LAW AND ETHICS COURSE

3 HOURS/ UNITS

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1. Scope of Practice

1A. MFT Scope of Practice

Overview

SB 801: The 2022 Updated MFT Scope of Practice

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

MFT Scope of Practice BBS Full Update

Scope of Practice: Marriage and Family Therapy

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

BPC §4980.02.
(a) For the purposes of this chapter, the practice of marriage and family therapy shall mean the application of psychotherapeutic and family systems theories, principles, and methods in the delivery of services to individuals, couples, or groups in order to assess, evaluate, and treat relational issues, emotional disorders, behavioral problems, mental illness, alcohol and substance use, and to modify intrapersonal and interpersonal behaviors.
(b) The application of marriage and family therapy principles and methods includes, but is not limited to, all of the following:
(1) Assessment, evaluation, and prognosis.
(2) Treatment, planning, and evaluation.
(3) Individual, relationship, family, or group therapeutic interventions.
(4) Relational therapy.
(5) Psychotherapy.
(6) Client education.
(7) Clinical case management.
(8) Consultation.
(9) Supervision.
(10) Use, application, and integration of the coursework and training required by Sections 4980.36, 4980.37, and 4980.41, as applicable.

(c) The amendments to this section made by the act adding this subdivision do not constitute a change in, but are declaratory of, existing law. It is the intent of the Legislature that these amendments shall not be construed to expand or constrict the existing scope of practice of a person licensed pursuant to this chapter.

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

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

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

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

- ✓ MFTs and LCSWs "may practice psychotherapy" as it relates to the treatment of relational issues and social adjustments.
- ✓ MFTs and LCSWs may diagnose and treat mental disorders as it relates to the treatment of relational issues and social adjustments.
- ✓ MFTs and LCSWs may administer psychological tests, as long as the testing instrument used is within a therapist's scope of competence as established by education, training, or experience and as long as the test is administered within the context of providing therapy. In other

> words, stand-alone testing of persons who are not psychotherapy clients would be outside the scope of practice for MFTs and LCSWs.

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

1B. LCSW Scope of Practice

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

1C. LPCC Scope of Practice

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

(a) (1) “Professional clinical counseling” means the application of counseling interventions and psychotherapeutic techniques to identify and remediate cognitive, mental, and emotional issues, including personal growth, adjustment to disability, crisis intervention, and psychosocial and environmental problems. “Professional clinical counseling” includes conducting assessments for the purpose of establishing counseling goals and objectives to empower individuals to deal adequately with life situations, reduce stress, experience growth, change behavior, and make well-informed rational decisions. (2) “Professional clinical counseling” is focused exclusively on the application of counseling interventions and psychotherapeutic techniques for the purposes of improving mental health, and is not intended to capture other, nonclinical forms of counseling for the purposes of licensure. For the purposes of this paragraph, “nonclinical” means non mental health. ~~(3) “Professional clinical counseling” does not include the assessment or treatment of couples or families unless the professional clinical counselor has completed all of the following additional training and education, beyond the minimum training and education required for licensure: (A) One of the following: (i) Six semester units or nine quarter units specifically focused on the theory and application of marriage and family therapy. (ii) A named specialization or emphasis area on the qualifying degree in marriage and family therapy; marital and family therapy; marriage, family, and child counseling; or couple and family therapy. (B) No less than 500 hours of documented supervised experience working directly with couples, families, or children. (C) A minimum of six hours of continuing education specific to marriage and family therapy, completed in each license renewal cycle.~~ (4) “Professional counseling” does not include the provision of clinical social work services. (b) “Counseling interventions and psychotherapeutic techniques” means the application of cognitive, affective, verbal or nonverbal, systemic or holistic counseling strategies that include principles of development, wellness, and maladjustment that reflect a pluralistic society. These interventions and techniques are specifically implemented in the context of a professional clinical counseling relationship and use of a variety of counseling theories and approaches. (c) “Assessment” means selecting, administering, scoring, and interpreting tests, instruments, and other tools and methods designed to

measure an individual's attitudes, abilities, aptitudes, achievements, interests, personal characteristics, disabilities, and mental, emotional, and behavioral concerns and development and the use of methods and techniques for understanding human behavior in relation to coping with, adapting to, or ameliorating changing life situations, as part of the counseling process. "Assessment" shall not include the use of projective techniques in the assessment of personality, individually administered intelligence tests, neuropsychological testing, or utilization of a battery of three or more tests to determine the presence of psychosis, dementia, amnesia, cognitive impairment, or criminal behavior. (d) Professional clinical counselors shall refer clients to other licensed health care professionals when they identify issues beyond their own scope of education, training, and experience.

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

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

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

2A. Unprofessional Conduct and Negligence

§ 4982. UNPROFESSIONAL CONDUCT

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

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

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

guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

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

(c) Administering to them-self any controlled substance or using of any of the dangerous drugs specified in Section 4022, or of any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

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

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

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

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

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

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

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

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

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

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

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

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

except when disclosure of the fee has been made in compliance with subdivision (n).

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

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

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

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

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

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

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

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

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

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

(z) Failure to comply with Section 2290.5.

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

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

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

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

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

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

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

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

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

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

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

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

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

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

(c) Administering to himself or herself any controlled substance or using of any of the dangerous drugs specified in Section 4211, or of any alcoholic beverage to the extent, or in such manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that such use impairs the ability of such person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more

than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof. The board shall deny an application for a registration or license or revoke the license or registration of any person other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4983.1 (Proceedings, Court Action)

2C. Law

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

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

- Abiding by laws established to protect and maintain client confidentiality.

- Complying with responsibilities to report abuse and danger to others to the appropriate authorities, and to protect clients who are dangerous to themselves.
- Abiding by laws pertaining to the need for consent to treat a minor.
- Following laws that forbid sexual contact with clients and distributing to clients the pamphlet “Professional Therapy Never Includes Sex” if clients disclose that another therapist engaged in sexual misconduct.
- Disclosing fees prior to the commencement of treatment.
- Abiding by laws prohibiting making or receiving payments for client referrals.
- Securing patient authorization to release or obtain confidential information.
- Keeping patient records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.
- For therapists who are “covered entities” under HIPAA, certain additional laws pertaining to the Federal Privacy Act must be adhered to which set forth further restrictions to protect the privacy of a client's records and specify the language to be used to inform clients of these additional rights and restrictions.

2D. Ethics

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

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

- Establishment and maintenance of professional boundaries to protect the welfare of the patient. Examples: the regulation of physical contact in the counseling setting, providing a therapeutic frame with

consistent session times, and commonly understood office policies, roles and responsibilities.

- Avoidance of dual relationships by not entering into business or social relationships with clients simultaneous with or shortly after the termination of therapy.
- Obtaining a client's informed consent for treatment by providing necessary information about the nature of the therapeutic process so that the client can make meaningful decisions for or against treatment.

By law, informed consent *must* include:

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

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

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

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

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

2) The limitations of confidentiality

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

4) Client access to records

5) Length of time the therapist retains records

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

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

8) The therapist's professional qualifications and theoretical orientation

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

10) The expected length of sessions and treatment

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

12) Procedures for collecting and raising fees

12) Cancellation policy

13) Telephone policy

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

2E. Standard of Care

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

- Skillful
- Knowledgeable
- Careful and competent

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

- **Assessment:** Gather information about the client via intake, observation, inventories, test instruments, etc. Information gathered should be incorporated into the progress notes. Some information gathering examples include:
  - ✓ What are the clients problems and concerns?
  - ✓ What are the precipitating events?
  - ✓ What is the unit of treatment
  - ✓ Is the motivation for being in therapy strong or weak?

- ✓ Any previous therapy?
- ✓ Human diversity and/or cultural considerations?
- ✓ Socio-economic, political, or spiritual considerations?

- **Evaluation:** What does this information mean? How will I interpret this information and take action when/where necessary? Some evaluation examples include:
  - ✓ Scope of competence and practice? These standards can best be referenced in the Code of Ethics and The BBS Statutes and Regulations.
  - ✓ Does this client need to be referred?
  - ✓ Evaluating medical needs, the need for psychological testing, and community resources.
- **Management:** This phase is more active and therefore requires action from the clinician. Some management examples include
  - ✓ Creating a treatment plan.
  - ✓ Referral to a psychiatrist for a medication evaluation.
  - ✓ Consulting with colleagues as well as other providers regarding treatment possibilities.

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

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

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

Medical Standard of Care Definitions

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

Some common examples include:

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

In legal terms, it is the level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances. The medical malpractice plaintiff must establish the appropriate standard of care and demonstrate that the standard of care has been breached.

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

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

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

Goals

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

SMART

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

Standard of Care and Suicide

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

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

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

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

3. Legal Issues

3A. Privilege

Privilege is essentially the client's right not to have confidential information revealed during a legal proceeding without their prior authorization. Privilege protects clients from confidences being revealed publicly without prior authorization. Psychotherapist-client privilege applies not only to licensed providers but also to MFT interns, associate social workers, and trainees. MFT's and LCSW's have a legal responsibility to assert privilege on behalf of their client unless the client or the court direct otherwise.

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

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

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

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

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

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

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

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

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

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

California Evidence Code states in regards to minors that:

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

California Evidence Code identifies exceptions to privilege which explains that:

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

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

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

    c. breach of duty (Evidence Code 1020)

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

        2) The client sues the therapist for malpractice.

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

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

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

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

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

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

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

3B. Search Warrants

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

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

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

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

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

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

3C. Subpoenas

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

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

- A subpoena “duces tecum” is a command to produce records or written evidence.
- Subpoenas can be issued by a judge or by an attorney.
- Due to psychotherapist-patient privilege, therapists have a legal duty to assert the privilege.
- A therapist must assert privilege on behalf of a client when testimony or records are sought.
- The source of the subpoena should be identified.
- After receiving a subpoena, a therapist:

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

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

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

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

3D. Confidentiality

California Evidence Code, Section 1012 states "confidential communication between patient and psychotherapist means information, including information obtained by an examination of the patient, transmitted between a patient and his psychotherapist in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses the information to no third persons other than those who are present to further the interest of the patient in the consultation, or those to whom disclosure is

reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the psychotherapist is consulted, and includes a diagnosis made and the advice given by the psychotherapist in the course of that relationship."

The patient holds the privilege to release confidential information in legal proceedings. While objections may exist to the patient using these records, solid grounds must exist in order to object. The holder of the privilege also retains the right to read all information in his or her file with the exception of your personal notes which belong solely to you as the provider. Many therapists keep separate files in order to ensure that their personal notes do not become integrated into the patient's legal record.

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

Section 5150

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

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

a person other than the officer, member of the attending staff, or professional person, such person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

5150 Rights

Inst. Code § 5325; 9 C.C.R. § 865.2):

- The right to wear one's own clothing. (Although many 5150 designated facilities have large contraband lists, for example often times patients are not allowed to have shoelaces, wire bras, belts, hair-ties, or short tops).
- The right to keep and use one's own personal possessions, including toilet articles, in a place accessible to the patient.
- The right to keep and spend a reasonable sum of one's money for small purchases.
- The right to have access to individual storage space for one's own use.
- The right to see visitors each day.

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

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

During the period of confinement, a confined individual is evaluated by a mental health professional to determine if a psychiatric admission is warranted. Confinement and evaluation usually occurs in a county mental health hospital or in a designated emergency department. If the individual is then admitted to a psychiatric unit, only a psychiatrist may rescind the 5150 and allow the person to either remain voluntarily or be discharged. On or

previous to the expiration of the 72 hours, the psychiatrist must assess the person to see if they still meet criteria for hospitalization. If so, the person may be offered a voluntary admission. If it is refused, then another hold for up to 14 days, the 5250 (WIC-5250), must be written to continue the involuntary confinement of the person. A Certification Review Hearing (W&I 5256) must occur within four days before a judge or hearing officer to determine whether probable cause exists to support the 5250. Alternatively, the person can demand a writ of habeas corpus to be filed for their release after they are certified for a 5250, and once filed, by law, the person must be in front of a judge in two (2) days, which, is two days sooner than the Certification Review Hearing. If the person demands to file a writ of habeas corpus right at the time of being given notice of certification, the Certification Review Hearing will not take place. Many patients wait to see how things go at the Certification Review Hearing first, because if the person loses at the Certification Review Hearing, he/she can then take advantage of the right to file writ of habeas corpus and end up having two hearings, instead of just one. If the 72-hour timeframe has elapsed before the person is offered a voluntary admission or placed on the 5250 hold, the person must be immediately released.

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

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

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

1. Danger to self: The person must be an immediate threat to themselves, usually by being suicidal. Someone who is severely depressed and wishes to die would fall under this category.

2. Danger to others: The person must be an immediate threat to someone else's safety.
3. Gravely disabled (W&I 5008(h)):
    - Adult (patients over 18 years of age): The person's mental condition prevents him/her from being able to provide for food, clothing, and/or shelter, and there is no indication that anyone is willing or able to assist him/her in procuring these needs. This does not necessarily mean homeless, as a homeless person who is able to seek housing (even in a temporary shelter) when weather demands it would not fall under this category. Also, the mere lack of resources to provide food, clothing, or shelter is not dispositive; the inability must be caused by the psychiatric condition.
    - Minor (patients under 18 years of age): The person is unable to provide for his/her food, clothing, and/or shelter or to make appropriate use of them even if these are supplied directly--for example, a psychotic adolescent who refuses to eat because he/she believes their parents are poisoning them.
4. Mental disorder: Though undefined by statute or regulation, this is generally taken to refer to a diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders. Page 14 of the LA County LPS Designation Manual states that *the initiator must be able to articulate behavioral symptoms of a mental disorder either temporary or prolonged* (People v. Triplett, 144 Cal. App. 3d 283).

Tarasoff and the Duty to Warn

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

Prosenjit Poddar was born into the Dalit ("untouchable") caste in Bengal, India. He came to UC Berkeley as a graduate student in September 1967 and resided at the International House. In the fall of 1968 he attended folk

dancing classes at the International House, and it was there he met Tatiana Tarasoff. They saw each other weekly throughout the fall, and on New Year's Eve she kissed Poddar. He interpreted the act to be a recognition of the existence of a serious relationship. This view was not shared by Tatiana who, upon learning of his feelings, told him that she was involved with other men and otherwise indicated that she was not interested in entering into an intimate relationship with him. This gave rise to feelings of resentment in Poddar. He began to stalk her and soon had feelings of killing her.

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

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

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

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

The California Supreme Court found that a mental health professional has a duty not only to a patient, but also to individuals who are specifically being

threatened by a patient. This decision has since been adopted by most states in the U.S. and is widely influential in jurisdictions outside the U.S. as well ("Protection and Advocacy, Inc., Contracted by the State of California to advocate for involuntary persons, Hearing Options". http://www.pai-ca.org/pubs/502401.pdf. 72-Hour Hold and Hearing Options).

In the majority opinion, Justice Mathew O. Tobriner famously stated: "... the confidential character of patient-psychotherapist communications must yield to the extent that disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins." Justice Clark dissented, stating in his minority opinion that "the very practice of psychiatry depends upon the reputation in the community that the psychiatrist will not tell".

Child Abuse

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

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

allegation. Any attempts to investigate may have a negative clinical impact on the child and family.

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

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

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

Elder and Dependent Adult Abuse Reporting

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

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

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

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

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

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

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

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

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

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

hospital or a state developmental center), reports should be made to the local ombudsman or to the local law enforcement agency.

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

3F. Treatment of Minors

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

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

Emancipated minors are treated legally as adults and, thus, may be treated without parental permission. Therapists can treat minors age 12 or over without parental permission when the minor is mature enough to participate intelligently in mental health treatment or counseling and the minor would

present a serious danger of physical or mental harm to him or herself or others without treatment or counseling or is the alleged victim of incest or child abuse. The minor does hold privilege when being treated without parental consent (unless he or she has a guardian or foster parent.) However, when treating minors under these circumstances, the therapist can act as the "claimer" of the privilege, but must obtain the minor's permission in order to access the minor's medical records.

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

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

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

A minor may become emancipated if they legally marry, enlists in the military or files an emancipation petition with the courts stating that he or she is at least 14 years of age, is willingly living separate and apart from parents or guardians with their consent or acquiescence, is managing his or her own financial affairs and is not deriving illegal income. The court will grant the petition unless it judges that emancipation would be contrary to the minor's best interests.

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

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

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

3G. Sex with Clients

Psychotherapists can be prosecuted both civilly and criminally for engaging in sexual relations with their clients. Prosecution may also occur if a

therapist engages in sex with a former client prior to two years following the termination of therapy. In accordance with C.C. 43.93, therapists are civilly liable when they engage in sexual relations with former clients prior to two years after the termination of therapy. According to B.&P.C. 729, criminal liability in such cases results only when therapists terminate therapy solely for the purpose of engaging in sexual relations with a client. A client has a cause for civil action against a psychotherapist when sexual contact occurs during the course of therapy, within two years following termination of therapy and/or by means of deception. This law also requires the therapist to give a brochure that explains the client's right to any client that revealed prior sexual contact with their therapist. Failure to distribute this brochure is considered unprofessional conduct.

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

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

Professional Therapy Never Includes Sex 2019 Update :

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

Definition of Terms

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

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

“Therapy” includes any type of counseling from any of the licensed or registered professionals listed above. “Client” refers to anyone receiving therapy, or counseling, or other services. “Sexual contact” means the touching of an intimate part of another person, including sexual intercourse. “Sexual behavior” means inappropriate contact or communication of a sexual nature. This definition does not include the provision of appropriate therapeutic interventions relating to sexual issues. “Touching” means physical contact with another person either through the person’s clothes or directly with the person’s skin. “Intimate part” means the sexual organ, anus, groin, or buttocks of any person, and the breast of a female. “License” includes certificate, registration, or other means to engage in a business or profession regulated by Chapter 1, General Provisions, section 475 of the Business and Professions Code.

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

According to California law:

- ❖ Any act of sexual contact, sexual abuse, sexual exploitation, sexual misconduct or sexual relations by a therapist with a patient is unprofessional, illegal, as well as unethical as set forth in Business and Professions Code sections 726, 729, 2960(o), 4982(k) and 4992.3(k).

- ❖ "Sexual contact" means the touching of an intimate part of another person, including sexual intercourse.

- ❖ "Touching" means physical contact with another person either through the person's clothes or directly with the person's skin.

- ❖ "Intimate part" means the sexual organ, anus, groin or buttocks of any person and the breast of a female. Sexual exploitation can include sexual intercourse, sodomy, oral copulation, or any other sexual contact between a therapist and a patient or a former patient under certain circumstances. Sexual misconduct includes a much broader range of activity, which may include fondling, kissing, spanking, nudity, verbal suggestions, innuendoes or advances. This kind of sexual behavior by a therapist with a patient is unethical, unprofessional and illegal.

WARNING SIGNS

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

- Sending obscene images or messages to the client.
- Telling sexual jokes or stories.
- Unwanted physical contact.
- Excessive out-of-session communication (e.g., text, phone, email, social media, etc.) not related to therapy.
- Inviting a client to lunch, dinner, or other social and professional activities.
- Dating.

- Changing the office's business practices (e.g., scheduling late appointments when no one is around, having sessions away from the offce, etc.).
- Confiding in a client (e.g., about the therapist's love life, work problems, loneliness, marital problems, etc.).
- Telling a client that he or she is special, or that the therapist loves him or her.
- Relying on a client for personal and emotional support.
- Giving or receiving significant gifts.
- Suggesting or supporting the client's isolation from social support systems, increasing dependency on the therapist.

Another warning sign is "special" treatment by a therapist, such as:

- Inviting a patient to lunch, dinner or other social activities.
- Dating.
- Changing any of the office's business practices (for example, scheduling late appointments so no one is around, having sessions away from the office, etc.).
- Confiding in a patient (for example, about the therapist's love life, work problems, etc.).
- Telling a patient that he or she is special, or that the therapist loves him or her.
- Relying on a patient for personal and emotional support.
- Giving or receiving significant gifts.
- Providing or using alcohol (or drugs) during sessions.
- Providing or using alcohol or drugs during sessions.

California's lawmakers, licensing boards, professional associations and ethical therapists want such inappropriate sexual behavior stopped. This booklet was developed to help patients who have been sexually exploited by their therapists. It outlines their rights and options for reporting what happened. It also defines therapist sexual exploitation, gives warning signs of unprofessional behavior, presents a "Patient Bill of Rights," and answers some frequently asked questions.

Signs of inappropriate behavior and misuse of power include:

- ✓ Hiring a patient to do work for the therapist, or bartering goods or services to pay for therapy.

- ✓ Suggesting or supporting the patient's isolation from social support systems, increasing dependency on the therapist.

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

Therapy is meant to be a guided learning experience, during which therapists help patients to find their own answers and feel better about themselves and their lives. A patient should never feel intimidated or threatened by a therapist's behavior.

Licensing Boards

In the Department of Consumer Affairs, three different boards license therapists. They can give general information on appropriate behavior for therapists and your rights for reporting what happened, as well as how to file a complaint.

Sexual Assault/Crisis Centers

These centers have staff trained in all types of sexual abuse and exploitation. They can provide general information on appropriate behavior for therapists, crisis services, your rights for reporting what happened, and names of therapists and support groups that may be helpful. Centers are located throughout California. Look in your telephone book under "sexual assault center" or "crisis intervention service."

Professional Associations

Each licensed therapy profession has at least one professional association. Associations can provide general information on appropriate behavior for therapists, your rights for reporting what happened, and how to file a complaint. They can provide names of therapists who may be helpful.

Client Options

Clients have several options including:

- ➢ **Reporting the Therapist** —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. Updated BBS Requirements Through 2023

4A. 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.

4B. 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.

4C. 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.

4D. Changes to Definition of Support Dog

AB 468: Changes to Definition of Support Dog Overview

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

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

Click here for more information on the BBS website

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

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

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

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

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

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

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

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

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

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

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

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

4E. 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.)

4F. 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:

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.

4G. 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.

4H. 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.

4I. 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.

4J. 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).

4K. 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.

4L. 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.

4M. New Laws Directly Affecting the Board's Application and Renewal Process Through 2023

2023 New Laws and Updates

Telehealth Training

On or after July 1, 2023, applicants for licensure and current licensees (before their first renewal after January 1, 2023) are required to complete three (3) hours of training or coursework in the provision of mental health services via telehealth. For more information visit the BBS FAQs.

Continuing Education in Law & Ethics for Registered Associates

Effective January 1, 2023, the BBS will require registered associates to complete a minimum of three (3) hours of CE on law and ethics during each registered associate's renewal period (annually) regardless of whether they

have passed the California Law & Ethics exam. For more information visit the BBS FAQs.

12-Hour L&E Course No Longer Required

Effective January 1, 2023, registered associates who have failed the California law and ethics examination no longer need to take a 12-hour course in California law and ethics in order to take the exam again in their next renewal period. For more information visit the BBS FAQs.

Effective July 1, 2023, all applicants for licensure and current licensees who are up for renewal after January 1, 2023, will be required to complete three hours of training or coursework in telehealth mental health services. Registered associates will also be required to complete a minimum of three hours of continuing education in law and ethics annually during their renewal period, regardless of whether they have passed the California Law & Ethics exam. However, as of January 1, 2023, registered associates who have previously failed the California law and ethics exam will no longer be required to take a 12-hour course before being eligible to retake the exam during their next renewal period. For more information, please visit the BBS FAQs.

• **AB 2113**: Expedited Licensure for Refugees, Asylees, and Special Immigrant Visa Holders. This bill requires boards under the Department of Consumer Affairs, including the Board of Behavioral Sciences, to expedite the initial licensure process for an applicant who can provide satisfactory evidence of being admitted to the United States by one of the following methods:

a. As a refugee under Section 1157 of Title 8 of the United States Code;

b. Granted political asylum by the Secretary of Homeland Security or U.S.Attorney General pursuant to Section 1158 of Title 8 of the United States Code; or

c. Granted a special immigrant visa with a status under Section 1244 of Public Law 110-181, Public Law 109-163, or Section 602(b) of Title VI of Division F of Public Law 111-8, as follows:

i. Provides a set of criteria for granting special immigrant status to certain individuals from Iraq. (Section 1244 of Public Law 110-181)

ii. Sets forth provisions for granting special immigrant status to certain qualifying individuals who have served as a translator for the U.S. Armed Forces. (Section 1059 of Public Law 109-163)

iii. Provides a set of criteria for granting special immigrant status to certain individuals from Afghanistan. (Section 602(b) of Title VI of Division F of Public Law 111-8)

This bill became effective on January 1, 2021. An expedite request form, as well as further instructions, will be available on the Board's website soon.

• **AB 3330**: **Increase to Board's Licensing Fees**

This bill, effective January 1, 2021, increases the Board's fees for each of its license types. In setting the new fee amounts, the Board ensured fees were equitable across license types. For example, all licensees will now pay the same license renewal fee amount, regardless of whether they are an LMFT, LCSW, LPCC, or LEP. Similarly, all applicants will pay the same amount for associate registration, regardless of the type of associate registration they are applying for.

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