, the member has been found to have violated the CAMFT Code of Ethics.

If there is to be publication of the Board of Directors' findings and actions, it will be in The Therapist and shall include the member's full name, any earned degree, his/her geographical location, and the section or section(s) of the CAMFT Code of Ethics that was/were violated.

Part II, The Procedures, was revised, effective December 2019. The previous revision was effective March 2011.

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.

5B. ACA Code of Ethics

The following includes portions of the 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.

(American Counseling Association 2014. ACA Code of Ethics. Alexandria, VA: Author.)

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

American Counseling Association (2014). ACA Code of Ethics. Alexandria, VA: Author.

5C. NASW Code of Ethics

The following includes portions of the NASW Code of Ethics, (National Association of Social Workers, 2017. 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 BBS ESD Info

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.

* Medicare allowed charges include the amounts paid by Medicare in addition to any coinsurance and deductibles. The billed charges for private insurers are likely in many cases higher than the paid rates, which cannot be observed in these data (MarketScan).

† For example, Colorado provides for higher payments to facilities operated by the Denver Health and Hospital Authority and Maryland has different requirements for HMOs and PPOs.

State Legislative Approaches

A majority of states have attempted to address surprise billing for the insurance plans they regulate. Researchers developed criteria for a comprehensive approach to surprise billing and have identified legislation in 18 states that fully meet those specifications, with an additional 15 states taking less comprehensive actions. States with comprehensive approaches address all of these items: they extend protections to both emergency department and in-network hospital settings; apply laws to all types of insurance, including both HMOs and PPOs; protect consumers by holding them harmless from extra provider charges; prohibit providers from balance billing; and adopt either an adequate payment standard to determine how much the insurer pays the provider or a dispute-resolution process to resolve payment disputes between providers and insurers.

How these states determine payment amounts in disputed cases varies. Some states have established a payment standard either through legislation or regulation; others have established a process for resolving disputed claims through an independent third party. Some states combine approaches. Seven states have established payment standards, with significant variation both across and within states. They are typically derived from a fixed fee schedule, and options include the Medicare fee schedule, the plan's median contracted rate for a similar service, or information derived from publicly

available data from multiple insurers such as a state's all-payer claims database.

Nine of the "comprehensive" states identified in Figure 2 have established varying independent dispute resolution processes. Six of the nine states use a "baseball-style" best and final offer process, where the arbiter chooses between two discrete offers – either choosing the provider's offer or the insurer's offer.11 Some states use a combination of approaches, for example, by setting a payment standard when the claim in question is not large and authorizing arbitration for larger amounts.

The impact of state surprise billing laws in many cases is unclear, in part because many have not been in place for long. However, New York's law has been in place since 2015 and has been closely scrutinized. New York uses a baseball-style arbitration, and its arbiters have received guidance to consider the 80th percentile of charges in determining the payment amount.‡ Since the amount providers charge is typically much higher than the actual negotiated rate, this approach risks leading to significantly higher overall costs, and this has been supported by the evidence to date. Through 2018, New York's approach had resulted in arbitration decisions that averaged 8 percent higher than the 80th percentile of charges and has the potential to alter negotiations between insurers and their network providers, leading to higher future consumer costs.13 A peer reviewed study in 2021 of New Jersey's system, where billed charges or usual and customary rates are taken into consideration, also found it was associated with high payments – with a median arbitration award 5.7 times higher than median in-network commercial rates.

State actions on surprise billing have other important limitations. First and foremost, roughly 67 percent of workers with employer−sponsored health coverage are enrolled in self−insured plans.17 State insurance rules do not apply to self−insured employee benefit plans established or maintained by private sector employers, which are subject to federal oversight.

Further, states have been unable to address the costs of air ambulance services because the Airline Deregulation Act of 1978 preempts state law and prevents states from regulating air ambulance costs. While states have tried to litigate the issue, they have not been successful.19

The No Surprises Act and Its Implementation

The No Surprises Act (the Act) and its implementing rules were designed to address these gaps in state policies and apply protections against surprise billing nationwide. The Act addresses surprise billing in both emergency and certain non-emergency contexts, as well as for air ambulance services. The Act generally prohibits out-of-network providers and facilities from balance billing for emergency services and requires that cost-sharing for such services (including copayments, coinsurance, and deductibles) not be greater than what would be charged on an in-network basis, and without requirements for prior authorization. In non-emergency situations where a facility providing care may be in-network but the care involves out-of-network providers, the Act allows balance billing by certain types of providers, if the patient has consented to being balance billed and has been provided with an easy-to-understand notice explaining this requirement with a good faith estimate of costs.

Thus, the Act will effectively remove the patient from payment disputes between health plans and out-of-network providers when the payment a provider wishes to receive is higher than the amount a plan is willing to pay. The Act provides an outline for an independent dispute resolution process for these circumstances but left many details of that process to rulemaking. The Act and its implementing regulations provide for four ways to determine out-of-network payments in these disputed circumstances:

- ➡ Payment as established by an applicable All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS) to test and operate systems of all-payer payment reform;
- ➡ If there is no applicable All-Payer Model Agreement, the amount determined by an applicable state law (referred to as a specified state law);
- ➡ If there is no applicable All-Payer Model Agreement or applicable specified state law, an amount agreed upon by provider and payer; or
- ➡ If none of these apply, an amount determined by a certified independent dispute resolution (IDR) entity.

The Congressional Budget Office estimated that the provisions of the No Surprises Act, in most markets, would typically reduce premiums by between 0.5 percent and 1 percent. Lower costs for health insurance would also reduce federal deficits.

Process for Resolving Disputed Claims

The Departments, along with the Office of Personnel Management, issued an Interim Final Rule with comment period published in the Federal Register October 7, 2021 (the October rule). The October rule is designed to provide a process for resolving disputed claims that is fair to both providers and plans that also does not increase aggregate healthcare system costs. The provisions contained in the rule are applicable to plan or policy years beginning on or after January 1, 2022.

Below are the steps involved in resolving a disputed claim:

- Prior to initiating an IDR process, disputing parties must attempt, over a period of 30 business days, to reach agreement on the payment amount.
- If this attempt fails, ether party can invoke the federal IDR process. The parties jointly select a certified IDR entity without conflicts of interest to resolve the dispute, or if they don't make a choice, the Departments select the certified IDR entity. The parties submit their offers for payment along with supporting documentation. The IDR entity then issues a binding determination selecting one of the parties' offers as the payment amount.
- The certified IDR entity must select the offer closest to the qualifying payment amount (QPA) unless the certified IDR entity determines that credible information submitted by either party as defined by the Act clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the QPA but in opposing directions. In these cases, the certified IDR entity must select the offer as the out-of-network rate that the certified IDR entity determines best represents the value of the qualified IDR item or services. The QPA is generally an amount based on indexed median contracted rates, but the Act and the July rule provide for alternate methods of determining the QPA in some circumstances, such as when the payer has insufficient information to calculate the median contracted rates. **

Unanswered Questions and Reporting Requirements

The July rule identifies questions about the impact of these surprise billing provisions that will only be answered over time. We do not know how often the IDR process will be used and whether its usage will vary based on the size of the insurer or on other characteristics. It is not clear whether the 30-business-day pre-IDR negotiation period will lead to disputes being resolved sooner. The Act and regulation allow for the batching of similar claims, but whether this happens and its potential impact remains to be seen. Future

evaluation will be needed to assess the impact of these provisions on the costs of emergency and non-emergency services. The No Surprises Act itself includes provisions that will assist in answering these questions.
The Act includes monthly reporting requirements for certified IDR entities. These requirements will elucidate the nature of each claim that undergoes the IDR process, provider characteristics, how the claim is resolved, and whether a payment exceeds the QPA, among other aspects of disputed claims. This reporting will provide timely information on how the process is working. The Act also includes requirements for regular reporting related to air ambulance services. In addition, the Act requires several related reports to Congress, some by HHS in consultation with the Federal Trade Commission and the Attorney General, and others by the GAO.

The first of the reports produced by HHS in consultation with the Federal Trade Commission and the Attorney General is due on January 1, 2023, and annually thereafter for four years. These reports will cover the effects of the Act with particular attention paid to patterns of vertical or horizontal integration, overall health care costs, and access to health care services, particularly in rural areas and health professional shortage areas. The GAO reports will examine the effects of the Act on health care provider networks, insurance coverage, fee schedules and amounts paid for health care services, the adequacy of provider networks in commercial health plans, and the IDR process.

Conclusions

The No Surprises Act addresses a significant burden faced by millions of U.S. consumers. State legislation has only been partially able to address these challenges, and in some cases, state approaches to settling payment disputes has led to increased health care costs. The approach taken in the 2021 Interim Final Rules under the No Surprises Act is designed to create a fair process that is expected to lower overall health care costs. The Act, through its multiple reporting requirements, will provide the evidence needed to evaluate the law's performance over time to inform any future policy changes that may be warranted in this area.

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.

7. Continuing Education

Statutes and Regulations Relating to the Practice of Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, and Social Work, Board of Behavioral Sciences

ARTICLE 3. RENEWAL AND CONTINUING EDUCATION § 4989.30. EXPIRATION OF LICENSE

A license issued under this chapter shall expire no later than 24 months after its date of issue. The expiration date of the original license shall be set by the board.

§ 4989.32. RENEWAL OF UNEXPIRED LICENSE
To renew an unexpired license, the licensee shall, on or before the expiration date of the license, take all of the following actions:

(a) Apply for renewal on a form prescribed by the board.

(b) Pay a renewal fee prescribed by the board.
(c) Inform the board of whether he or she has been convicted, as defined in Section 490, of any misdemeanor or felony and whether any disciplinary action has been taken by a regulatory or licensing board in this or any other state after the prior issuance or renewal of his or her license.
(d) Complete the continuing education requirements described in Section 4989.34.

§ 4989.34. CONTINUING EDUCATION REQUIREMENTS
(a) To renew his or her license, a licensee shall certify to the board, on a form prescribed by the board, completion in the preceding two years of not less than 36 hours of approved continuing education in, or relevant to, educational psychology.
(b) (1) The continuing education shall be obtained from either an accredited university or a continuing education provider as specified by the board by regulation.
(2) The board shall establish, by regulation, a procedure identifying acceptable providers of continuing education courses, and all providers of continuing education shall comply with procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.
(c) Training, education, and coursework by approved providers shall incorporate one or more of the following:
(1) Aspects of the discipline that are fundamental to the understanding or the practice of educational psychology.
(2) Aspects of the discipline of educational psychology in which significant recent developments have occurred.
(3) Aspects of other disciplines that enhance the understanding or the practice of educational psychology.
(d) The board may audit the records of a licensee to verify completion of the continuing education requirement. A licensee shall maintain records of the completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon its request.
(e) The board may establish exceptions from the continuing education requirements of this section for good cause, as determined by the board.
(f) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral

Sciences Fund. The amount of the fees shall be sufficient to meet, but shall not exceed, the costs of administering this section.
(g) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

First-time Renewals

Licensees renewing for the first time, must complete 18 hours of continuing education within the two years prior to first license renewal. This includes specific coursework required by law. Please refer to the CE Chart for more information.

Subsequent Renewals

Licensees must complete 36 hours of continuing education within the two years prior to each license renewal date, including 6 hours of Law and Ethics. Licensees are required to complete 6 hours of Law and Ethics training with every renewal. All other mandatory courses are one-time requirements. Please refer to the CE Chart for more information.

Mandatory Coursework

Licensees are required to complete 6 hours of Law and Ethics training with every renewal. All other mandatory courses are one-time requirements.Please refer to the CE Chart for more information.

ARTICLE 8. CONTINUING EDUCATION REQUIREMENTS FOR MARRIAGE AND FAMILY THERAPISTS, LICENSED CLINICAL SOCIAL WORKERS, LICENSED EDUCATIONAL PSYCHOLOGISTS, AND LICENSED PROFESSIONAL CLINICAL COUNSELORS

§ 1887. DEFINITIONS.
As used in this article:
(a) A continuing education "course" means a form of systematic learning at least one hour in length including, but not limited to, academic studies, extension studies, lectures, conferences, seminars, workshops, viewing of videotapes or film instruction, viewing or participating in other audiovisual

activities including interactive video instruction and activities electronically transmitted from
another location that has been verified and approved by the continuing education provider.
(b) A "provider" means an organization, institution, association, university, or other person or entity assuming full responsibility for the course offered.
(c) An "initial renewal period" means the period from issuance of an initial license to the license's first expiration date.
(d) A "renewal period" means the two-year period that spans from the effective date of the license to the expiration date.
(e) An "approval agency" means an organization recognized by the board that evaluates and approves providers of continuing education, ensures courses offered by its providers meet the continuing education requirements of the board, and monitors the quality of each approved continuing education course.
Note: Authority cited: Sections 4980.60, 4989.34, and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22 and 4999.76, Business and Professions Code.

§ 1887.1. LICENSE RENEWAL REQUIREMENTS.
(a) Except as provided in Section 1887.2, a licensee shall certify in writing, when applying for license renewal, by signing a statement under penalty of perjury that during the preceding renewal period the licensee has completed thirty-six (36) hours of continuing education credit as set forth in Sections 4980.54, 4989.34, 4996.22, and 4999.76 of the Code.
(b) A licensee who falsifies or makes a material misrepresentation of fact when applying for license renewal or who cannot verify completion of continuing education by producing a record of course completion, upon request by the board, is subject to disciplinary action under Sections 4982(b), 4989.54 (b), 4992.3(b), and 4999.90(b) of the Code.
Note: Authority cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22 and 4999.90, Business and Professions Code.

§ 1887.2. EXCEPTIONS FROM CONTINUING EDUCATION REQUIREMENTS.
(a) A licensee in his or her initial renewal period shall complete at least eighteen (18) hours of continuing education prior to his or her first license renewal.

(b) A licensee is exempt from the continuing education requirement if his or her license is inactive pursuant to Sections 4984.8, 4989.44, 4997 or 4999.112 of the Code.
(c) A licensee may submit a written request for exception from, or reasonable accommodation for, the continuing education requirement, on a form entitled "Request for Continuing Education Exception – Licensee Application," Form No. 1800 37A-635 (Rev 3/10), hereby incorporated by reference, for any of the reasons listed below. The request must be submitted to the board at least sixty (60) days prior to the expiration date of the license. The board will notify the licensee, within thirty (30) working days after receipt of the request for exception or reasonable accommodation, whether the exception or accommodation was granted. If the request for exception or accommodation is denied, the licensee is responsible for completing the full amount of continuing education required for license renewal. If the request for exception or accommodation is approved, it shall be valid for one renewal period.
(1) The board shall grant an exception if the licensee can provide evidence, satisfactory to the board, that:
(A) For at least one year during the licensee's previous license renewal period the licensee was absent from California due to his or her military service;
(B) For at least one year during the licensee's previous license renewal period the licensee resided in another country; or
(2) The board may grant a reasonable accommodation if, for at least one year during the licensee's previous license renewal period, the licensee or an immediate family member, including a domestic partner, where the licensee is the primary caregiver for that family member, had a physical or mental disability or medical condition as defined in Section 12926 of the Government Code. The physical or mental disability or medical condition must be verified by a licensed physician or psychologist with expertise in the area of the physical or mental disability or medical condition. Verification of the physical or mental disability or medical
condition must be submitted by the licensee on a form entitled "Request for Continuing Education Exception – Verification of Disability or Medical Condition," Form No. 1800 37A-636 (New 03/10), hereby incorporated by reference.
Note: Authority cited: Sections 4980.54, 4980.60, 4989.34, 4990.20(a), 4996.22 and 4999.76, Business and Professions Code; and Sections 12926 and

12944, Government Code. Reference: Sections 4980.54, 4989.34, 4996.22 and 4999.76, Business and Professions Code.

§ 1887.3. CONTINUING EDUCATION COURSE REQUIREMENTS.

Please also refer to the updated continuing education requirements discussed in chapter six

(a) During each renewal period, a licensee shall accrue at least thirty-six (36) hours of continuing education coursework as defined in Section 1887.4.0.
(b) Marriage and family therapists and clinical social workers who started graduate study prior to January 1, 1986, shall take a continuing education course in the detection and treatment of alcohol and other chemical substance dependency during their first renewal period after the effective date of these regulations. The course shall be at least seven (7) hours in length and its content shall comply with the requirements of Section 29 of the Code. This is a one-time requirement for those licensees specified above. Equivalent alcohol and other chemical substance dependency courses taken prior to the effective date of these regulations, or proof of equivalent teaching or practice experience, may be submitted to the board for approval in lieu of this requirement; however, this coursework or experience shall not be credited as hours towards the continuing education requirements.
(c) A marriage and family therapist, clinical social worker, and professional clinical counselor licensee shall take a continuing education course in the characteristics and methods of assessment and treatment of people living with human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) during their first renewal period after the effective date of these regulations. The course shall be at least seven (7) hours in length and its content shall comply with the requirements of Section 32 of the Code. This is a one-time requirement for all licensees.

Equivalent HIV and AIDS courses taken prior to the effective date of these regulations, or proof of equivalent teaching or practice experience, may be submitted to the board for approval in lieu of this requirement; however, this coursework or experience shall not be credited as hours towards
the continuing education requirements. (d) Any person renewing his or her license shall complete a minimum of six (6) hours of continuing education in the subject of law and ethics for each renewal period. The six (6) hours shall be
considered part of the thirty-six (36) hour continuing education requirement.

(e) If a licensee teaches a course, the licensee may claim credit for the course only one time during a single renewal period, receiving the same amount of hours of continuing education credit as a licensee who attended the course.
(f) A licensee may not claim the same course more than once during a single renewal period for hours of continuing education credit.
(g) A licensee who takes a course as a condition of probation resulting from disciplinary action by the board may not apply the course as credit towards the continuing education requirement.
(h) A licensee who attends the board enforcement case review training may be awarded up to six hours of continuing education in the renewal cycle in which the case review training was attended.
The continuing education hours earned by attending a board enforcement case review training may only be used to satisfy the law and ethics portion of the continuing education requirement.
(i) A licensee who acts as a board subject matter expert (SME) for an enforcement case review may be awarded six hours of continuing education in the renewal cycle in which the enforcement case review was performed. The continuing education hours earned by acting as a board enforcement case SME may only be used to satisfy the law and ethics portion of the continuing education requirement.
(j) A licensee who participates in a board examination development workshop may be awarded six hours of continuing education in the renewal cycle in which the examination development workshop was attended. The continuing education hours earned by participating in a board examination development workshop may only be used to satisfy the law and ethics portion of the continuing education requirement.
(k) A licensee who participates in a professional organization's law and ethics review committee may be awarded up to six hours of continuing education in the renewal cycle in which the participation occurred. The continuing education earned by participating in a professional organization's law and ethics review committee may only be used to satisfy the law and ethics portion of the continuing education requirement.
Note: Authority cited: Sections 4980.60, 4989.34, 4990.20 and 4999.76, Business and Professions Code. Reference: Sections 29, 32, 4980.54, 4989.34,
4996.22 and 4999.76, Business and Professions Code.

§ 1887.5. HOURS OF CONTINUING EDUCATION CREDIT.
(a) One hour of instruction is equal to one hour of continuing education credit.

(b) One academic quarter unit is equal to ten (10) hours of continuing education credit.
(c) One academic semester unit is equal to fifteen (15) hours of continuing education credit.
Note: Authority Cited: Sections 4980.60, 4989.34, 4990.20, and 4999.76, Business and Professions Code. Reference: Sections 4980.54, 4989.34, 4996.22, and 4999.76, Business and Professions Code.

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

§ 28. TRAINING FOR CHILD, ELDER AND DEPENDENT ADULT ABUSE ASSESSMENT AND REPORTING; LICENSING PREREQUISITES
(a) The Legislature finds that there is a need to ensure that professionals of the healing arts who have demonstrable contact with victims and potential victims of child, elder, and dependent adult abuse, and abusers and potential abusers of children, elders, and dependent adults are provided with adequate and appropriate training regarding the assessment and reporting of child, elder, and dependent adult abuse that will ameliorate, reduce, and eliminate the trauma of abuse and neglect
and ensure the reporting of abuse in a timely manner to prevent additional occurrences.
(b) The Board of Psychology and the Board of Behavioral Sciences shall establish required training in the area of child abuse assessment and reporting for all persons applying for initial licensure and renewal of a license as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist. This training shall be required one time only for all persons applying for initial licensure or for licensure renewal.

(c) All persons applying for initial licensure or renewal of a license as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist shall, in addition to all other requirements for licensure or renewal, have completed coursework or training in child abuse assessment and reporting that meets the requirements of this section, including detailed
knowledge of the Child Abuse and Neglect Reporting Act (Article 2.5 (commencing with Section 11164) of Chapter 2 of Title 1 of Part 4 of the Penal Code). The training shall meet all of the following requirements:
(1) Be obtained from one of the following sources:
(A) An accredited or approved educational institution, as defined in Sections 2902,
4980.36, 4980.37, 4996.18, and 4999.12, including extension courses offered by
those institutions.
(B) A continuing education provider as specified by the responsible board by regulation.
(C) A course sponsored or offered by a professional association or a local, county, or state department of health or mental health for continuing education and approved or accepted by the responsible board.
(2) Have a minimum of seven contact hours.
(3) Include the study of the assessment and method of reporting of sexual assault, neglect,
severe neglect, general neglect, willful cruelty or unjustifiable punishment, corporal punishment or injury, and abuse in out-of-home care. The training shall also include physical and behavioral indicators of abuse, crisis counseling techniques, community resources, rights and responsibilities of reporting, consequences of failure to report, caring for a child's needs after a report is made, sensitivity to previously abused children and adults, and implications and methods of treatment for children and adults.
(4) An applicant shall provide the appropriate board with documentation of completion of the required child abuse training.
(d) The Board of Psychology and the Board of Behavioral Sciences shall exempt an applicant who applies for an exemption from this section and who shows to the satisfaction of the board that there would be no need for the training in the applicant's practice because of the nature of that practice.
(e) It is the intent of the Legislature that a person licensed as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist have minimal but appropriate training in the areas of child, elder, and dependent adult abuse assessment and reporting. It is not intended

that, by solely complying with this section, a practitioner is fully trained in the subject of
treatment of child, elder, and dependent adult abuse victims and abusers.
(f) The Board of Psychology and the Board of Behavioral Sciences are encouraged to include coursework regarding the assessment and reporting of elder and dependent adult abuse in the required training on aging and long-term care issues prior to licensure or license renewal.

§ 29. CHEMICAL DEPENDENCY AND EARLY INTERVENTION TRAINING; CONTINUING EDUCATION REQUIREMENTS

(a) The Board of Psychology and the Board of Behavioral Sciences shall consider adoption of continuing education requirements including training in the area of recognizing chemical dependency and early intervention for all persons applying for renewal of a license as a psychologist, clinical social worker, marriage and family therapist, or professional clinical counselor.
(b) Prior to the adoption of any regulations imposing continuing education relating to alcohol and other chemical dependency, the boards are urged to consider coursework to include, but not necessarily be limited to, the following topics:
(1) Historical and contemporary perspectives on alcohol and other drug abuse.
(2) Extent of the alcohol and drug abuse epidemic and its effects on the individual, family, and community.
(3) Recognizing the symptoms of alcoholism and drug addiction.
(4) Making appropriate interpretations, interventions, and referrals.
(5) Recognizing and intervening with affected family members.
(6) Learning about current programs of recovery, such as 12 step programs, and how therapists can effectively utilize these programs.

§ 32. LEGISLATIVE FINDINGS; AIDS TRAINING IN CONTINUING EDUCATION REQUIREMENTS FOR SPECIFIED LICENSES

(a) The Legislature finds that there is a need to ensure that professionals of the healing arts who have or intend to have significant contact with patients who have, or are at risk to be exposed to, acquired immune deficiency syndrome (AIDS) are provided with training in the form of continuing education regarding the characteristics and methods of assessment and treatment of the condition.
(b) A board vested with the responsibility of regulating the following licensees shall consider including training regarding the characteristics and method of assessment and treatment of acquired immune deficiency

syndrome (AIDS) in any continuing education or training requirements for those licensees: chiropractors, medical laboratory technicians, dentists, dental hygienists, dental assistants, physicians and surgeons, podiatrists, registered nurses, licensed vocational nurses,
psychologists, physician assistants, respiratory therapists, acupuncturists, marriage and family therapists, licensed educational psychologists, clinical social workers, and professional clinical counselors.

§ 4980.39. ADDITIONAL COURSEWORK: AGING AND LONG-TERM CARE

(a) An applicant for licensure whose education qualifies him or her under Section 4980.37 shall complete, as a condition of licensure, a minimum of 10 contact hours of coursework in aging and long-term care, which may include, but is not limited to, the biological, social, and psychological aspects of aging. On and after January 1, 2012, this coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse
and neglect.

(b) Coursework taken in fulfillment of other educational requirements for licensure pursuant to this chapter, or in a separate course of study, may, at the discretion of the board, fulfill the requirements of this section.

(c) In order to satisfy the coursework requirement of this section, the applicant shall submit to the board a certification from the chief academic officer of the educational institution from which the applicant graduated stating that the coursework required by this section is included within the institution's required curriculum for graduation, or within the coursework, that was completed by
the applicant.

(d) The board shall not issue a license to the applicant until the applicant has met the requirements of this section.

§ 4980.396. 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.

§ 4980.57. CONTINUING EDUCATION FOR SPOUSAL OR PARTNER ABUSE

(a) The board shall require a licensee who began graduate study prior to January 1, 2004, to take a continuing education course during his or her first renewal period after the operative date of this section in spousal or partner abuse assessment, detection, and intervention strategies, including community resources, cultural factors, and same gender abuse dynamics. On and after January 1, 2005, the course shall consist of not less than seven hours of training. Equivalent courses in spousal or partner abuse assessment, detection, and intervention strategies taken prior to the operative date of this section or proof of equivalent teaching or practice experience may be

submitted to the board and at its discretion, may be accepted in satisfaction of this requirement.
(b) Continuing education courses taken pursuant to this section shall be applied to the 36 hours of approved continuing education required under subdivision (c) of Section 4980.54.

§ 4980.72. OUT-OF-STATE APPLICANTS: LICENSURE BY CREDENTIAL

The board may issue a license to a person who, at the time of submitting an application for a license pursuant to this chapter, holds a license in another jurisdiction of the United States as a marriage and family therapist at the highest level for independent clinical practice if all of the following requirements are met:
(a) The applicant's license in the other jurisdiction has been current, active, and unrestricted in that jurisdiction for at least two years immediately before the date the application was received by the board. The applicant shall disclose to the board for review any past restrictions or disciplinary action on an out-of-state license, and the board shall consider these actions in determining whether to issue a license to the applicant.
(b) The applicant's degree that qualified the person for the out-of-state license is a master's or doctoral degree that was obtained from an accredited or approved institution.
(c) The applicant complies with the fingerprint requirements established by Section 144
(d) The applicant completes the coursework specified in paragraphs (1) and (2) from an accredited institution or an approved institution or from an acceptable provider of continuing education as specified in Section 4980.54. Undergraduate coursework shall not satisfy these requirements.
(1) A minimum of 12 hours of coursework in California law and professional ethics that includes, but is not limited to, instruction in advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous clients, psychotherapist-client privilege, record keeping, client access to records, state and federal laws relating to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to clients, the application of legal and ethical standards in different types of work settings, and licensing law and the licensing process.

(2) At least one semester unit, or 15 hours, of instruction that includes an understanding of various California cultures and the social and psychological implications of socioeconomic position.
(e) The applicant obtains a minimum of seven contact hours of training or coursework in child abuse assessment and reporting, as specified in Section 28, and any regulations promulgated pursuant to that section.
(f) On or after January 1, 2021, the applicant shall show proof of completion of at least six hours of coursework or applied experience under supervision in suicide risk assessment and intervention using one of the methods specified in Section 4980.396.
(g) The applicant passes the board-administered California law and ethics examination specified in subdivision (d) of Section 4980.40. The clinical examination specified in subdivision (d) of Section 4980.40 shall be waived for an applicant qualifying under this section.
(h) This section was developed based on an examination of the licensure requirements for marriage and family therapists on a national level. This section shall not be construed to apply to any provisions under this division or Division 3 (commencing with Section 5000) other than this act.

8. Telehealth

8A. State Telehealth Laws and Regulations

Please also see chapter 6 for any updated telehealth laws under the section "other changes". This section is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.

State Telehealth Laws and Policies

Introduction

The Center for Connected Health Policy's (CCHP) release of the "State Telehealth Laws and Reimbursement Policies" report highlights the changes that have taken place in state telehealth policy. The report offers policymakers, health advocates, and other interested health care professionals a summary guide of telehealth-related policies, laws, and regulations for all 50 states and the District of Columbia.

While this guide focuses primarily on Medicaid fee-for-service policies, information on managed care is noted in the report as well. The report also notes particular areas where we were unable to find information. Recently passed legislation and regulation have also been included in this version of the document with their effective date noted in the report (if applicable). This information also is available electronically in the form of an interactive map and search tool accessible on our website cchpca.org. Consistent with previous editions, the information will be updated biannually, as laws, regulations and administrative policies are constantly changing.

Telehealth Policy Trends

States continue to refine and expand their telehealth reimbursement policies though they are not treated across the board in the same manner as in-person delivered services. Limitations in regards to reimbursable modality, services and location of the patient continue to be seen. Although each state's laws, regulations, and Medicaid program policies differ significantly, certain trends are evident. Live video Medicaid reimbursement, for example, continues to far exceed reimbursement for store-and-forward and remote patient monitoring (RPM). Reimbursement for RPM and store-and- forward continue to be limited. There has been some increased interest in reimbursing for eConsult as California Medicaid joined Connecticut Medicaid in reimbursing for at least one eConsult code. Other noteworthy trends include the addition of the home and schools as an eligible originating site in some states, and the inclusion of teledentistry and substance use disorder services as a specialty qualifying for Medicaid reimbursement and/ or required to be reimbursed by private insurers.

The release of the Center for Connected Health Policy's (CCHP) report of state telehealth laws and Medicaid reimbursement policies is the eighteenth updated version of the report. Like its previous iterations, the report is updated on a biannual basis, in spring and fall. An interactive map version of the report is available on CCHP's website, cchpca.org. Due to constant changes in laws, regulations, and policies, CCHP will continue to update the information in both PDF and map formats twice a year to keep it as accurate and timely as possible.

It should be noted that even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into

its Medicaid program. Throughout the report, CCHP has notated changes in law that have not yet been incorporated into the Medicaid program, as well as laws and regulations that have been approved, but not yet taken effect.

METHODOLOGY

CCHP examined state law, state administrative codes, and Medicaid provider manuals as the report's primary resources. Additionally, other potential sources such as releases from a state's executive office, Medicaid notices, transmittals or Agency newsletters were also examined for relevant information. In some cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in this report specifically focuses on fee-for-service; however, information on managed care plans has also been included if available from the utilized sources. Newly approved regulations related to specific telehealth standards for various professions are noted in the "Miscellaneous" section of the state's Professional Regulation/Health & Safety category area. The survey focused on three primary areas for telehealth policy including Medicaid reimbursement, private payer laws and professional regulation/ health & safety requirements. Within each category, information is organized into various topic and subtopic areas. These topic areas include:

Medicaid Reimbursement:
• Definition of the term telemedicine/telehealth
• Reimbursement for live video
• Reimbursement for store-and-forward
• Reimbursement for remote patient monitoring (RPM)
• Reimbursement for email/phone/fax
• Consent issues
• Out-of-state providers

Private Payer Laws
• Definitions
• Requirements
• Parity (service and payment)
Professional Regulation
• Definitions
• Consent
• Online Prescribing
• Cross-State Licensing

Key Findings

No two states are alike in how telehealth is defined and regulated. While there are some similarities in language, perhaps indicating states may have utilized existing verbiage from other states, noticeable differences exist. These differences are to be expected, given that each state defines its Medicaid policy parameters, but it also creates a confusing environment for telehealth participants to navigate, particularly when a health system or practitioner provides health care services in multiple states. In most cases, states have moved away from duplicating Medicare's restrictive telehealth policy, with some reimbursing a wide range of practitioners and services, with little to no restrictions.

As noted previously, even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into its Medicaid program. In the findings below, there are a few cases in which a law has passed requiring Medicaid reimbursement of a specific telehealth modality or removal of restrictions, but Medicaid policies have yet to reflect this change. CCHP has based its findings on current Medicaid policy according to those listed in their program regulations, manuals or other official documentation. Requirements in newly passed legislation will be incorporated into the findings section of future editions of CCHP's report once they are implemented in the Medicaid program, and CCHP has located official documentation confirming this.

While this Executive Summary provides an overview of findings, it must be stressed that there are nuances in many of the telehealth policies. To fully understand a specific policy and all its intricacies, the full language of it must be read. Below are summarized key findings in each category area contained in the report.

Definitions

States alternate between using the term "telemedicine" or "telehealth". In some states both terms are explicitly de ned in law and/or policy and regulations. "Telehealth" is sometimes used to reflect a broader definition, while "telemedicine" is used mainly to define the delivery of clinical services. Additional variations of the term, primarily utilizing the "tele" pre x are also becoming more prevalent. For example, the term "telepractice" is

being used frequently as it relates to physical and occupational therapy, behavioral therapy, and speech language pathology. “Telesychiatry” is also a term commonly used as an alternative when referring specifically to psychiatry services.

Some states put specific restrictions within the definitions, which often limit the term to “live” or “interactive”, excluding store-and-forward and RPM from the definition and subsequently from reimbursement. The most common restriction states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. Forty- nine states and the District of Columbia have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both. Only Alabama lacks a definition for either term.

BBS and California State Telehealth Regulations

The following is a summary of the Board of Behavioral Sciences regulations on the standards of practice for telehealth:

The Board of Behavioral Sciences (BBS) developed regulations on the standards of practice for telehealth that became effective July 1, 2016. All therapists licensed or registered with the BBS, who are interested in or are engaged in the practice of telehealth, need to be aware of these regulations. Non compliance could possibly result in unprofessional conduct (*Regulatory and Legal Considerations for Telehealth*, Tran A., The Therapist)

Definitions

Under law, “telehealth” is the mode of delivering health care via information and communication technologies, including, but not limited to, telephone and/or internet Licensees may deliver health care, under their scope of practice, via telehealth, under certain conditions Licensees are responsible for understanding all applicable laws, to deliver health care via telehealth Failure to comply with any provisions regarding telehealth may be subject to disciplinary action by the Board

The two most common modes of telehealth for psychotherapy are via 1) live videoconferencing either through a personal computer with a webcam or a mobile communications device with two-way camera capability, and 2) telephone. According to Tran A, “The BBS recognizes the practice of

psychotherapy via telehealth as falling within its jurisdiction and subject to the same statutes and regulations that apply to in-person psychotherapy. Therefore, all California and/or federal laws regarding the confidentiality and privacy of health care information and a client's right of access to his or her medical information apply to telehealth services." (*Regulatory and Legal Considerations for Telehealth*, Tran A., The Therapist)

Regulations

- Individuals providing psychotherapy or counseling, either in person, via telephone, or via internet, must be licensed in California. LMFT, LCSW and LPCC must have a current license issued by the BBS in order to provide psychotherapy services to clients who are physically located in California.
- MFT Trainees, while under appropriate supervision and working in lawful, exempt settings, may provide psychotherapy services via telehealth (Business and Professions Code Section 2290.5)
- All laws regarding the confidentiality of health care information and a patient's right to their medical information shall apply to telehealth interactions.

§ 1815.5. Standards of Practice for Telehealth.

"(a) All persons engaging in the practice of marriage and family therapy, educational psychology, clinical social work, or professional clinical counseling via telehealth, as defined in Section 2290.5 of the Code, with a client who is physically located in this State must have a valid and current license or registration issued by the Board.

(b) All psychotherapy services offered by board licensees and registrants via telehealth fall within the jurisdiction of the board just as traditional face-to-face services do. Therefore, all psychotherapy services offered via telehealth are subject to the board's statutes and regulations.

(c) Upon initiation of telehealth services, a licensee or registrant shall do the following:

(1) Obtain informed consent from the client consistent with Section 2290.5 of the Code.

(2) Inform the client of the potential risks and limitations of receiving treatment via telehealth.

(3) Provide the client with his or her license or registration number and the type of license or registration.

(4) Document reasonable efforts made to ascertain the contact information of relevant resources, including emergency services, in the patient's geographic area.
(d) Each time a licensee or registrant provides services via telehealth, he or she shall do the following:
(1) Verbally obtain from the client and document the client's full name and address of present location, at the beginning of each telehealth session.
(2) Assess whether the client is appropriate for telehealth, including, but not limited to, consideration of the client's psychosocial situation.
(3) Utilize industry best practices for telehealth to ensure both client confidentiality and the security of the communication medium.
(e) A licensee or registrant of this state may provide telehealth services to clients located in another jurisdiction only if the California licensee or registrant meets the requirements to lawfully provide services in that jurisdiction, and delivery of services via telehealth is allowed by that jurisdiction.
(f) Failure to comply with these provisions shall be considered unprofessional conduct.
Note: Authority cited: Sections 4980.60 and 4990.20, Business and Professions Code. Reference: Sections 2290.5, 4980, 4989.50, 4996, 4999.30 and 4999.82, Business and Professions Code."

Summary of Above stated Code

Prior to the delivery of health care via telehealth, the provider initiating the use of telehealth shall:

1. **Obtain Consent:** This is required by the Telehealth statute Business and Professions Code Section 2290.5 where the therapist must
    - Inform the client/patient about the use of telehealth
    - Obtain, and document, verbal or written consent from the client/ patient for this use.
2. **Discuss Risks/Limitations**: The therapist must inform the client either verbally and/or in writing of the potential risks and limitations of receiving psychotherapy via telehealth which may include but are not limited to technical failures; interruption by unauthorized persons; unauthorized access to transmitted and/or stored confidential information; and decreased availability of the therapist in the event of a crisis.

3. **The CAMFT Code of Ethics (2019)** "Section 1.4.2 ELECTRONIC THERAPY: When patients are not physically present (e.g., therapy by telephone or Internet) during the provision of therapy, marriage and family therapists take extra precautions to meet their responsibilities to patients. Prior to utilizing electronic therapy, marriage and family therapists consider the appropriateness and suitability of this therapeutic modality to the patient's needs. When therapy occurs by electronic means, marriage and family therapists inform patients of the potential risks, consequences, and benefits, including but not limited to, issues of confidentiality, clinical limitations, transmission difficulties, and ability to respond to emergencies. Marriage and family therapists ensure that such therapy complies with the informed consent requirements of the California Telemedicine Act.
4. **Licensee License/Registration**: The therapist must either verbally or in writing, provide the client with their license or registration number and the type of license or registration. This is usually located on the informed consent form.
5. **Provide Contact Information of Relevant Resources:** CAMFT Code of Ethics (2019) "1.5.3 EMERGENCIES/CONTACT BETWEEN SESSIONS: Marriage and family therapists inform patients of the extent of their availability for emergencies and for other contacts between sessions. When a marriage and family therapist is not located in the same geographic area as the patient, he/she shall provide the patient with appropriate resources in the patient's locale for contact in case of emergency." According to Tran A, "The therapist may achieve this by sending or emailing the relevant resources to the client or by providing the information verbally and documenting in the client's record (e.g., the therapist informed the client of the University Hospital, located on Washington Street, which provides emergency services and inpatient psychiatric services, including specialized services for children). The emergency services near the client's location may include telephone numbers and addresses for nearby emergency rooms, the psychiatric emergency team telephone number; and telephone numbers to local crisis hotlines/centers." (*Regulatory and Legal Considerations for Telehealth*, Tran A., The Therapist. September).

During every telehealth session the therapist must:

1. **Verbally obtain from the client the client's name** and document such name and the address of the client's present location for identify confirmation and emergency purposes.
2. **Assess whether the client is appropriate for telehealth**. This includes but is not limited to, consideration of the client's psychosocial situation. This is intended to evaluate the client's possible changing mental health from session to session thereby determining continued appropriateness for telehealth. The therapist should document accordingly.
3. **Utilize industry best practices for telehealth** including ensuring both client confidentiality and the security of the telehealth platform. Documentation of the therapist's due diligence in this process is necessary.

Telehealth Outside of California

California licensees or registrants who wish to engage in telehealth with a client located in another jurisdiction need to check with that jurisdiction to determine its laws related to telehealth, and if licensure in that jurisdiction is required. Several states currently consider a client located in their state to be under their jurisdiction. Therefore, a practitioner needs to comply with that jurisdiction's laws in order to avoid any potential violations of those laws.

Currently, there are six states (Arizona, Colorado, Florida, New Jersey, Utah, and Wyoming), including D.C., that allow for out-of-state licensed MFTs to temporarily practice marriage and family therapy (and via telehealth) to clients located in those states. Because states vary in their regulations, it is recommended for a therapist to contact the state's MFT licensing board for an inquiry into the requirements for lawful practice of marriage and family therapy, or if the jurisdiction has relevant telehealth statutes, the practice of marriage and family therapy via telehealth in that state.

Resources

The California Telehealth Resource Center (CTRC) is nationally recognized as one of fourteen federally designated Telehealth Resource Centers around the country. CTRC has a vision to achieve the fully optimized use of telehealth and other technology enabled health care in order to: 1) improve access to health care for all California citizens; 2) improve clinical efficiency and access to health information and education; and 3) reduce the cost of

providing needed health care. Visit the CTRC website at http://www.caltrc.org.

The Center for Connected Health Policy (CCHP) is a program of the Public Health Institute which was established in 2008 to integrate telehealth virtual technologies into the health care system through advancing sound policy based on objective research and informed practices. Visit the CCHP website at http://cchpca.org.

The California Telehealth Network (CTN), an independent 501(c)(3) non-profit, focuses on increasing access to healthcare, including telehealth, telemedicine and health information exchange, through the innovative use of technology. CTN is funded through the Federal Communications Commission's Rural Health Care Pilot Program. CTN is California's authorized FCC broadband consortium for healthcare. Visit the CTN website at http://www.caltelehealth.org.

California Telehealth Resource Center Legislation & Regulation

The CA Telehealth Resource Center provides telehealth technical assistance to the state of California.

California Current and Upcoming Bills

Jurisdiction: CA
Bill Number: AB 32
Bill Title: Telehealth.
Sponsor: Rebecca Bauer-Kahan
Introduced Date: 12/08/2020
Last Action: Bill Created - (12/09/2020)
Status: CCHP Classification: Medicaid Reimbursement Coronavirus
Notes: This bill would delete the above-described references to contracts issued, amended, or renewed on or after January 1, 2021, would require these provisions to apply to the plan or insurer's contracted entity, as specified, and would delete the exemption for Medi-Cal managed care plans. The bill would subject county organized health systems, and their subcontractors, that provide services under the Medi-Cal program to the above-described Knox-Keene requirements relative to telehealth. The bill would authorize a provider to enroll or recertify an individual in Medi-Cal

programs through telehealth and other forms of virtual communication, as specified.

This bill would require the State Department of Health Care Services to indefinitely continue the telehealth flexibilities in place during the COVID-19 pandemic state of emergency. The bill would require the department, by January 2022, to convene an advisory group with specified membership to provide input to the department on the development of a revised Medi-Cal telehealth policy that promotes specified principles. The bill would require the department, by December 2024, to complete an evaluation to assess the benefits of telehealth in Medi-Cal, including an analysis of improved access for patients, changes in health quality outcomes and utilization, and best practices for the right mix of in-person visits and telehealth. The bill would require the department to report its findings and recommendations from the evaluation to the appropriate policy and fiscal committees of the Legislature no later than July 1, 2025.

Jurisdiction: CA
Bill Number: AB 14
Bill Title: Communications: broadband services: California Advanced Services Fund.
Sponsor: Cecilia M. Aguiar-Curry
Introduced Date: 12/08/2020
Last Action: Bill Created - (12/09/2020)
CCHP Classification: Miscellaneous
Notes: This bill would require that the CASF program promote remote learning and telehealth, in addition to economic growth, job creation, and the substantial social benefits of advanced information and communications technologies.

Jurisdiction: CA
Title: Standards of Practice for Telehealth
Action: PROPOSED ACTION ON REGULATIONS
Type: Proposed Rule
Published Date: 08/15/2020
Agency: Board of Psychology
CCHP Classification: Regulatory, Licensing and Advisory Boards
Notes: Creates telehealth practice requirements for the CA Board of Psychology. Conditions of service include holding a valid license, obtaining consent, determining the provision of services is appropriate, posessing the

appropriate knowledge and abilities, ensuring appropriate security of any transmitted client data, and complying with all Psychology Licensing laws.

8B. Telehealth in the Age of Coronavirus

The Following notification was issued by California Health and Human Services (HHS):

Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

We are empowering medical providers to serve patients wherever they are during this national public health emergency. We are especially concerned about reaching those most at risk, including older persons and persons with disabilities. – Roger Severino, OCR Director.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).

Telehealth Discretion During Coronavirus

During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.

OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients. OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

For example, a covered health care provider in the exercise of their professional judgement may request to examine a patient exhibiting COVID-19 symptoms, using a video chat application connecting the provider's or patient's phone or desktop computer in order to assess a greater number of patients while limiting the risk of infection of other persons who would be exposed from an in-person consultation. Likewise, a covered health care provider may provide similar telehealth services in the exercise of their professional judgment to assess or treat any other medical condition, even if not related to COVID-19, such as a sprained ankle, dental consultation or psychological evaluation, or other conditions.

Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

Under this Notice, however, Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers.

Covered health care providers that seek additional privacy protections for telehealth while using video communication products should provide such

services through technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements (BAAs) in connection with the provision of their video communication products. The list below includes some vendors that represent that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA BAA.

Skype for Business / Microsoft Teams
Updox
VSee
Zoom for Healthcare
Doxy.me
Google G Suite Hangouts Meet
Cisco Webex Meetings / Webex Teams
Amazon Chime
GoToMeeting
Spruce Health Care Messenger

Note: OCR has not reviewed the BAAs offered by these vendors, and this list does not constitute an endorsement, certification, or recommendation of specific technology, software, applications, or products. There may be other technology vendors that offer HIPAA-compliant video communication products that will enter into a HIPAA BAA with a covered entity. Further, OCR does not endorse any of the applications that allow for video chats listed above.

Under this Notice, however, OCR will not impose penalties against covered health care providers for the lack of a BAA with video communication vendors or any other noncompliance with the HIPAA Rules that relates to the good faith provision of telehealth services during the COVID-19 nationwide public health emergency.

OCR has published a bulletin advising covered entities of further flexibilities available to them as well as obligations that remain in effect under HIPAA as they respond to crises or emergencies at https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf - PDF.

Guidance on BAAs, including sample BAA provisions, is available at https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html.

Additional information about HIPAA Security Rule safeguards is available at https://www.hhs.gov/hipaa/for-professionals/security/guidance/index.html.

HealthIT.gov has technical assistance on telehealth at https://www.healthit.gov/telehealth.

The following was issued by the Board of Behavioral Sciences (BBS):

Updated Statement on Telehealth to Reflect Governor's Executive Order N-43-20
New Telehealth Information Pursuant to Executive Order N-43-20
The Governor's new Executive Order, N-43-20, issued on April 3, 2020, does the following:
1. Suspends the requirements specified in Business and Professions Code (BPC) section 2290.5(b). BPC §2290.5(b) states the following:
(b) Before the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.
2. Acknowledges and permits compliance with the current federal order issued by the Office for Civil Rights in the U.S. Department of Health and Human Services (issued March 17, 2020). This means that if you are a "covered health care provider" subject to the HIPAA Rules and described in the "Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency" ("Notification"), your delivery of telehealth services is permitted to be consistent with that Notification. Where the Notification encourages particular measures to safeguard patient privacy, but does not require such measures, covered health care providers shall give due consideration to such measures and shall endeavor to adopt them to the extent possible. The following link on the Board's website contains further information about the Notification, and contains a link to the U.S. Department of Health and Human Services' full announcement.

Board Licensees, Registrants, and Trainees and Telehealth

Except for the items discussed above from the Executive Order, Board licensees,

registered associates, and trainees utilizing telehealth are still required to comply with the laws and regulations related to telehealth. The Board strongly urges review of its statutes and regulations related to telehealth to ensure compliance with the law. These can be found by visiting the following link and clicking on "Telehealth": https://bbs.ca.gov/licensees/hipaa.html

Licensees and Telehealth

All California licensed marriage and family therapists, educational psychologists, clinical social workers, and professional clinical counselors are permitted to perform services with clients who are located in California via telehealth.

Associates and Telehealth

All associate marriage and family therapists, associate clinical social workers, and
associate professional clinical counselors who are registered in California are permitted to perform services via telehealth with clients who are located in California under the supervision of their supervisor. If the associate is working in a governmental entity, school, college, university, or an institution that is nonprofit and charitable, the required weekly direct supervisor contact may be via two-way, real-time videoconferencing. If the associate is working in a setting other than the types listed above, the law requires the supervisor contact to be in person.

Social Work Interns and Telehealth

The law defines social work interns as individuals enrolled in a master's or doctoral training program in social work in an accredited school or department of social work.
These individuals are not yet under the jurisdiction of the Board. It is up to the school and the school's accrediting agency to determine the permissibility of telehealth for social work interns.

Clinical Counselor Trainees and Telehealth

Clinical counselor trainees are unlicensed and unregistered individuals who are

currently enrolled in their master's or doctoral degree program designed to qualify them for licensure as a professional clinical counselor, and who have completed at least 12 semester units or 18 quarter units of their degree program.

The law does not prohibit clinical counselor trainees from providing services via telehealth. The school must approve and have a written agreement with the site detailing, among other things, the methods by which supervision shall be provided. Therefore, they may perform services via telehealth and receive supervision via videoconferencing as long as the school allows it.

Marriage and Family Therapist Trainees and Telehealth

Marriage and family therapist trainees are unlicensed and unregistered individuals who are currently enrolled in their master's or doctoral degree program designed to qualify them for licensure as a marriage and family therapist, and who have completed at least 12 semester units or 18 quarter units of their degree program.

MFT trainees are permitted to provide services via telehealth. The school must approve and have an agreement with the site detailing, among other things, the methods by which supervision shall be provided. MFT trainees can count pre-degree hours toward licensure, so they need to make sure they follow the law regarding counting experience hours. If they are working in a governmental entity, school, college, university, or institution that is nonprofit and charitable, they may obtain supervision via videoconferencing. If they are working in a setting other than the types listed above, the law requires the supervisor contact to be in person.

9. Supervision

Legal and Ethical Issues in Supervision

In today's environment, legal and ethical issues in supervision, as in counseling, have become more numerous and complex. Clinical supervisors have an obligation to know the relevant State laws that apply to their practice and to ensure that their supervisees also have this knowledge.

Malpractice and liability claims related to clinical supervision include cases involving situations where supervisors failed in their duty to properly supervise counselors and oversee cases. Legal issues include vicarious liability, by which a supervisor is responsible for the supervisees behavior; duty to warn and to protect, which for clinicians involves supervisory guidance; and malpractice. A good defense against malpractice is consultation with colleagues and documentation of when supervisory sessions took place and what was discussed (Powell &Brodsky). Thorough discussions of legal issues are in most supervision texts (Falvey, Reamer).

Ethical issues for supervisors, as for counselors, vary. Supervisors are responsible for adherence to their own discipline's code of ethics and for ensuring that their supervisees adhere to theirs. Dual relationships occur when a supervisor has a second relationship with a supervisee, such as a social, financial, business, or workplace relationship. "Sexual or romantic interactions or relationships with current supervisees are prohibited" according to the ACA 2005 Code of Ethics
(ACA, 2005, p. 14; see also Falvey).

Boundary violations are a type of dual relationship. They can occur in the structure of the supervisory relationship (e.g., having a supervisory session in one's living room or during dinner in a restaurant) or in its process (e.g., giving gifts, physical contact). A number of studies of the frequency of sexual misconduct in supervision have been conducted. Between 1.4 and 4.0 percent of supervisors have had sexual relationships with their supervisees (Falender & Shafranske).

Some boundary issues are clear; others are difficult to resolve. The client must give informed consent for the counselor to discuss his or her case with the supervisor. Bernard and Goodyear suggested that informed consent should occur at three levels: client consent to treatment, client consent to supervision of their case, and supervisee consent to supervision. (For a detailed explanation of these three levels, see Falvey.)

Supervisor confidentiality is analogous to counselor confidentiality, which must be maintained unless clearly defined circumstances demand disclosure to protect the welfare of the client or the public at large. Supervisors must know the limits of confidentiality, at both State and Federal levels.
Over half the psychotherapy interns in one study reported at least one ethical violation by their supervisor (Ladany, Lehrman-Waterman, Molinaro, &

Wolgast). The most common were inadequate performance evaluation, breach of confidentiality, and inability to work with alternative perspectives. The existence of these perceived violations was associated with a weaker supervisory relationship and lower satisfaction.

Several models for resolving ethical dilemmas are suggested by Falender and Shafranske. (See also Falvey, Clinical Supervision: Ethical Practice and Legal Risk Management, and Reamer, Tangled Relationships: Managing Boundary Issues in the Human Services). Supervision contracts or agreements are generally recommended. Besides listing the basics, including the frequency, length of sessions, and length of the course of supervision, the agreement should specify the modality and approaches to be used, along with the duties and responsibilities of all parties (Bernard & Goodyear, Campbell, Northwest Frontier ATTC).

Dual Relationships and Boundary Issues

Dual relationships can occur at two levels: between supervisors and supervisees and between counselors and clients. You have a mandate to help your supervisees recognize and manage boundary issues. A dual relationship occurs in supervision when a supervisor has a primary professional role with a supervisee and, at an earlier time, simultaneously or later, engages in another relationship with the supervisee that transcends the professional relationship. Examples of dual relationships in supervision include providing therapy for a current or former supervisee, developing an emotional relationship with a supervisee or former supervisee, and becoming an Alcoholics Anonymous sponsor for a former supervisee. Obviously, there are varying degrees of harm or potential harm that might occur as a result of dual relationships, and some negative effects of dual relationships might not be apparent until later. Therefore, firm, always-or-never rules aren't applicable. You have the responsibility of weighing with the counselor the anticipated and unanticipated effects of dual relationships, helping the supervisee's self-reflective awareness when boundaries become blurred, when he or she is getting close to a dual relationship, or when he or she is crossing the line in the clinical relationship. Exploring dual relationship issues with counselors in clinical supervision can raise its own professional dilemmas. For instance, clinical supervision involves unequal status, power, and expertise between a supervisor and supervisee. Being the evaluator of a counselor's performance and gatekeeper for training programs or credentialing bodies also might involve a dual relationship. Further,

supervision can have therapy-like qualities as you explore countertransferential issues with supervisees, and there is an expectation of professional growth and self-exploration. What makes a dual relationship unethical in supervision is the abusive use of power by either party, the likelihood that the relationship will impair or injure the supervisor's or supervisee's judgment, and the risk of exploitation.

The most common basis for legal action against clinicians (20 percent of claims) and the most frequently heard complaint by certification boards against counselors (35 percent) is some form of boundary violation or sexual impropriety. Codes of ethics for most professions clearly advise that dual relationships between counselors and clients should be avoided. Dual relationships between counselors and supervisors are also a concern and are addressed in the substance abuse counselor codes and those of other professions as well. Problematic dual relationships between supervisees and supervisors might include intimate relationships (sexual and non-sexual) and therapeutic relationships, wherein the supervisor becomes the counselor's therapist. Sexual involvement between the supervisor and supervisee can include sexual attraction, harassment, consensual (but hidden) sexual relationships, or intimate romantic relationships. Other common boundary issues include asking the supervisee to do favors, providing preferential treatment, socializing outside the work setting, and using emotional abuse to enforce power. It is imperative that all parties understand what constitutes a dual relationship between supervisor and supervisee and avoid these dual relationships. Sexual relationships between supervisors and supervisees and counselors and clients occur far more frequently than one might realize (*Falvey*). In many States, they constitute a legal transgression as well as an ethical violation.

Informed Consent

Informed consent is key to protecting the clinician and/or supervisor from legal concerns, requiring the recipient of any service or intervention to be sufficiently aware of what is to happen, and of the potential risks and alternative approaches, so that the person can make an informed and intelligent decision about participating in that service. The supervisor must inform the supervisee about the process of supervision, the feedback and evaluation criteria, and other expectations of supervision. The supervision contract should clearly spell out these issues. Supervisors must ensure that

the supervisee has informed the client about the parameters of counseling and supervision (such as the use of live observation, video- or audio taping).

Confidentiality

In supervision, regardless of whether there is a written or verbal contract between the supervisor and supervisee, there is an implied contract and duty of care because of the supervisor's vicarious liability. Informed consent and concerns for confidentiality should occur at three levels: client consent to treatment, client consent to supervision of the case, and supervisee consent to supervision (*Bernard & Goodyear*). In addition, there is an implied consent and commitment to confidentiality by supervisors to assume their supervisory responsibilities and institutional consent to comply with legal and ethical parameters of supervision. (See also the Code of Ethics of the Association for Counselor Education and Supervision [ACES], available online at http://www.acesonline.net/ethical_guidelines.asp).

With informed consent and confidentiality comes a duty not to disclose certain relational communication. Limits of confidentiality of supervision session content should be stated in all organizational contracts with training institutions and credentialing bodies. Criteria for waiving client and supervisee privilege should be stated in institutional policies and discipline-specific codes of ethics and clarified by advice of legal counsel and the courts. Because standards of confidentiality are determined by State legal and legislative systems, it is prudent for supervisors to consult with an attorney to determine the State codes of confidentiality and clinical privileging.

In the substance abuse treatment field, confidentiality for clients is clearly defined by Federal law: 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA). Key information is available at http://www.hipaa.samhsa.gov. Supervisors need to train counselors in confidentiality regulations and to adequately document their supervision, including discussions and directives, especially relating to duty-to-warn situations. Supervisors need to ensure that counselors provide clients with appropriate duty- to-warn information early in the counseling process and inform clients of the limits of confidentiality as part of the agency's informed consent procedures. Under duty- to-warn requirements (e.g., child abuse, suicidal or homicidal ideation), supervisors need to be aware of and take action as soon as possible in situations in which confidentiality may

need to be waived. Organizations should have a policy stating how clinical crises will be handled (*Falvey*). What mechanisms are in place for responding to crises? In what timeframe will a supervisor be notified of a crisis situation? Supervisors must document all discussions with counselors concerning duty-to-warn and crises. At the onset of supervision, supervisors should ask counselors if there are any duty-to-warn issues of which the supervisor should be informed.

New technology brings new confidentiality concerns. Websites now dispense information about substance abuse treatment and provide counseling services. With the growth in online counseling and supervision, the following concerns emerge: (a) how to maintain confidentiality of information, (b) how to ensure the competence and qualifications of counselors providing online services, and (c) how to establish reporting requirements and duty to warn when services are conducted across State and international boundaries. New standards will need to be written to address these issues. (The National Board for Certified Counselors has guidelines for counseling by Internet at http://www.nbcc.org/AssetManagerFiles/ethics/internetcounseling.pdf.)

Supervisor Ethics

The standards and ethics regard to dual relationship and other boundary violations include that supervisors will:

- ✓ Uphold the highest professional standards of the field.
- ✓ Seek professional help (outside the work setting) when personal issues interfere with their clinical and/or supervisory functioning.
- ✓ Conduct themselves in a manner that models and sets an example for agency mission, vision, philosophy, wellness, recovery, and consumer satisfaction.
- ✓ Reinforce zero tolerance for interactions that are not professional, courteous, and compassionate.
- ✓ Treat supervisees, colleagues, peers, and clients with dignity, respect, and honesty.
- ✓ Adhere to the standards and regulations of confidentiality as dictated by the field. This applies to the supervisory as well as the counseling relationship.

Supervisor Training and Supervision

Please see updated requirements for supervisors in chapter 6. Training of supervisors has become a significant concern at the State and Federal level, with increasing attention given, especially with the advent of credentialing requirements for certified clinical supervisors. A number of training models are available. An Internet search will indicate resources in addition to the following:

- Northwest Frontier ATTC, Clinical Supervision: Building Chemical Dependency Counselor Skills.
- New England ATTC, Evidence-Based Practices and Clinical Supervision.
- Mid-Atlantic ATTC, Motivational Interviewing and Clinical Supervision.

Administrative Issues in Supervision

Organizational support for supervision is essential to instilling the belief that clinical supervision is key to staff retention and workforce development. Strategies for reducing the costs involved in a supervision program include agreements with other agencies, using retired supervisors interested in part-time employment, and group supervision (Roche, Todd, & O'Connor).

Other key organizational issues include how certain organizational models and styles of management influence the process of clinical supervision and how organizational receptivity to supervision affects the outcome and effectiveness of clinical supervision. Although little research has been conducted on these issues, they remain key factors that influence the adoption of clinical supervision within an organization.

*Supervision and Training Using New Technologie*s

Many counselor training and education activities are already conducted using computers and the Internet, and research generally indicates that these technologies are effective for this purpose (Ferreira, Liebowitz, Murdock, Williams, Becker, Bruce, & Young). Computer technologies also offer a number of potential benefits for the training of counselors, such as the ability to provide real-time feedback to trainees who are conducting practice sessions. Trepal, Haberstroh, Duffey, and Evans discussed some of the issues involved in teaching counseling skills via the Internet, especially in terms of establishing a relationship. A review by Hayes discussed the use of computers in training and supervising counselors, including such factors as

use of computer based simulations, student attitudes toward new technology, and ethical issues. Individual and group instruction can be conducted using Web-based technology; at least one study has found the latter to be an effective training platform for teaching CBT to counselors (Weingardt, Cucciare, Bellotti, & Lai).

Vaccaro and Lambie reviewed options for conducting computer-based training and supervision, as well as advantages and disadvantages and ethical concerns for this type of supervision/training. Smith, Carpenter, et al., randomly assigned 97 substance use disorder treatment counselors who were enrolled in a 2-day motivational interviewing workshop to receive live supervision conducted using video conferencing technology, supervision using videotaped practice sessions, or the workshop alone without an additional supervision component. Participants' sessions with clients were rated 1, 8, and 20 weeks after the workshop using the Motivation Interviewing Treatment Integrity Coding System. Participants who used teleconferencing for supervision had significantly better compliance compared with those who used the workshop alone, and they did a significantly better job in maintaining a proper ratio between questions and reflections than did those in either of the other groups.

Clinical supervision can also be conducted using phone and Internet technologies. Abbass et al., reviewed literature on the use of Web conferencing technology to supervise psychotherapists. They noted its benefits in terms of reducing costs, enabling long-distance supervision, and integrating supervision with training and educational materials. They also reviewed some potential problems, such as technical difficulties, the absence of local support during times of crisis, and possible difficulties/anxieties relating to the supervisory alliance.

Standards of Best Practice

According to the NASW, "The use of technology for supervision purposes is gradually increasing. Video-conferencing is a growing technological tool used to provide supervision, especially in remote areas. Some jurisdictions allow electronic means for supervision; others may limit the amount of supervision that can be provided from a distance. When using technology to provide distance supervision, one must be aware of standards of best practice for providing this tool and be knowledgeable of the statutes and regulations governing the provision of such services."

According to the ASWB, “When using or providing supervision and consultation by technological means, social work supervisors and supervisees shall follow the standards that would be applied to a face-to-face supervisory relationship and shall be competent in the technologies used.”, The ASWB further clarifies it’s interpretation of this by stating, “Social workers should follow applicable laws regarding direct services, case, or clinical supervision requirements and the use of technology for the purposes of licensure. Supervision for purposes of licensure is governed by regulatory boards that may have specific definitions and requirements pertaining to the use of technology in supervision. Social workers receiving supervision for the purposes of licensure have a responsibility to become familiar with these definitions and meet the requirements. Third-party payers and professional entities may have additional requirements that need to be followed.

Social workers should retain a qualified supervisor or consultant for technology concerns that may arise. When using technology for client services, proper training should be obtained to become familiar with the technologies being used. As with all supervisor–supervisee relationships, the supervisor may share the responsibility for services provided and may be held liable for negligent or inadequate practice by a supervisee.”

Supervisory Problems and Resources

Supervisors may encounter a broad array of issues and concerns. The following are resources for supervision:

- Code of Ethics from the Association of Addictions Professionals (NAADAC; http://naadac.org).
- International Certification & Reciprocity Consortium’s Code of Ethics (http:// www.icrcaoda.org).
- Codes of ethics from professional groups such as the American Association for Marriage and Family Therapy (http://www.aamft.org), the American Counseling Association (http://www.counseling.org), the Association for Counselor Education and Supervision (http:// www.acesonline.net), the American Psychological Association (http:// www.apa.org), the National Association of Social Workers (http:// www.socialworkers.org), and the National Board for Certified Counselors (NBCC; http://www.nbcc.org).

- ACES Standards for Counseling Supervisors; ACES Ethical Guidelines for Counseling Supervisors (http://www.acesonline.net/ethical_guidelines.asp); and NBCC Standards for the Ethical Practice of Clinical Supervision.

Barriers to Implementing Clinical Supervision, Source: Roche, Todd, & O'Connor, p. 244; Powell & Brodsky

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About the Course Presenter:
Course Presenter Nicole Hiltibran, MA, LMFT, is a graduate from Pepperdine University, where she earned her Masters Degree in Clinical Psychology with an emphasis in Marriage and Family Counseling, and is a Licensed Psychotherapist. Nicole has 25 years of experience serving adults, children, couples and families both in the public sector and private practice. Nicole has written state licensing exams for the California State Board of Behavioral Sciences for 10 years as well as offering continuing education courses to licensed mental health and social work professionals including LMFT's, LCSW's, LPCCs, RN's, and PhD's.