



Board of Behavioral Sciences



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

## **Exempt Setting Committee Meeting Notice and Agenda**

**February 23, 2018  
8:30 a.m.**

Department of Consumer Affairs  
Hearing Room  
1625 North Market Blvd., #S-102  
Sacramento, CA 5834

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

- I. Call to Order, Establishment of Quorum, and Introductions\*
- II. Discussion and Possible Recommendations Regarding Practice Settings for LCSW, LMFT and LPCC Students
- III. Report on Meeting with Nonprofit and Charitable Organizations Providing Clinical Mental Health Services
- IV. Discussion and Possible Recommendations Regarding the Exempt and Private Practice Setting Survey Results
- V. Discussion and Possible Recommendations Regarding Registrant Employment by Temporary Staffing Agencies
- VI. Discussion Regarding Unlicensed Masters of Social Work Employees Billing as Psychotherapists
- VII. Suggestions for Future Agenda Items
- VIII. Public Comment for Items Not on the Agenda

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

*(Continued on Reverse)*

## IX. Adjournment

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

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

*This agenda as well as Board meeting minutes can be found on the Board of Behavioral Sciences website at [www.bbs.ca.gov](http://www.bbs.ca.gov).*

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



Board of Behavioral Sciences

# Memo

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**To:** Exempt Setting Committee Members                      **Date:** February 16, 2018  
**From:** Christy Berger  
Regulatory Analyst    **Telephone:** (916) 574-7817  
**Subject:** **Discussion and Possible Recommendations Regarding Practice Settings  
for LCSW, LMFT and LPCC Students**

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The results of the survey regarding practicum/fieldwork placements for students pursuing clinical (LCSW, LMFT and/or LPCC) licensure were presented to the Committee in November 2017. At that time, the Committee expressed interest in the following:

- Clarifying the acceptable sites for practicum students.
- Strengthening the school, practicum site and supervisor's responsibilities regarding placement and monitoring of students in the field.
- Creating a definition of "Private Practice" as well as settings that do not fall into the definition of "Private Practice" or "Exempt."

The Committee directed staff to bring back some additional information for consideration.

## 1. Background

Notable findings from the practicum coordinator survey results are provided in **Attachment A** for reference. This survey was voluntary and anonymous and was distributed to programs offering a degree leading to licensure. Note that only LMFT student hours may count toward licensure; therefore, supervisors of LCSW and LPCC students do not have to meet BBS qualifications. It is also important to keep in mind that the BBS does not directly regulate MSW practicum/fieldwork. However, BBS law does specify that private practice settings for MSW students performing clinical work are not allowed.

## 2. Defining Types of Settings

Current law defines the types of settings in which LMFT and LPCC students (Trainees) may work as follows:

- Setting must lawfully and regularly provide mental health counseling or psychotherapy.
- Setting must provide oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in law and is within the scope of practice for the profession.
- Is not a private practice

Unfortunately, there is no definition of private practice in LMFT or LPCC law. LCSW law contains the following definition, which seems incomplete:

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

In developing a definition, it is important to keep in mind that it will affect other laws that reference “private practice.” A listing of those laws is provided in **Attachment B**. To assist in developing a working definition, **Attachment C** contains example definitions from a variety of sources. A couple of the themes that appear among those definitions:

- Has ownership and responsibility for the practice and is not an employee
- Receives direct payment or third-party reimbursement

According to CAMFT<sup>1</sup>, there are several types of business entities that can form a “private practice”:

**A sole proprietorship:** The only type of entity that can be formed by an single therapist. No state filing requirements. Completely managed and controlled by the practitioner, who has sole liability for the the business and its obligations.

**A general partnership:** An association of two or more licensees who operate as co-owners. A written agreement specifies rights with regard to management and control of the practice. Each practitioner is liable for the business and its obligations. Each partner has obligations to the partnership such as fiduciary duties, duty of care, etc. No state filing requirements.

**Limited partnership:** *Not frequently used by mental health professionals.* A partnership formed by two or more licensees, containing one or more general partners and one or more limited partners. The general partner(s) have control of management and the same obligations as in a general partnership. Limited partners are typically passive investors without management authority. Must file articles of incorporation and meet federal and state requirements.

**Professional corporation:** A corporation formed by two or more licensees. Only licensees can be shareholders. Must file articles of incorporation and meet federal and state requirements, and is subject to the Moscone-Knox Professional Corporation Act. In addition, most of the laws governing general corporations also apply to professional corporations. Must have bylaws, which provide a set of standard rules for the corporation and its board of directors. Must obtain a federal tax identification number and a California employer identification number.

Based on the above information, the text below may be a starting point for the definition of “private practice”:

*A business that provides clinical mental health services which is owned and operated by one or more licensed mental health professionals who have responsibility for the practice and services provided, and set up conditions of client payment or reimbursement.*

<sup>1</sup> “Selecting and Forming the Right Private Practice Entity.” *The California Therapist*, March/April 2002 (updated in August 2010), California Association of Marriage and Family Therapists.

However, this definition may exclude other types of for-profit entities such as:

- General corporations such as Telecare (see **Attachment D**) or Health Net of California which owns MHN, an employee assistance program.
- Other types of corporations
- Substance abuse recovery programs
- For-profit hospitals
- For-profit medical groups (such as Kaiser Permanente, though Kaiser's hospital and health plan are nonprofit)

There are also not-for-profit entities that are not a 501c3. A 501c3 is a "nonprofit and charitable" entity that has registered with the IRS and received that designation. Some nonprofits are not considered "charitable" and would have a different federal code, such as a 501c19, a veteran's service organization, such as Veterans of Foreign Wars.

It may be important to create definitions for the above types of entities, especially as they relate to Trainee placement settings, as discussed later in this memo. All of the above types of agencies are currently allowed if they meet all requirements in current law. These setting types, as reported by practicum coordinators, are listed in **Attachment E**.

The only fully-defined types of settings in current law are "exempt" settings, which are (1) nonprofit and charitable entities (aka 501c3s), (2) schools (whether public, private, for-profit or non-profit) and (3) governmental agencies. Churches and religious organizations who meet certain federal requirements are also considered "nonprofit and charitable" (though not required to file as a 501c3), and are therefore also considered an exempt setting.

### **3. History of BBS Changes Regarding Acceptable Student Trainee Sites**

The Committee directed staff to research the history of law changes regarding allowable Trainee placements. SB 1077 (Chapter 607, Statutes of 2003) made the most recent changes to statute regarding acceptable sites for MFT Trainees. The legislation deleted the specific types of settings listed in MFT law and implemented our current-day language that is more general, and also applies to LPCC students. The pre-2003 allowable setting types were:

- Governmental entity
- School, college or university,
- Nonprofit and charitable corporation (501c3)
- Any of the below settings as defined in the California Health and Safety Code (licensed by the state):
  - Licensed health facility
  - Social rehabilitation facility
  - Community treatment facility
  - Pediatric day health and respite care facility
  - Licensed alcoholism or drug abuse recovery or treatment facility

According to the committee meeting notes, the above settings had been selected because of the assumption of institutional infrastructure and controls (as opposed to a private practice, which by its very nature lacks infrastructure and controls). Law changes were proposed in 2002 for three reasons:

- Simply having a list of setting types did not help ensure that Trainees were gaining appropriate experience;
- There were not enough Trainee placements available; and,
- There was a growing problem with agencies contracting with entities that were not acceptable settings.

The Board considered adding additional setting types, but felt that would not have directly addressed concerns regarding the appropriateness of a Trainee's supervised experience, and it would have been difficult to enumerate all of the variations on setting types. The Board's goal was to keep the law simple and clear, while also providing for public protection. The resulting language (now current law for LMFT and LPCC Trainees) is provided in the next section.

#### 4. **BBS Law Relating to LMFT and LPCC Practicum**

The laws regarding practicum hours, practicum content and Trainee supervision are provided in **Attachment F**. Current law regarding acceptable practicum sites specifies the following:

- Setting must lawfully and regularly provide mental health counseling or psychotherapy.
- Setting must provide oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in law and is within the scope of practice for the profession.
- Is not a private practice
- Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

#### 5. **Survey Results Regarding Setting Types and Possible Concerns**

The Board's survey of practicum coordinators provided the following information about common setting types where Trainees are placed.

- **Exempt Settings:** The results indicated that every school places students in exempt settings, with 501c3s (96%), schools (87%) and governmental entities (79%) being the most common.

**NOTE:** While governmental entities and public schools have governmental oversight along with institutional controls, there is little oversight of non-profit and charitable (501c3) settings and private schools.

- **Other (currently undefined) Settings:** 42% of programs place students in for-profit entities that are NOT private practices; 31% of programs place students in not-for-profit entities that are NOT registered 501(c)(3)s.

**NOTE:** BBS staff, schools and professional associations all struggle when presented with a question as to whether such settings are acceptable. While some of these settings do have governmental oversight and/or institutional controls, some do not. For a list of the above setting types as listed by the practicum coordinators responding to the survey, see **Attachment E**. For information on the types of facilities licensed by the state, see **Attachment G**.

The survey responses also provided a window into the concerns that schools sometimes have in placing Trainees. These issues include:

- Sites with lacking or poor supervision
- Sites that have poor monitoring
- Sites that are limited in scope, such as substance abuse treatment centers or crisis centers
- Sites that present with ethical issues
- Sites that are unstable

## **6. Accreditation Standards**

The Committee directed staff to bring back information regarding accreditation requirements for practicum/fieldwork sites. Excerpts from the the Council on Social Work Education (CSWE), the Council for Accreditation of Counseling and Related Educational Programs (CACREP), and the Commission on Accreditation for Marital and Family Therapy Education (COAMFTE) are provided in **Attachment H**.

CSWE standards do not specify site requirements, but they do require the program to detail certain information, which is then evaluated by CSWE. This includes how the field education program supports student safety, the criteria for selecting field settings and placing students, and how the program provides for continuing dialog with field education settings.

CACREP and COAMFTE standards also do not specify site requirements. They do not require the programs to address field education other than supervision (especially emphasized in CACREP standards) or supervisor qualifications (especially emphasized in COAMFTE standards).

American Psychological Association's (APA) accreditation standards do recommend certain practicum and internship site requirements. The Board of Psychology requires<sup>2</sup> pre-doctoral and post-doctoral internships to be accredited by the APA or another acceptable entity. The APA requirements are provided in **Attachment I**. The APA allows practicum and internships to be gained in any type of setting, including "independent practice." Among other things, the APA asks the program to document the following:

- How the program ensures the quality of the practicum sites, including regularly scheduled site reviews.
- The use of evaluation procedures for practicum experiences, methods for identifying strengths and weaknesses of practicum settings, and how a problem with a site is managed.
- The administrative methods used to ensure that practicum placements meet these criteria and discuss how students are matched to these sites.

## **7. Required Written Agreement Between School and Site**

BBS law requires schools leading to LMFT or LPCC licensure to have a written agreement with its practicum sites that details each party's responsibilities, including the methods by which supervision will be provided. The agreement must provide for regular progress reports and evaluations of the student's performance at the site. While the law does not further define this agreement, a consortium of the MFT schools in California developed a sample "4-

<sup>2</sup> Title 16, California Code of Regulations Section 1387

Way Agreement” that is used as a template by many schools (the exact number using this template is unknown). A sample agreement is provided in **Attachment J**. The 4-Way Agreement contains provisions that apply to the school, the site, the site supervisor and the student, and is signed by all parties.

The Committee may want to consider adding the following language from the template 4-Way Agreement into BBS law:

- Require the school to evaluate the appropriateness of the site in terms of educational objectives and clinical appropriateness of the experience to be provided to the Trainee.
- Require the site to provide adequate resources to the Trainee and supervisor which are necessary for providing clinically appropriate services to clients.
- Require the site to provide the Trainee with a crisis/emergency response plan that assures the personal safety of the Trainee, supervisor and clients.
- Require the site to evaluate and verify the qualifications of any employee who provides clinical supervision to a Trainee.
- Require the site to be familiar with, operate under, and require adherence to the laws that govern the practice of LMFTs and/or LPCCs.
- Require the site to adhere to the ethical guidelines of one of the following professional organizations: CAMFT, AAMFT, ACA, NASW, APA, AMA.
- Require the site to notify the school and the Trainee of any change of address, phone, ownership or other status that may affect the ability of the Trainee to gain experience at the setting.

While the BBS does not regulate practicum sites, and does not have an enforcement mechanism for the written agreement. Adding to the terms of the agreement would provide parameters that would help the school and student to evaluate the appropriateness of a practicum site. It is not known what types of steps are taken by schools to ensure these agreements are followed. The Committee may wish to discuss language that would require the school to take steps should there be a concern.

## **8. Defining Acceptable Sites for LMFT and LPCC Students**

Keeping in mind that 30% of schools do not have enough placements for their students (but also in balance with protection of clients and students), there are some options to consider that would further clarify or define the types of acceptable practicum settings. Some possible options are:

- A. If the Committee believes that current law regarding acceptable practicum sites is adequate: The Board could publish guidance on how schools can determine whether a setting is allowable according to current law (note that the law will become clearer by virtue of creating a definition of “private practice”).
- B. If the Committee believes it may be necessary to prohibit certain specific types of practicum sites: Once the setting type definitions have been developed, staff can gather additional information that would help the Committee to determine which setting types should be specifically prohibited. Once we have established why such settings should be prohibited, law changes can be pursued.



C. If the Committee believes that current law regarding practicum sites should be strengthened, but does not believe there is adequate justification for banning certain types of sites: Determine some additional requirements that could be enforced by the schools. This may include strengthening the written agreements as discussed in the prior section, and additional possibilities for consideration are provided below. The new requirements could be applied to all settings, or only to settings that are of possible concern. New requirements could include:

- 1) An assigned agency employee who is the liaison between the site, the student, the clinical supervisor and the school.
- 2) Require the clinical supervisor to be a licensed mental health professional (not currently required for LPCC, but is required for LMFT students pursuing licensure).
- 3) Require the school to monitor and evaluate the Trainee's ability to provide services at the site where he or she will be practicing and to the particular clientele being served (currently a requirement for supervisors of LMFT students).
- 4) If the clinical supervisor is off-site or not employed by the site, require the site to explain who has ultimate authority to direct the Trainee's clinical decisions and provide direction for the client's treatment; and also to describe the level of access the supervisor has to the client records (similar requirements currently exist for LMFT Trainees and Interns whose supervisor is a volunteer).
- 5) If a for-profit setting, prohibit the site from charging Trainees any fees other than for fingerprinting.
- 6) Require the student to evaluate the supervision and the agency periodically on a form provided by the school.

#### **9. Consistency of LPCC/LMFT Requirements**

Lastly, because LPCC students cannot count pre-degree experience toward licensure, the Board does not as closely regulate PCC Trainee practicum experience. The Committee may want to consider implementing some of the MFT Trainee requirements relating to supervision (See **Attachment B**, #9, last two bullets for examples).

#### **10. Recommendations**

- Develop an initial framework for definitions of different settings types.
- Decide on critical concepts for strengthening school-site agreements.
- Determine how to better define allowable settings for LMFT and LPCC students.
- Determine whether to increase consistency between LMFT and LPCC where it makes sense to do so.
- Reach out to the schools prior to the next Exempt Committee meeting to solicit information and feedback.

**Attachments**

**Attachment A:** Practicum Coordinator Survey Results – Notable Findings

**Attachment B:** California Laws Referencing “Private Practice”

**Attachment C:** Example Private Practice Definitions

**Attachment D:** Company Brochure from Telecare

**Attachment E:** List of “For-Profit” Setting Types and Non-501c3 Settings that are “Not-for-Profit” from Practicum Coordinator Survey Results

**Attachment F:** LMFT and LPCC Law Re: Practicum Hours, Practicum Content and Trainee Supervision

**Attachment G:** List of Health Care Facility Types Licensed by the State of California

**Attachment H:** Excerpts of CSWE, CACREP and COAMFTE Accreditation Standards

**Attachment I:** APA Accreditation Standards - Excerpt

**Attachment J:** Sample 4-Way Written Agreement

**ATTACHMENT A**  
**PRACTICUM COORDINATOR SURVEY RESULTS**  
**SUMMARY OF NOTABLE FINDINGS**

1. Nearly 50% of the survey responses were from dual track LMFT/LPCC programs (Q1).
2. 80% of the responding degree programs were primarily traditional, classroom-based (Q2).
3. 78% of students are unpaid in their practicum placement (Q3).
4. The top three most common placement settings where students are performing clinical services are exempt settings (Q5):
  - Nonprofit and charitable (501c3) agencies (reported by 96% of schools)
  - Public Schools (reported by 87% of schools)
  - Governmental agencies (reported by 79% of schools)
5. Just over 40% of programs place students who will be performing clinical services in for-profit entities that are not private practices (Q6).
6. For just over 50% of programs, the school and the student share the responsibility of finding a suitable placement for the student (Q8).
7. The top three most important qualities of a suitable practicum setting were reported as (Q10):
  - Effective supervision
  - Quality learning/training opportunities available
  - Exposure to a diverse spectrum of clients and/or experiences
8. Nearly 40% of respondents indicated that there are certain types of settings allowed by law that are generally not suitable for student placement (Q11).
  - Of those 40% who provided an explanation, most described settings that are either:
    - 1) Limited in scope, such as substance abuse treatment centers or crisis centers; or,
    - 2) Organizations with ethical issues or that are unstable.
9. Of the nearly 70% of schools that use extra precaution when placing students in certain settings, most indicated that these were settings that treat severely mentally ill or high-risk clients. (Q13).
10. Over 30% of schools reported that they do NOT believe that there are certain types of settings where is necessary to use extra precaution when placing students (Q13).
11. The number one factor that may lead a school to decide against placing students at a site are lacking/poor supervision or monitoring (Q14).
12. Nearly 30% of schools do not have enough placements available for their students (Q16).

13. Respondents estimated that an average of 32% of students continue at their site after graduation (Q17).
14. The most common types of questions or issues respondents encounter when applying BBS requirements when selecting student placement settings include (Q18):
- Site understands the requirements for a qualified supervisor
  - Site understands the requirements for counting hours toward licensure
  - Whether for-profit agencies (non-private-practice) are acceptable (*Note: This is a frequent question received by the BBS from schools. This issue is complicated by the fact that there is no definition of "Private Practice" in law.*)

## **ATTACHMENT B**

### **California Laws Referencing “Private Practice”**

#### Business and Professions Code (BPC):

- Prohibits a licensee who has been granted a renewal waiver due to being on active military duty from working in a private practice while holding the waiver. (BPC section 114.3)
- Prohibits anyone from working in a private practice until registered with the Board as an AMFT or APCC or ASW. (BPC sections 4980.43, 4996.23, 4999.34, 4999.44, 4999.45 and 4999.46)
- Requires an AMFT or APCC working in a private practice to be under the direct supervision of a qualified supervisor who is either employed by and practices at the same site as the intern’s employer, or who is an owner or shareholder of the private practice. (BPC section 4980.43, Title 16, California Code of Regulations (16CCR) sections 1820 and 1833)
- Allows MFT and PCC Trainees or Interns who serve as volunteers and provide services in any setting other than a private practice to be considered employees and not independent contractors if they receive no more than \$500 per month in reimbursement of expenses. (BPC sections 4980.43 and 4999.47)
- Prohibits an LMFT, LCSW, or LPCC in private practice from employing, at any one time, more than three BBS registrants. (BPC sections 4980.45, 4996.24 and 4999.455)
- Subjects LMFT, LCSW and LPCC professional corporations to all laws governing experience and supervision gained in a private practice setting. (BPC sections 4980.45, 4996.24 and 4999.455)
- Prohibits a LMFT or LCSW who conducts a private practice under a fictitious business name from using a name which is false, misleading or deceptive, and requires informing clients of the name and license type of the practice owner(s). (BPC sections 4980.46, 4992.10 and 4999.72)
- Prohibits an AMFT, ASW or APCC from being employed or volunteering in a private practice after the initial six-year registration runs out. (BPC sections 4984.01, 4996.28, 4999.45 and 4999.100)
- States that it is unprofessional conduct for an LEP, when employed by another person or agency, to encourage the employer’s or agency’s clientele to use his or her private practice for further counseling without the approval of the employing agency or administration. (BPC section 4989.54)
- Excludes private practices from the definition of “community mental health setting” in LPCC law. (16CCR section 1820)

Welfare and Institutions Code (WIC):

- The office of State Program of Problem Gambling shall develop a treatment program for California residents, which may consist of a network of licensed health providers authorized to receive reimbursement from the state for providing treatment. This may include individuals in private practice. (WIC section 4369.2(b)(2))
- The Department of Health Care Services shall ensure that managed care health plans or Medi-Cal providers who contract to provide Medi-Cal benefits and services, comply with network adequacy requirements. This may include contracting with providers including “small and private practice providers” who have traditionally treated dual eligible patients. Managed care plans must establish participation standards for such providers. (WIC section 14182.17(d)(5)(E))

## ATTACHMENT C: EXAMPLE PRIVATE PRACTICE DEFINITIONS

State/Agency	Private Practice Definition
<b>CA Board of Behavioral Sciences</b>	LCSW law only: A private practice setting is a setting that is owned by a licensed clinical social worker, a licensed marriage and family therapist, a licensed psychologist, a licensed professional clinical counselor, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.
<b>CA Board of Psychology</b>	Prior to some recent regulation changes, BOP required a psychological assistant in a private practice setting to submit a plan for supervised experience to the Board. A private practice setting had been defined as a psychological corporation or a medical corporation, with the exception of a nonprofit corporation supported by donations, or a clinic that provides mental health services under contract to a local mental health agency (Note: The BOP has since deleted this definition, formerly under Title 16 CCR 1387(b)(11).
<b>AZ, FL</b>	None
<b>NY</b>	None in law, but the licensing website provides the following definition: <ul style="list-style-type: none"> <li>• Occurs when any licensee commences practicing for profit absent any planned corporate structure.</li> <li>• The practitioner is responsible independently for his/her professional actions which result in charges of professional misconduct and civilly liable for his/her actions and those of any employee</li> </ul>
<b>OH</b>	"Private practice" and "private practitioner" mean an individual who independently, in partnership, or in corporation practices counseling, social work, or marriage and family therapy and sets up his/her own condition of exchange with those clients, and identifies himself/herself in any manner as a counselor, social worker, or marriage and family therapist in offering such services.
<b>OR, TX, VT, VA</b>	None
<b>CAMFT, AAMFT, ACA, NBCC</b>	None
<b>NASW</b>	Private practitioners are social workers who, wholly or in part, practice social work outside a governmental or duly incorporated voluntary agency, who have responsibility for their own practice and set up conditions of exchange with their clients, and identify themselves as social work practitioners in offering services.
<b>Association of Social Work Boards Model Law</b>	Private Practice means the provision of Clinical Social Work services by a licensed clinical social worker who assumes responsibility and accountability for the nature and quality of the services provided to the Client in exchange for direct payment or third-party reimbursement.
<b>Mosby's Medical Dictionary</b>	The work of a professional health care provider who is independent of economic or policy control by professional peers except for licensing and other legal restrictions; To engage in one's profession as an independent provider rather than as an employee.
<b>National Health Service Corps</b>	Solo or Group Private Practice – A clinical practice that is made up of either one or many providers in which the providers have ownership or an invested interest in the practice. Private practices can be arranged to provide primary medical, dental and/or mental health services and can be organized as entities on the following basis: fee-for-service; capitation; a combination of the two; family practice group; primary care group; or multi-specialty group.

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ATTACHMENT D





## Telecare: *A Story of Hope*

*In 2015, Telecare celebrates its present and future through the lens of a half-century of service to public and private customers, clients, and their families, as well as to its communities.*

*From a single 96-bed hospital in Oakland, California, Telecare has grown to 85 programs in eight states\* serving nearly 34,000 clients a year. Telecare's past is the foundation on which its future is being built.*

*We celebrate the creative and dynamic values of our founders that inspire our efforts today and will enable us to thrive for decades to come.*

At the heart of the Telecare story is the commitment of more than 3,000 employees to making a positive difference in the lives of people with serious mental illness. Our clients thrive because of the creativity and energy of staff who believe that individuals with mental illness can have their hopes renewed and dreams fulfilled.

"Telecare was founded on the belief that rehabilitation and recovery from serious mental illness are possible and that people can realize their full potential — and recover their hopes, dreams, and life roles," says Anne Bakar, President and CEO.

Over the past 50 years, during times of historic changes in psychiatric treatment, the people of Telecare have made that founding belief a reality. They have done this by creating and maintaining a culture that promotes partnership and trust, and that adapts to an ever-changing healthcare landscape. Day in and day out, the culture creates respectful and accountable relationships between the company and its customers, between leadership and employees, and between clients and staff.

### **Mental patients may be moved** *Budget cuts forcing shift from Napa State Hospital*

**By Judy Ronningen**  
*Tribune staff writer*

Alameda County may move 70 chronic mentally ill patients from Napa State Hospital to a county-run hospital in East Oakland, where officials say they can offer the same treatment for less money.

It is the first sign that Alameda County is flexing its new

County officials say that in the long run, sales tax revenues will recover. In the meantime, they will have authority to streamline services or see if new approaches to health care or juvenile programs have more bang for the buck.

Ideas raised at a special budget meeting yesterday include:

■ The county has already ap

■ The state pays for another 60 Alameda County mentally ill to live in lower-security nursing homes throughout Northern California. Alameda County would contract with TeleCare, a private psychiatric company, to care for them at Garfield Hospital, 1441 28th Ave., Oakland.

Kears said patients would be closer to their families and jobs

\*California, Washington, Oregon, Nebraska, North Carolina, Arizona, Pennsylvania, and Texas

# A Philosophy of Respect, Recovery & Results

Telecare's founders — Mort Bakar, a businessman; Art Gladman, a psychiatrist; and Lida Hahn, a psychiatric nurse — believed in treating clients with respect and delivering services in as much of a non-institutional setting as possible.

Many people with serious mental illnesses at that time were placed in large state institutions, often far from their homes and families. Even people with short-term acute problems lacked an appropriate caring environment. The medications that were used to ease symptoms had significant side effects.

Telecare's founders built a hospital, designed by a student of Frank Lloyd Wright, that had a welcoming and comfortable environment. They got rid of uniforms and formality. Clients and physicians worked together to create a treatment philosophy that respected patient input and encouraged clients to participate in the community and not be isolated. Gladman Memorial Hospital was the area's first freestanding acute psychiatric hospital and the first alternative to the large state institution available to residents of the San Francisco Bay Area.

## A Tradition of Responding to Customers' Needs

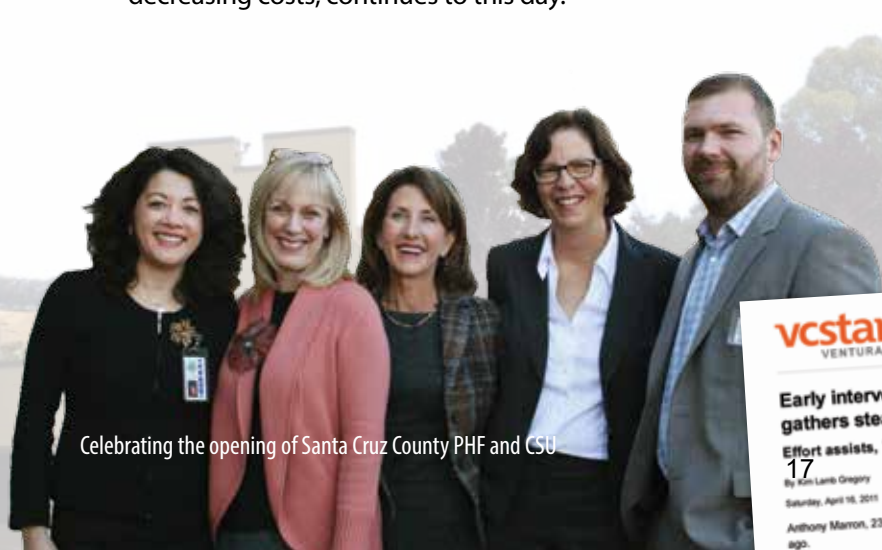
Beginning in the 1970s, legal and treatment philosophy changed to allow individuals with mental illness greater rights and freedoms, and emphasized more locally-based treatment. This deinstitutionalization resulted in the closing of many state-run psychiatric hospitals. In California, thousands of individuals with the most severe forms of mental illness became the responsibility of counties that were not prepared to provide needed services. The result was a spiral of acute hospital admissions and readmissions, and of people with mental illness landing in jails and public shelters.

In the late 1970s and early 1980s, Telecare began partnering with Alameda County to address this problem. As a private company, Telecare was adaptable, had ready access to capital, and could act quickly. The partnership's goal was to develop local capacity for high-risk, high-cost, severely disabled individuals that would both save the county money and provide appropriate local treatment for deinstitutionalized clients.

"There was no way the county, using only county staff, could figure out how to come up with the necessary resources as quickly as we needed them," says David Kears, former Director of the Alameda County Health Care Services Agency. "We really needed private help."

David Heffron, Vice President of Operations for Southern California, who joined Telecare in 1981, says, "I remember Mort really encouraging us to create something different and new for the Alameda County customer." The result was creation of two inpatient subacute facilities where clients could be more properly treated closer to home.

Says David Heffron, "All these years later, our culture still permits us to use our creativity and skills and take measured risks." Telecare's focus on responding to customers' needs, delivering excellent care, and decreasing costs, continues to this day.



Celebrating the opening of Santa Cruz County PHF and CSU



## A New Leader & A Commitment to Family & Employee Ownership

In 1987, following the untimely death of patriarch Mort Bakar, his daughter, Anne Bakar, 29, assumed leadership of the company. Anne brought an entrepreneurial track record from the financial sector to Telecare, along with an instinctive appreciation for Telecare's purpose, and a passion for learning and growth. By recruiting some of the best and brightest people with experience in business and clinical management to her leadership team, and focusing on the development of a mission-centered culture, she advanced Telecare to a new level.

Joan Meisel, Ph.D., a veteran healthcare strategic policy and marketing analyst and a Telecare board member says, "One of Anne's most remarkable traits is that she's totally unthreatened by having smart, capable people around her. That's allowed her to hire very strong, talented people, who themselves have carried on that tradition of hiring highly effective people."

In addition to recovery and results as core company values, Anne believes in the value of collaboration, and introduced an Employee Stock Ownership Plan (ESOP), enabling those who serve our clients and customers to have a stake in the company. Employees now own 40% of Telecare's stock, which has increased in value 525% since 1997.

"I think being an ESOP company really brings value. It aligns the vision and mission of the organization with the employees' actions, and as a result, we all benefit — on a staff and organizational level — from the stability and security that comes with growth," says Marcie Atchison, Senior Vice President of Human Resources.





These are just a few of Telecare's 40+ customers, which include public mental health, health plans and hospital systems, and other systems of care.

## A Successful Organization & Public/Private Partnership Expands

With a family-employee ownership structure that was focused on recovery and responsiveness to changing customer needs, Telecare experienced dynamic change over the next two decades. It expanded its service spectrum, geography, breadth of public/private partnerships, and most significantly, its capacity to help individuals with increasingly specialized and complex needs.

Telecare opened the first Assertive Community Treatment (ACT) program in California in 1994, and soon expanded to more diverse community-based services including crisis, intensive case management, and residential programs. These community-based programs addressed the needs of individuals with severe mental illness, substance abuse, homelessness, developmental disabilities, and histories of incarceration.

Telecare also expanded the populations and variety of customers it served in the early 2000s, beyond California, to Oregon, Washington, Texas, and Nebraska, disseminating best and promising practices from one region to the next, while staying responsive to each customer's unique culture and system. With some new customers, like in Oregon and Nebraska, Telecare introduced an innovative and cost-effective 16-bed subacute alternative to the state hospital. In other states, like California with the passage of the Mental Health Services Act, Telecare was able to help expand the use of more evidenced-based early intervention services, intensive case management and crisis services to several new California counties. Telecare also began working more with hospital systems and health plans like Kaiser to serve the crisis and acute needs of adults and adolescents.

Telecare's success is predicated on a consistent formula and philosophy: to deliver excellent results for its public/private partners, and renewed hope and resilience for the thousands of individuals at the heart of its work.

Anne Bakar, President & CEO



## A Commitment to Innovation & to Results That Make a Difference

The sum of Telecare's half-century of learning and experience has been consolidated into the Recovery-Centered Clinical System (RCCS), a richly personal, holistic, innovative, and comprehensive approach to recovery that incorporates evidence-based best practices. "Traditionally, the provider's orientation dictated the services a client would receive," says Stephen Wilson, recently retired Chief Medical Officer and creator of the RCCS. "But with the RCCS, we start with the client and build services that make a real difference in lives. The improvement in clients is dramatic."

Telecare's programs are accredited by JCAHO and CARF International, whose surveyors recently praised Telecare for its many strengths, including freely sharing the RCCS with other organizations, and its commitment to continuous innovation. Telecare has consistently demonstrated its responsiveness to customer needs through performance contracts with measureable results.

Recent examples include:

### **In acute settings:**

35% improvement in measures of hopefulness in sample acute settings upon completion of treatment

### **In ACT/FSP settings\*:**

30% reduction in hospital days

80% decrease in incarceration days

75% decrease in homeless days

\*Averages for programs since opening

### **In subacute settings\*:**

95% reduction in seclusions

93% reduction in restraints

51% reduction in assaults

\*Per 1000 bed days, from the past 15 years



**"Recovery is seeing myself differently." - Kallin W.**

## Telecare: What's in a name?

Mort Bakar and Art Gladman began making plans in 1963 to create a modern psychiatric hospital in Oakland. A couple of years later, while driving to a local gym, Art was considering what to name the hospital's operating company, and "Tender Loving Care" came to mind in the form of T.L.Care.

However, when we got our license from California's Commissioner of Corporations, our name was accidentally misread, and the periods were mistaken for "e's." Because of this turn of events, our name became Telecare! In the early years, we only had one program, Gladman Memorial Hospital, and everyone knew us as Gladman. However, as we grew and added more programs, the Telecare Corporation name has stuck and generated tremendous goodwill because of the reputation we built. There is still quite a bit of internal discussion about the lessons of this story, and where the fun history of our name might lead us in the future!

# 50 Years of *Growth & Innovation*

## Opening First Freestanding Psychiatric Hospital

- 1965      Telecare is founded
- 1966      Opened Gladman Memorial Hospital: first freestanding psychiatric hospital in Bay Area; provided acute level care
- 1970s     Partnered with Alameda County at Gladman in order to bring individuals out of state institutions and receive supports in a smaller setting, closer to home

## Partnering to Create Subacute Alternatives

- 1980-81    Opened two subacutes in Alameda County
- 1982      Opened subacute in San Mateo County
- 1986      Opened geropsychiatric services subacute services in LA County
- 1987      Opened subacute services in LA County
- 1987      Morton Bakar dies; Anne Bakar assumes leadership of Telecare
- 1990-92    Opened subacute services in San Diego County
- 1991-92    Redesigned Gladman into subacute facility

## Collaborating to Deliver Community-Based Services

- 1994      Opened first Assertive Community Treatment (ACT) and case management programs at Telecare in Alameda, San Diego Counties
- 1994-99    Expanded ACT and case management programs in Solano, Stanislaus, Alameda, and LA Counties including dual diagnosis and older adult services
- 1996      Opened first residential programs at Telecare in Santa Barbara and Ventura Counties
- 1998      Opened first case management program with health plan, Kaiser, in San Diego
- 1999      Created first community-based programs at Telecare targeted to homeless outreach

## Meeting the Need for Acute and Crisis Care

- 1996-2001  Opened short-term acute inpatient programs in Solano and Placer Counties, plus first in-jail acute program in Alameda County
- 2000-02    Opened first mobile crisis program in Dallas, Texas, and urgent/crisis stabilization services in Alameda and LA Counties

## Expanding to New Geographic Territories, Serving New Customers, Populations, and Systems

- 2000      Entered Texas with ACT and crisis services
- 2002      Entered Oregon with recovery-centered subacute services
- 2003      Entered North Carolina with ACT services
- 2003      Opened first subacute program with the California Regional Centers system, serving individuals with DD/SMI
- 2005      Entered Nebraska with subacute services
- 2005      Expanded work with health plan, Kaiser, to include acute inpatient services
- 2007      Opened first acute adolescent program, serving county and health plan clients
- 2005      Opened first prevention and early intervention program in Ventura County
- 2009      Opened first community-based programs with California Department of Corrections in LA, San Diego, and San Bernardino areas
- 2010      Entered Washington with acute services
- 2011      Entered Pennsylvania with geropsychiatric inpatient acute services
- 2011-13    Opened AB109 programs across California
- 2013      Entered Santa Cruz County with acute and crisis services
- 2013-14    Opened first coordinated care programs with health plans focusing on integrated care
- 2014      Entered Riverside County with acute, crisis and ACT services; and Contra Costa County with crisis residential
- 2015      Entered Arizona with ACT services

## Innovating to Meet Continually Evolving Needs

- 2015+     Telecare is actively working on new approaches for whole person care integrating mental health, physical health, and substance use services; deepening capabilities with peer-led services; creating better services for justice-involved individuals, and much more.

Visit [www.telecarecorp.com](http://www.telecarecorp.com) to learn more about specific programs and services provided.



## The Programs & Services Evolve, The Purpose Endures

“Our scope of programs, the number and type of customers, and the complexity of the clients served have evolved dramatically,” says Anne Bakar. “We have grown from being the premier provider of acute freestanding psychiatric care in Northern California to revolutionizing institutional mental healthcare, to providing services and systems of care for individuals with serious mental illness and complex needs nationally. The purpose of helping individuals with mental illness recover their health, hopes, and dreams has been continuous.”

From the beginning, Telecare has understood the necessity of adapting to a changing environment. The positive attitude toward recovery and partnership skills learned over the past 50 years will enable Telecare to thrive for decades to come, benefiting both those who receive care and those who provide it.

“At Telecare, I’ve seen more powerful, long-term gains and success stories than in any organization I’ve ever worked,” says Shannan Taylor, Administrator of Telecare’s Sacramento Outreach Adult Recovery program. “I’ve seen amazing transformations. Individuals who have gone from believing that they would never have a job, find a partner, raise a family, drive a car, or just live in the community without restrictions, are now working, driving, in healthy relationships, marrying, having families. Some are getting off drugs, which had been the only constant factor in their lives. With treatment, they have gone on to thrive, become a part of the community, share their story, and inspire others to begin the path toward recovery.”

“Telecare was a home for me. Mr. Bakar believed in me. It was a place where I could thrive and truly make a difference.”

Mary Mosely, Retired, 40 years, Villa Fairmont

“Going forward, I am very optimistic that the company will be much larger, and a brand in the United States that people will recognize more broadly as the quality standard for treating mental health.”

Marshall Langfeld, Director and SVP Finance





## ATTACHMENT E

### List of “For-Profit” Settings and Non-501c3 Settings that are “Not-for-Profit” From Practicum Coordinator Survey Results

*\*=Facility requires state licensure    \*\*=May require state licensure depending on specific type*

*Schools reported placing students in the below types of settings, which do not fall under the definition of “Exempt.” Any of the below settings that require state licensure were also acceptable as practicum sites under the “old” (pre-2003) BBS law.*

<b>For-Profit and Not-for-Profit (non-501c3) Setting Types</b>	<b>Percent of Schools Placing Students in This Setting</b>
Mental health clinic/counseling center**	79%
Outpatient intensive mental health treatment center**	58%
Outpatient alcohol and drug treatment center*	56%
Residential mental health treatment center*	44%
Domestic violence program	44%
Inpatient alcohol and drug treatment center*	42%
Medical hospital*	40%
Homeless shelter or service program	40%
Psychiatric hospital*	37%
Crisis care/intervention program	35%
Other licensed health facilities*	33%
Adult day health and/or respite care facility*	28%
Skilled nursing home or assisted living facility*	28%
Military and/or veteran's service program	23%
Social rehabilitation facility*	21%
Developmental and/or Intellectual disability program**	16%
Professional corporation	12%
Pediatric day health and/or respite care facility*	9%
Employee assistance program	2%

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**ATTACHMENT F**  
**LMFT and LPCC Law**  
**Practicum Hours, Practicum Content and Trainee Supervision**  
**Business and Professions Code (BPC)**

**LMFT Law (BPC sections 4980.36(d)(1)(B) and 4980.42:**

1. A minimum of six semester or nine quarter units of practicum in a supervised clinical placement that provides supervised fieldwork experience.
2. A minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.
3. In addition to the 150 hours, 75 hours of either of the following, or a combination thereof:
  - a. Client centered advocacy
  - b. Face-to-face experience counseling individuals, couples, families, or groups.
4. Student must be enrolled in a practicum course while counseling clients, unless the period of lapsed enrollment is less than 90 calendar days and is immediately preceded by enrollment in practicum and immediately followed by enrollment in practicum or graduation.
5. The practicum shall provide training in all of the following areas:
  - Applied use of theory and psychotherapeutic techniques.
  - Assessment, diagnosis, and prognosis.
  - Treatment of individuals and premarital, couple, family, and child relationships, including trauma and abuse, dysfunctions, healthy functioning, health promotion, illness prevention, and working with families.
  - Professional writing/documentation.
  - How to connect clients with resources.
6. All hours of experience shall be coordinated between the school and the site where the hours are being accrued.
7. The school shall approve each site.
8. The school shall have a written agreement with each site that details each party's responsibilities, including the methods by which supervision shall be provided. The agreement shall provide for regular progress reports and evaluations of the student's performance at the site.
9. If the student will be gaining experience toward licensure, the site and supervisor must follow all supervision requirements for licensure. Those requirements include:
  - An average of at least one (1) hour of individual supervision or two (2) hours of group supervision for every five (5) hours of client contact in each setting during each week (groups may contain no more than eight (8) supervisees).
  - The supervisor must ensure that the extent, kind and quality of counseling performed is consistent with the education, training and experience of the student.
  - The supervisor must review client records, monitor and evaluate assessment, diagnosis and treatment decisions, monitor and evaluate the ability of the trainee to provide

services at the sites where he or she will be practicing and to the particular clientele being served, and ensuring compliance with laws.

**LPCC Law (BPC sections 4999.33(c)(3) and 4999.36:**

- A minimum of 280 hours of face-to-face supervised clinical experience counseling individuals, families, or groups.
- Not less than six semester units or nine quarter units of supervised practicum or field study experience that involves direct client contact in a clinical setting that provides a range of professional clinical counseling experience, including the following:
  - Applied psychotherapeutic techniques.
  - Assessment, Diagnosis, Prognosis.
  - Treatment.
  - Issues of development, adjustment, and maladjustment.
  - Health and wellness promotion.
  - Professional writing/documentation.
  - How to find and use resources.
  - Other recognized counseling interventions.
- All practicum and field study hours gained as a clinical counselor trainee shall be coordinated between the school and the site where hours are being accrued.
- The school shall approve each site.
- The school shall have a written agreement with each site that details each party's responsibilities, including the methods by which supervision shall be provided. The agreement shall provide for regular progress reports and evaluations of the student's performance at the site.
- An average of at least one (1) hour of individual supervision or two (2) hours of group supervision for every five (5) hours of client contact in each setting during each week. Groups may contain no more than eight (8) supervisees.

## Appendix A. State-Regulated Categories of Health Care Facilities and Professionals

The following chart provides a list of the categories of health care-related facilities, designations, and professionals in California that are regulated by state agencies. (Designation refers to approval given to a facility to provide specific services, separate from any license for the facility; some designations may be given to facilities not licensed by the designating agency.) The chart arranges the categories under the California Health and Human Service Agency departments and the Business, Consumer Services, and Housing Agency, Department of Consumer Affairs, boards and committees responsible for their regulation and oversight.

Note: The number in brackets indicates the number of facilities or professionals within the category. Categories without a number indicate that the regulating board, committee, or other agency did not respond to the invitation to complete a survey.

	FACILITIES OR DESIGNATIONS REGULATED	PROFESSIONALS REGULATED
<b>California Health and Human Services Agency</b>		
California Department of Aging	CBAS [260: 246 open, 16 closed and in suspense]	
California Department of Public Health*	<ul style="list-style-type: none"> <li>➤ Acute Psychiatric Hospital [38]</li> <li>➤ Adult Day Health Center [300]</li> <li>➤ Alternative Birthing Centers [8]</li> <li>➤ Ambulatory Surgical Centers [771]</li> <li>➤ Biologics License [220]</li> <li>➤ Certificate of Registration/Licenses (Laboratory) [14,974]</li> <li>➤ Certificate of Registration (Radiologic) [approx. 30,000]</li> <li>➤ Chemical Dependency Recovery Hospital [6]</li> <li>➤ Chronic Dialysis Clinics [4 licensed only, 571 licensed and certified as ESRD]</li> <li>➤ Community Clinic [1,127]</li> <li>➤ Comprehensive Outpatient Rehabilitation Facility [3]</li> <li>➤ Congregate Living Health Facility (A, B, &amp; C) [55]</li> <li>➤ Correctional Treatment Centers [19]</li> <li>➤ Critical Access Hospital [31]</li> <li>➤ Drug Manufacturer License [453]</li> <li>➤ End Stage Renal Dialysis [567]</li> <li>➤ Federally Qualified Health Center or FQHC Look-alike</li> <li>➤ Free Clinic [43]</li> <li>➤ General Acute Care Hospital [437]</li> <li>➤ Home Health Agency [1,451]</li> <li>➤ Home Medical Device Retail [1,331]</li> <li>➤ Hospice [435]</li> <li>➤ Hospice Facility [1]</li> <li>➤ Intermediate Care Facility [5]</li> <li>➤ Intermediate Care Facility/Developmentally Disabled [10]</li> </ul>	<ul style="list-style-type: none"> <li>➤ Bioanalyst [48]</li> <li>➤ Certified Hemodialysis Technician [5,676]</li> <li>➤ Certified Home Health Aide [49,172]</li> <li>➤ Certified Industrial Radiographer [unknown]†</li> <li>➤ Certified Nuclear Medicine Technologist [2,229]</li> <li>➤ Certified Nursing Assistant [163,658]</li> <li>➤ Certified Radiologic Technologist [24,952]</li> <li>➤ Certified Supervisor/Operator (Radiologic) [23,859]</li> <li>➤ Clinical Laboratory Scientist [16,589]</li> <li>➤ Clinical Laboratory Scientist (Limited) and Cytotechnologist [2,582]</li> <li>➤ Director License (Laboratory) [167]</li> <li>➤ Genetic Counselor [464]</li> <li>➤ Home Medical Device Retail Exemptee [2,806]</li> <li>➤ Limited Permit X-Ray Technician [4,602]</li> <li>➤ Medical Laboratory Technician [280]</li> <li>➤ Medical Physicist [562]</li> <li>➤ Nursing Home Administrator [2,045]</li> <li>➤ Occupational Therapist in Independent Practice/Physical Therapist in Independent Practice/Speech Therapist [84]</li> <li>➤ Phlebotomist [approx. 36,000]</li> <li>➤ Public Health Microbiologist [1,885]</li> <li>➤ Sickle Cell Anemia Counselor [4]</li> <li>➤ Trainee (Laboratory) [1,086]</li> </ul>

\*In addition to regulating facilities and professionals, the CDPH regulates medical devices that contain a radiologic source: Source and Device Registry (80).

†Requires certification by other entity but does not directly issue certificate.

	FACILITIES OR DESIGNATIONS REGULATED	PROFESSIONALS REGULATED
California Department of Public Health,* <i>continued</i>	<ul style="list-style-type: none"> <li>▶ Intermediate Care Facility/Developmentally Disabled/Habilitative [760]</li> <li>▶ Intermediate Care Facility/Developmentally Disabled/Nursing [419]</li> <li>▶ Medical Device Manufacturers License [1,333]</li> <li>▶ Pediatric Day Health and Respite Care Facility [16]</li> <li>▶ Prenatal Diagnostic Center [139]</li> <li>▶ Private Duty Nursing Agency [0]</li> <li>▶ Psychology Clinic [25]</li> <li>▶ Radioactive Materials License [approx. 1,800]</li> <li>▶ Referral Agency [6]</li> <li>▶ Rehabilitation Clinic [16]</li> <li>▶ Rural Health Clinic [271]</li> <li>▶ Skilled Nursing Facility [1,287]</li> <li>▶ Specialty Hospital [0]</li> <li>▶ Surgical Clinic [37]</li> <li>▶ Tissue Bank [646]</li> </ul>	
Department of Health Care Services	<ul style="list-style-type: none"> <li>▶ Alcoholism or Drug Abuse Recovery or Treatment Facility [1,357]</li> <li>▶ County Designated Facility Under LPS Act for W&amp;I Code §5150 [159]</li> <li>▶ California Children's Services (CCS) Approval for Hospitals, PICU/NICU, and Special Care Centers That Meet CCS Standards Requirements [820]</li> <li>▶ Driving Under the Influence Program [500]</li> <li>▶ Narcotic Treatment Program [156]</li> <li>▶ Mental Health Rehabilitation Center [20]</li> <li>▶ Program for All-Inclusive Care for the Elderly [7]</li> <li>▶ Psychiatric Health Facility [24]</li> <li>▶ Residential Alcoholism or Drug Abuse Recovery or Treatment Facility [802]</li> </ul>	<ul style="list-style-type: none"> <li>▶ Alcohol and Other Drug (AOD) Counselor [approx. 36,000]</li> <li>▶ California Children's Services Approval for Doctors and Allied Health Professionals [unknown]</li> </ul>
Department of Social Services	<ul style="list-style-type: none"> <li>▶ Adult Residential Facility [5,159]</li> <li>▶ Adult Residential Facility for Persons with Special Needs [26]</li> <li>▶ Community Treatment Facility [2]</li> <li>▶ Residential Care Facility for the Chronically Ill [19]</li> <li>▶ Residential Care Facility for the Elderly [7,497]</li> <li>▶ Small Family Home [183]</li> <li>▶ Social Rehabilitation Facility [26]</li> </ul>	<ul style="list-style-type: none"> <li>▶ Residential Care Facility for the Elderly, Administrator</li> </ul>
Emergency Medical Services Authority	<ul style="list-style-type: none"> <li>▶ Ambulance and Air Ambulance Zones [338]</li> <li>▶ Trauma System and Trauma Center Designation (Hospital) [73]</li> </ul>	<ul style="list-style-type: none"> <li>▶ Advanced Emergency Medical Technician [93]</li> <li>▶ Emergency Medical Technician [approx. 59,000]</li> <li>▶ Paramedic [approx. 20,000]</li> </ul>
Office of Statewide Health Planning and Development	<ul style="list-style-type: none"> <li>▶ OSHPD-3 Clinic (Building Construction Permit, Certificate of Occupancy, Certification of Compliance) [varies]</li> <li>▶ Seismic Standard Compliance [unknown]</li> </ul>	<ul style="list-style-type: none"> <li>▶ Hospital Inspector Certification [Class A: 848; Class B: 68; Class C: 96]</li> </ul>

## Regulatory Oversight for Categories Related to Behavioral Health–Related Systems of Care

The following is a list of the distribution for regulatory oversight of facility and professional categories related to behavioral health–related systems of care. These responsibilities are under the jurisdiction of two state agencies and four state departments.

CDPH licenses and/or certifies the following categories:

- ▶ Acute Psychiatric Hospitals
- ▶ Chemical Dependency Recovery Hospitals
- ▶ General Acute Care Hospitals with Psychiatric Units and/or Outpatient Psychiatric Services
- ▶ Primary Care Clinics and other clinics (Rural Health Clinics and FQHCs) that provide integration of primary care and behavioral health treatment
- ▶ Psychiatric Health Facilities (limited oversight upon request by CMS)
- ▶ Psychology Clinics
- ▶ SNFs that operate a Special Treatment Program, a designation now under the authority of DHCS

DHCS licenses and/or certifies the following categories:

- ▶ Alcohol or Drug Counselors in licensed and certified facilities
- ▶ Alcoholism or Drug Abuse Recovery or Treatment Facility
- ▶ Driving-Under-the-Influence Program
- ▶ Mental Health Rehabilitation Centers
- ▶ Narcotic Treatment Program
- ▶ Psychiatric Health Facilities
- ▶ Residential Alcoholism Drug Abuse Recovery or Treatment Facility

DSS licenses the following categories:

- ▶ Adult Residential Facilities
- ▶ Group Homes
- ▶ Social Rehabilitation Facilities

DCA boards and bureaus license related professions:

- ▶ Board of Behavioral Science
- ▶ Board of Registered Nursing
- ▶ Board of Vocational Nursing and Psychiatric Technicians
- ▶ California Board of Psychology
- ▶ Medical Board of California

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# ATTACHMENT H

## CSWE ACCREDITATION STANDARDS - EXCERPT

### Accreditation Standard 2.2—Field Education

- 2.2.1** The program explains how its field education program connects the theoretical and conceptual contributions of the classroom and field settings.
- B2.2.2** The program explains how its field education program provides generalist practice opportunities for students to demonstrate social work competencies with individuals, families, groups, organizations, and communities and illustrates how this is accomplished in field settings.
- M2.2.2** The program explains how its field education program provides generalist practice opportunities for students to demonstrate social work competencies with individuals, families, groups, organizations, and communities and illustrates how this is accomplished in field settings.
- M2.2.3** The program explains how its field education program provides specialized practice opportunities for students to demonstrate social work competencies within an area of specialized practice and illustrates how this is accomplished in field settings.
- 2.2.4** The program explains how students across all program options in its field education program demonstrate social work competencies through in-person contact with clients and constituencies.
- 2.2.5** The program describes how its field education program provides a minimum of 400 hours of field education for baccalaureate programs and a minimum of 900 hours for master's programs.
- 2.2.6** The program provides its criteria for admission into field education and explains how its field education program admits only those students who have met the program's specified criteria.
- 2.2.7** The program describes how its field education program specifies policies, criteria, and procedures for selecting field settings; placing and monitoring students; supporting student safety; and evaluating student learning and field setting effectiveness congruent with the social work competencies.
- 2.2.8** The program describes how its field education program maintains contact with field settings across all program options. The program explains how on-site contact or other methods are used to monitor student learning and field setting effectiveness.
- B2.2.9** The program describes how its field education program specifies the credentials and practice experience of its field instructors necessary to design field learning opportunities for students to demonstrate program social work competencies. Field instructors for baccalaureate students hold a baccalaureate or master's degree in social work from a CSWE-accredited program and have 2 years post-social work degree practice experience in social work. For cases in which a field instructor does not hold a CSWE-accredited social work degree or does not have the required experience, the program assumes responsibility for reinforcing a social work perspective and describes how this is accomplished.
- M2.2.9** The program describes how its field education program specifies the credentials and practice experience of its field instructors necessary to design field learning opportunities for students to demonstrate program social work competencies. Field instructors for master's students hold a master's degree in social work from a CSWE-accredited program and have 2 years post-master's social work practice experience. For cases in which a field instructor does not hold a CSWE-accredited social work degree or does not have the required experience, the program assumes responsibility for reinforcing a social work perspective and describes how this is accomplished.
- 2.2.10** The program describes how its field education program provides orientation, field instruction training, and continuing dialog with field education settings and field instructors.
- 2.2.11** The program describes how its field education program develops policies regarding field placements in an organization in which the student is also employed. To ensure the role of student as learner, student assignments and field education supervision are not the same as those of the student's employment.

# CACREP ACCREDITATION STANDARDS - EXCERPT

## SECTION 3: PROFESSIONAL PRACTICE

**Professional practice, which includes practicum and internship, provides for the application of theory and the development of counseling skills under supervision. These experiences will provide opportunities for students to counsel clients who represent the ethnic and demographic diversity of their community.**

**The following Standards apply to entry-level programs for which accreditation is being sought.**

### ENTRY-LEVEL PROFESSIONAL PRACTICE

- A. Students are covered by individual professional counseling liability insurance policies while enrolled in practicum and internship.
- B. Supervision of practicum and internship students includes program-appropriate audio/video recordings and/or live supervision of students' interactions with clients.
- C. Formative and summative evaluations of the student's counseling performance and ability to integrate and apply knowledge are conducted as part of the student's practicum and internship.
- D. Students have the opportunity to become familiar with a variety of professional activities and resources, including technological resources, during their practicum and internship.
- E. In addition to the development of individual counseling skills, during *either* the practicum or internship, students must lead or co-lead a counseling or psychoeducational group.

### PRACTICUM

- F. Students complete supervised counseling practicum experiences that total a minimum of 100 clock hours over a full academic term that is a minimum of 10 weeks.
- G. Practicum students complete at least 40 clock hours of direct service with actual clients that contributes to the development of counseling skills.
- H. Practicum students have weekly interaction with supervisors that averages one hour per week of individual and/or triadic supervision throughout the practicum by (1) a counselor education program faculty member, (2) a student supervisor who is under the supervision of a counselor education program faculty member, or (3) a site supervisor who is working in consultation on a regular schedule with a counselor education program faculty member in accordance with the supervision agreement.
- I. Practicum students participate in an average of 1½ hours per week of group supervision on a regular schedule throughout the practicum. Group supervision must be provided by a counselor education program faculty member or a student supervisor who is under the supervision of a counselor education program faculty member.

## INTERNSHIP

- J. After successful completion of the practicum, students complete 600 clock hours of supervised counseling internship in roles and settings with clients relevant to their specialty area.
- K. Internship students complete at least 240 clock hours of direct service.
- L. Internship students have weekly interaction with supervisors that averages one hour per week of individual and/or triadic supervision throughout the internship, provided by (1) the site supervisor, (2) counselor education program faculty, or (3) a student supervisor who is under the supervision of a counselor education program faculty member.
- M. Internship students participate in an average of 1½ hours per week of group supervision on a regular schedule throughout the internship. Group supervision must be provided by a counselor education program faculty member or a student supervisor who is under the supervision of a counselor education program faculty member.

## SUPERVISOR QUALIFICATIONS

- N. Counselor education program faculty members serving as individual/triadic or group practicum/internship supervisors for students in entry-level programs have (1) relevant experience, (2) professional credentials, and (3) counseling supervision training and experience.
- O. Students serving as individual/triadic or group practicum/internship supervisors for students in entry-level programs must (1) have completed CACREP entry-level counseling degree requirements, (2) have completed or are receiving preparation in counseling supervision, and (3) be under supervision from counselor education program faculty.
- P. Site supervisors have (1) a minimum of a master's degree, preferably in counseling, or a related profession; (2) relevant certifications and/or licenses; (3) a minimum of two years of pertinent professional experience in the specialty area in which the student is enrolled; (4) knowledge of the program's expectations, requirements, and evaluation procedures for students; and (5) relevant training in counseling supervision.
- Q. Orientation, consultation, and professional development opportunities are provided by counselor education program faculty to site supervisors.
- R. Written supervision agreements define the roles and responsibilities of the faculty supervisor, site supervisor, and student during practicum and internship. When individual/triadic practicum supervision is conducted by a site supervisor in consultation with counselor education program faculty, the supervision agreement must detail the format and frequency of consultation to monitor student learning.

## **PRACTICUM AND INTERNSHIP COURSE LOADS**

- S. When individual/triadic supervision is provided by the counselor education program faculty or a student under supervision, practicum and internship courses should not exceed a 1:6 faculty:student ratio. This is equivalent to the teaching of one 3-semester credit hour or equivalent quarter credit hour course of a faculty member's teaching load assignment.
- T. When individual/triadic supervision is provided solely by a site supervisor, and the counselor education program faculty or student under supervision only provides group supervision, practicum and internship courses should not exceed a 1:12 faculty:student ratio. This is equivalent to the teaching of one 3-semester credit hour or equivalent quarter credit hour course of a faculty member's teaching load assignment.
- U. Group supervision of practicum and internship students should not exceed a 1:12 faculty:student ratio.
- V. When counselor education program faculty provide supervision of students providing supervision, a 1:6 faculty:student ratio should not be exceeded. This is equivalent to the teaching of one 3-semester or equivalent quarter credit hours of a faculty member's teaching load assignment.

# COAMFTE ACCREDITATION STANDARDS - EXCERPT

## INTERPRETATION GUIDE

### Rubric for Response

- Identify where and/or how the FCAs or ACAs are addressed in the curriculum.
- For Doctoral Programs and Post Degree Programs, demonstrate the course work that is offered and/or that students have completed course work, in all the areas contained in the foundational curriculum or that students demonstrate competence in those areas.
- For programs offering the Foundational Curriculum, provide a description of and rationale for the program's required integrative/capstone experience.
- For programs offering the Advanced Curriculum, describe how the balance of skills and competencies developed are appropriate to the program's mission, goals, and outcomes as well as the program's local context.

### Examples of Evidence/Documents

1. Syllabi
2. Chart connecting curriculum content with FCA and ACA areas
3. Policies and procedures for determining how doctoral and post-degree programs evaluate if students have fulfilled the Foundational Curriculum and evaluate competence.

### Key Element IV-C: Foundational and Advanced Application Components

The program must demonstrate they offer an application component with appropriate placement in the curriculum, duration, focus, and intensity consistent with their program's mission, goals, and outcomes.

### Foundational Practice Component

- Master's degree program and Post-degree programs that teach the foundational curriculum offer the foundational practice component (practicum and/or internship).
- Includes a minimum of 500 clinical contact hours with individuals, **couples, families** and other systems physically present, at least 40% of which must be relational. The 500 hours must occur over a minimum of twelve months of clinical practice. The 500 hours may include a maximum of 100 **alternative hours** or clinical activity (e.g., couple or family groups, live cases where reflecting teams are directly involved in working with clients, etc.) that is directly related to the program's mission, outcomes, and goals. Alternatively, the program may demonstrate that graduating students achieve a competency level equivalent to the 500 client contact hours. The program must define this competency level and document how students are evaluated and achieve the defined level. The program demonstrates a consistent set of evaluation criteria for achieving the defined level of competency across all students. In addition, programs that do not require 500 hours must document that students are informed about licensure portability issues that may result from not having 500 hours. Those programs requiring less than 500 hours may not use alternative hours to count toward total client contact hours.

- ☐ The program demonstrates a commitment to relational/systemic-oriented **supervision**. Students must receive at least 100 hours of supervision, and must receive supervision from an AAMFT Approved Supervisor or Supervisor Candidate for at least one hour each

week in which they are seeing clients. Additional supervision may be provided by AAMFT Approved Supervisors, Supervisor Equivalents, or State Approved Supervisors. Supervision can be **individual** (one supervisor with one or two supervisees) or **group** (one supervisor and eight or fewer students) and must include a minimum of 50 hours of supervision utilizing observable data. Supervision may utilize digital technology in which participants are not in the same location as long as the majority of supervision is with supervisor and supervisee physically present in the same location and appropriate mechanisms/precautions are in place to ensure the confidentiality and security of the means of technology delivery.

- Programs have agreements with practice sites that outline the institutions', the practice sites' and the students' responsibilities, and published procedures in place for managing any difficulties with sites, supervisors, or students.

### **The Advanced Practical Experience Component**

- ☐ **Programs** that teach the advanced curriculum must offer the advanced experience component.
- Areas include selected experiences consistent with the program's mission, goals, and outcomes in any of the following: **advanced research**, grant-writing, teaching, supervision, consultation, advanced clinical theory, clinical practice/innovation, program development, leadership, or policy. In addition, programs may offer experiences in presenting and professional writing.
- ☐ The program must demonstrate appropriate and adequate **mentoring** of students during the experience.
- ☐ The advanced experiences offered by doctoral degree programs must address a minimum of two of the areas noted above and combined be over a minimum of 9 months.
- ☐ The advanced experiences offered by post-graduate programs must address a minimum of one area and combined be over a minimum of 6 months.

## **INTERPRETATION GUIDE**

### **Rubric for Response**

- For Master's Degree Programs and Post-Degree Programs that teach the Foundational Curriculum, describe your program's requirements for meeting the Foundational Practice Component (FPC) for clinical contact hours.
- Describe how the application component's placement in the curriculum, duration, focus, and intensity is consistent with their program's mission, goals, and outcomes.
- Master's Degree Programs and Post-Degree Programs that teach the Foundational Curriculum and chose an equivalent competency level, rather than the required 500 clinical contact hours, must describe how the equivalency is defined and measured, what evidence the program has that students achieve a competency level that is equivalent to the same level of competency if they had required 500 client contact hours of all students in their program, how consistency of outcomes is assured across all students, how it relates to the program's mission, goals, and outcomes, and how students are informed about possible licensure portability issues related to the equivalency.

- For Master’s Degree Programs and Post-Degree Programs that teach the Foundational Curriculum, describe the program's commitment to relational/systemic-oriented supervision and how the standard's minimum supervisory requirements are accomplished, including specific description of digital technology's use when applicable.
- Describe how the program's agreements with practice sites accomplish the minimum requirements presented in the standard.
- For programs that teach the Advanced Curriculum, describe the Advanced Practice Component (APC) areas utilized by the program and verify that they include at least two from those presented by the standard with a duration of at least 9 months for a doctoral degree, or at least one with duration of 6 months for a post-graduate program.
- For programs that teach the Advanced Curriculum, demonstrate how students receive appropriate and adequate mentoring during the APC.

#### **Examples of Evidence/Documents**

1. Sample placement agreement forms
2. Documentation/program materials showing how student are informed of these program requirements.
3. Program manual/handbook
4. Program Policies and Procedures

#### **Key Element IV-D: Program and Regulatory Alignment**

The program demonstrates that graduates have met educational and clinical practice requirements (e.g., coursework, clinical experience, and supervision) that satisfy the regulatory requirements for entry-level practice in the state, province, or location in which the program physically resides or in which the student intends to practice. Programs must also document that students are informed (e.g., demonstrate review of appropriate regulatory sites or licensing laws) about the educational, clinical, and regulatory requirements for entry-level practice in the state, province, or location in which each student resides or intends to practice.

### **INTERPRETATION GUIDE**

#### **Rubric for Response**

- Provide program documentation and regulatory requirements for entry-level practice in the state or location the program resides.
- Describe how students are informed of these requirements.
- Describe how students are informed of the regulatory requirements in the state or location they plan to practice.

#### **Examples of Evidence/Documents**

1. Program manual/handbook
2. Documentation to show that students have been informed
3. Course assignments or projects

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## ATTACHMENT I

### APA DOCTORAL PROGRAM ACCREDITATION STANDARDS - EXCERPT

#### II.B.3 Required Practicum Training Elements.

- a. Practicum must include supervised experience working with diverse individuals with a variety of presenting problems, diagnoses, and issues. The purpose of practicum is to develop the requisite knowledge and skills for graduates to be able to demonstrate the competencies defined above. The doctoral program needs to demonstrate that it provides a training plan applied and documented at the individual level, appropriate to the student's current skills and ability, that ensures that by the time the student applies for internship the student has attained the requisite level of competency.
- b. Programs must place students in settings that are committed to training, that provide experiences that are consistent with health service psychology and the program's aims, and that enable students to attain and demonstrate appropriate competencies.
- c. Supervision must be provided by appropriately trained and credentialed individuals.
- d. As part of a program's ongoing commitment to ensuring the quality of their graduates, each practicum evaluation must be based in part on direct observation of the practicum student and her/his developing skills (either live or electronically).

#### Supporting Material:

- Upload REQUIRED TABLE: Download Table 4 Practicum Settings template. Use this template to provide required practicum information. Please label upload as - TABLE 4 Practicum Settings**

#### Focused Questions:

- Review: IR C-12 D: Practicum guidelines for doctoral programs and IR C-13 D: Telesupervision**
- Describe practicum sites in a narrative. The description should include the nature of the training provided, practicum availability, and the other content noted in II.B.3.**
- Discuss how the program ensures practicum evaluations are based in part on direct observation.**
- If students' practicum experiences utilize any amount of telesupervision, discuss how it is used and provide the reference for the policy addressing this supervision modality.**

#### II.B.4 Required Internship Training Elements

The program must demonstrate that all students complete a one year full-time or two year part-time internship. The program's policies regarding student placement at accredited versus unaccredited internships should be consistent with national standards regarding internship training.

- a. **Accredited Internships.** Students are expected to apply for, and to the extent possible, complete internship training programs that are either APA- or CPA-accredited. For students who attend accredited internships, the doctoral program is required to provide

only the specific name of the internship.

- b. **Unaccredited Internships.** When a student attends an unaccredited internship, it is the responsibility of the doctoral program to provide evidence demonstrating quality and adequacy of the internship experience. This must include information on the following: the nature and appropriateness of the training activities;
- i. frequency and quality of supervision;
  - ii. credentials of the supervisors;
  - iii. how the internship evaluates student performance;
  - iv. how interns demonstrate competency at the appropriate level;
  - v. documentation of the evaluation of its students in its student files.

Supporting Material:

- Upload REQUIRED TABLE: Download Table 5 Internship Placement template. Use this template to provide required placement information. Please label upload as - TABLE 5 Internship Placement**

Focused Questions:

- Review: IR C-17 D: Expected Internship Placements for Students in Accredited Doctoral Programs**
- Describe the program's policies, expectations of and requirements for internship placement.**
- If students do not complete an accredited internship, the program must provide the following:**
- a. the nature and appropriateness of the training activities;
  - b. frequency and quality of supervision;
  - c. credentials of the supervisors;
  - d. how the internship evaluates student performance;
  - e. how interns demonstrate competency at the appropriate level;
  - f. documentation of the evaluation of its students in its student files.

### **C-12 D. Practicum Guidelines for Doctoral Programs**

(formerly C-26; Commission on Accreditation, January 2010; revised November 2015)

Standard II.B.3 of the *Standards of Accreditation for Health Service Psychology* (SoA) for doctoral graduate programs identifies practicum as a required training element.

In reviewing practicum experiences within doctoral programs, the CoA looks to determine that the program is responsible for identifying how the practicum helps to realize the educational aims identified in the program's curriculum plan. This curriculum plan should

1. Include a clear statement of how practicum training provides opportunities for students to achieve and demonstrate profession-wide competencies, as well as any program-specific competencies for which practicum is a relevant curricular element.
2. Document outcome measures used within practicum to evaluate profession-wide and any relevant program-specific competencies ; and
3. Specify how practicum is clearly integrated with other elements of the program. This includes a description of how academic knowledge is integrated with practical experience through forums led by psychologists for the discussion of the practicum experience, as well as a description of how practicum training is sequential, cumulative and graded in complexity, and designed to prepare students for further organized training.

Further, each accredited doctoral program is expected to have clearly defined administrative policies and procedures in place for both internal and external practicum settings.

The guidelines below clarify the CoA's expectations as to how programs demonstrate and provide documentation of adherence to the required practicum training elements specified in Standard II.B.3 of the SoA during periodic program review (i.e., review of the program since its last self-study).

- The CoA recognizes that practicum training and experiences can include psychological testing, consultation, program development, outreach, and advocacy, as well as the use of evidence-based practice procedures and the ability to identify and use evidence-based procedures. The CoA also recognizes that not all interventions that may occur during practicum meet the definition of "empirically supported."
- When students are not being supervised on site by doctoral level psychologists, the program must provide on-going weekly opportunities for students to discuss their clinical work with a doctoral level psychologist appropriately credentialed for the jurisdiction in which the program is located.
- It is recognized that supervision on site can be provided by doctoral interns or post-doctoral fellows in psychology, under the supervision of a psychologist appropriately credentialed for the jurisdiction.
- The program should document how the program ensures the quality of the practicum sites, including regularly scheduled site reviews.
- The program should document the use of evaluation procedures for practicum experiences, methods for identifying strengths and weaknesses of practicum settings, and how a problem with a site is managed.
- The program should identify the administrative methods used to ensure that practicum placements meet these criteria and discuss how students are matched to these sites.
- The program should demonstrate how training and educational experiences are conducted in ways that integrate science and practice.
- The program's curriculum plan should provide clear evidence that practicum is integrated with other elements of the program.

- The program should discuss how it regularly evaluates the forum for the discussion of the practicum experience.
- The program should include a description of how it uses feedback from the clinical supervisors to address the progress, development, and competencies of the practicum student.
- The program should identify how the minimum acceptable level of achievement is defined and assessed, and identify policies for remediation or dismissal from a practicum site when this level of achievement is not met.
- The program should identify how the required practicum experiences are sufficient to prepare the students for internship.

**ATTACHMENT J - SAMPLE 4-WAY WRITTEN AGREEMENT**

**Please attach a photograph of yourself (passport size) at the time you submit this to the Counseling Department, Clinical Training Director.**

Attach head and shoulder photo here  
  
(affix with tape or staple only; do not use glue)

This document must be completed and on file in the Clinical Training Director's (CTD) office before the Trainee's hours may count towards MFT licensure! *California State University, Fullerton (CSUF) Department of Counseling has no authority to approve hours.* CSUF is only responsible for coordinating students' clinical experience and approving students to go into sites. Thus, we do our best to find sites whose clientele and methods of practice fall within the scope of the LMFT and LPCC license. Under penalty of perjury, supervisors attest that they are legally suitable to supervise MFT Trainees, and that they will insure that their Trainees practice within the law. We approve students' choices of sites and supervisors based upon the information provided to us by the site supervisor. *CSUF assumes no responsibility for the loss of hours caused by misstatements, incorrect information and/or negligence on the part of a supervisor and/or agency director.* Approval of hours is, and always has been, the purview of the Board of Behavioral Sciences (BBS). **NOTE:** Trainee hours, while required for graduation, do not count toward LPCC licensure as they are earned pre-degree.

**California State University, Fullerton**

Clinical Mental Health Counseling with a Specialty in Marriage and Family Therapy

Agreement between the

**QUALIFYING DEGREE PROGRAM, CLINICAL TRAINING DIRECTOR,  
SITE SUPERVISOR, AND MFT TRAINEE/CLINICAL COUNSELOR (CC) TRAINEE**

**"4-Way Agreement"**

Trainee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street, City & Zip Code: \_\_\_\_\_

\_\_\_\_\_ E-mail Address: \_\_\_\_\_

Phone (day): \_\_\_\_\_ Phone (evening): \_\_\_\_\_

Agency Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Agency E-mail Address: \_\_\_\_\_

**MFT LAW:** The California legislature would like the educators and supervisors of LMFT and LPCC students to work cooperatively in training their student/ trainees. Therefore, all hours of experience gained as a trainee shall be coordinated between the school and the site where the hours are being accrued. The school shall approve each site and shall have a written agreement with each site that details each party's responsibilities, including the methods by which supervision shall be provided. The agreement shall provide for regular process reports and evaluations of the student's performance at the site. "Process reports" refers to the monitoring of the student, as she or he learns to become an effective psychotherapist/counselor.

Instructions to the Student: First, read and sign this document. Second, take it to the director of your practicum site and to your clinical supervisor(s) to read and sign. Finally, take it to the CSUF Clinical Training Director (CTD). After the CTD has signed your agreement, the original will be placed in your file. If you would like a signed copy or copies of the original, please make an appointment with the Fieldwork Coordinator – Counseling (FCC) to arrange to pick up your original so you can make copies. **Note:** The completed "4-Way Agreement" must be turned in before supervised clinical hours are begun, in order to count for practicum experience hours.

<b>Clinical Training Director</b>	<b>Office</b>	<b>Phone#</b>	<b>Mailbox Location</b>
Mary M. Read, Ph.D.	EC-484	(657) 278-2167	EC-405
<b>Fieldwork Coordinator - Counseling</b>			
Nicole Folmer, M.S.	EC-479C	(657)278-7454	EC-405

Please note: You are responsible for retaining the original of this and all documents described within this agreement, should the BBS request them. CSUF cannot be responsible for providing you with additional copies. The "4-Way Agreement" is proof to the BBS that CSUF and you have complied with state law. You **must** notify your CTD upon early termination at your agency should that circumstance arise. You are required to have evaluations and Experience Verification forms completed and turned into the CTD for placement in your file.

**SECTION I RESPONSIBILITIES OF THE PARTIES (Students are responsible for reading all sections of this agreement.)**

CSUF, Department of Counseling, the QUALIFYING DEGREE PROGRAM:

- a. Shall approve the placement of each trainee at the supervised practicum setting;
- b. Shall have this written agreement with the supervised practicum setting, supervisor and trainee that details each party's responsibility, including the methods by which supervision will be provided;
- c. Shall provide forms for regular evaluations of the student's performance at each supervised practicum setting;
- d. Shall coordinate the terms of this agreement with each of the named parties;
- e. Shall evaluate the appropriateness of the supervised practicum experience for each trainee in terms of the educational objectives, clinical appropriateness and scope of the license of a Professional Clinical Counselor (LPCC) or a Marriage and Family Therapist (LMFT) as set forth in the California Business and Professions Code;
- f. Shall require that each student gaining clinical hours in a supervised practicum setting procure their own individual professional malpractice liability insurance coverage;

- g. Shall have a designated liaison to the practicum setting and clinical supervisors called the Clinical Training Director, who shall assume major responsibility for the coordination of this arrangement between students and clinical training sites in the Counseling Department's catchment area.

\_\_\_\_\_ Initials of the Clinical Training Director, CSUF, Department of Counseling

#### THE SUPERVISED PRACTICUM SITE/AGENCY DIRECTOR

- a. Shall provide the trainee and the supervisor with the documentation necessary to verify to the Board of Behavioral Sciences (BBS) that the placement is one that is named in law as appropriate for an MFT Trainee or Clinical Counselor Trainee and that the trainee is employed in the manner required by law. Such documentation, specified by the LMFT Experience Verification Form and by the BBS regulations for CC trainees may include but is not limited to the agency's 501c3, 1250, 1250.2 or 1250.3. A copy of this documentation is kept on file in the CTD office;
- b. Shall evaluate the qualifications and credentials of any employee who provides supervision to MFT or Clinical Counselor trainees;
- c. Shall provide adequate resources to the trainee and the supervisor in order that they may provide clinically appropriate services to clients;
- d. Shall orient the trainee to the policies and practices of the agency;
- e. Shall notify the qualifying degree program in a timely manner of any difficulties in the work performance of the trainee;
- f. Shall provide the trainee and the supervisor with an emergency response plan which assures the personal safety and security of trainee, supervisor and trainee's clients in the event of a fire, earthquake or other disaster;
- g. Shall provide the trainee with experience within the scope of practice of a Professional Clinical Counselor or Marriage and Family Therapist;

**Note:** The minimum requirement is 280 hours of direct client contact (DCC) per practicum year, related to the following guidelines:

1. An average of seven (7) direct client contact hours per week;
  2. one (1) hour of individual supervision per five (5) hours of client contact and two (2) hours of group supervision, with no more than 8 trainees or one (1) hour of individual supervision for client contact hours that exceed five (5) hours but do not exceed ten (10) client contact hours. If client contact hours exceed ten (10) hours per week, student will be provided appropriate supervision as stipulated by BBS regulations;
  3. additional activities may include: additional group supervision, staff meetings, case conferences, case management, seminars, and documentation (note writing);
- h. Shall be familiar with the laws and regulations that govern the practice of licensed Professional Clinical Counselors or licensed Marriage and Family Therapists in the State of California, and in particular, those that directly affect the MFT or CC trainee;
  - i. Shall provide the qualifying degree program with a photocopy of the current license of each supervisor who will be supervising the degree program's trainees;

- j. Shall provide the qualifying degree program with whatever documents are necessary to assure that the trainee's performance of duties conforms to BBS laws and regulations;
- k. Shall notify the qualifying degree program and the trainee of change of address, phone, ownership, or any other status that may affect the ability of the trainee to count hours gained at the practicum setting;
- l. Permit in-vivo supervision by the practicum supervisor, as needed;
- m. Provide access for the trainee to video record current clinical cases for practicum class review.

\_\_\_\_\_ Initials of the Representative of the Practicum Site

## THE SUPERVISOR

- a. Shall sign and abide by the "Responsibility Statement for Supervisors of the MFT License" as described in the California Code of Regulations (CCR); The supervisor is responsible to the BBS for the trainee's legal practice as a trainee. [NOTE: There is no equivalent form for LPCC supervision, being pre-degree.];
- b. Shall be responsible for assuring that all clinical experience gained by the trainee is within the parameters of marriage and family therapy;
- c. Will have been licensed for at least two years in California as a marriage and family therapist, professional clinical counselor, clinical social worker, psychologist or physician who is certified in psychiatry by the American Board of Psychiatry and Neurology;
- d. Will have completed and remained current with the appropriate "supervisor" continuing education requirements required by the BBS;
- e. Shall review and sign the "Weekly Summary of Hours of Experience" log on a weekly basis;
- f. Shall complete the "LMFT Experience Verification Form" upon termination of trainee's supervision, the totals of which should match the totals of the collected Weekly Summary of Hours of Experience;
- g. Shall describe in writing on Section II of this document the methods by which supervision will be provided;
- h. Shall provide regular process reports and evaluation of the student's performance at the site to the qualifying degree program at the middle and end of each semester (approximately twice per 15 weeks);
- i. Shall provide the trainee with one (1) hour of individual for five (5) hours of client contact provided by the trainee and one (1) hour of individual or two (2) hours of group supervision for client contact hours that exceed the five (5) hours but do not exceed ten (10) hours. If client contact hours provided by student exceed ten (10) hours, then supervision will be provided as stipulated by BBS regulations. This may be averaged over a period of 14 weeks;

**IMPORTANT:** Although client contact hours may be averaged across each semester, supervision may not. In other words, trainees *must* have either one hour of individual or two hours of group each week that they see clients. No hours of *any* kind will count if supervision has not occurred during the week they were claimed. The Department of Counseling at CSUF requires that both individual and group supervision be provided every week of the 15-week semester, even when this exceeds the BBS requirement.



- j. Shall abide by the ethical standards promulgated by the professional association to which the supervisor belongs (e.g., AAMFT, CALPCC, CAMFT, ACA, NASW, APA, AMA etc.);
- k. Shall provide the agency with a current copy of his or her current license and resume and notify the qualifying degree program and the trainee immediately of any action that may affect his or her license;
- l. Shall be familiar with the laws and regulations that govern the practice of Professional Clinical Counselor or Marriage and Family Therapy in the State of California, and in particular, those that directly affect the MFT or CC trainee;
- m. Shall provide the trainee with a policy and procedure for crisis intervention and other client/ clinical emergencies, in particular those that are mandated by law (e.g., child abuse, danger to self, others, etc.);
- n. Shall, if providing supervision on a voluntary basis attach the original written agreement between you (the supervisor), and the trainee's employer as required by the BBS;
- o. Shall complete all the required trainee evaluation forms (due at mid-semester and finals week) by their prescribed time.

\_\_\_\_\_ Initials of Clinical Site Supervisor

#### THE TRAINEE

- a. Shall have each supervisor complete and sign the "Responsibility Statement for Supervisors of the LMFT License" before gaining supervised experience. Trainees are to retain this original, signed document in order to send this form to the BBS when required. All trainees, however, must file a copy of this form with the CSUF Clinical Training Director. The trainee must verify that the supervisors' license is current (see note);
 

**Note:** A supervisor's license can be verified by contacting the BBS by telephone or via the Internet. The BBS website address is <http://www.bbs.ca.gov>. Click on "verify license" for LPCCs, LMFTs, or LCSWs and check that the supervisor's license is current. For a Licensed Psychologist, contact the Board of Psychology via phone or the Internet at <http://www/dca.ca.gov/psych>.
- b. Shall maintain a weekly log of all hours of experience gained toward licensure;
- c. Shall be responsible for learning those policies of the supervised practicum setting which govern the conduct of regular employees and trainees, and for complying with such policies;
- d. Shall be responsible for participating in the periodic evaluation of his or her supervised practicum experience and delivering it to the qualifying degree program;
- e. Shall be responsible for notifying the qualifying degree program in a timely manner of any professional or personal difficulties which may affect the performance of his or her professional duties and responsibilities;
- f. Shall abide by the ethical standards of the Board of Behavioral Sciences and the professional association of which the student is a member (e.g., AAMFT, CALPCC, ACA, CAMFT) and the CSUF Department of Counseling ethical/legal guidelines (see the Clinical Training Handbook).

- g. Shall have completed all prerequisite courses for COUN 530 Beginning Practicum, before providing supervised psychotherapeutic services to clients. If the student has not completed all prerequisite courses, he or she shall obtain written permission from the Clinical Training Director and the Site Supervisor acknowledging this fact. This letter must be filed with the Clinical Training Director;
- h. Shall be aware that the qualifying degree program requires that she or he obtain individual professional liability insurance coverage while working in a clinical placement. Student rate malpractice coverage can be obtained through professional associations (e.g., ACA, CAMFT);
- i. Shall gain a total number of 280 direct client contact (DCC) hours as required for nine units of practicum. These hours have been supervised during the week they were gained and supervision must average to a 5:1 ratio over the practicum year;
- j. Shall be aware that **practicum is a COURSE**, and to receive a passing grade for this course, the following criteria must be met:
  - 1. the student must attend the practicum classes and gain hours at an approved clinical placement *concurrently*; that is, at the same time;
  - 2. the student must have earned the required number of hours (item i above);
  - 3. the supervisor's evaluations and process reports must be favorable;
  - 4. the practicum instructor's evaluation must be favorable;
  - 5. no other data exists that questions the student's suitability for the psychotherapy/counseling profession and for the license of marriage and family therapist.

\_\_\_\_\_Initials of the Trainee

## SECTION II METHODS OF SUPERVISION

The supervisor shall monitor the quality of counseling or psychotherapy performed by the trainee by direct observation, audio or video recording, review of progress and process notes or records or by any other means deemed appropriate by the supervisor, and furthermore that the supervisor shall inform the trainee prior to the commencement of supervision of the methods by which the supervisor will monitor the quality of counseling or psychotherapy being performed.

Instructions to Supervisor: Section II of this agreement will serve to inform the trainee about the methods you will use to monitor the quality of his or her performance with clients. (Note: Supervision *must* include direct observation or audio or video recording).

Check all that apply:

\_\_\_\_\_ Direct Observation

\_\_\_\_\_ Student Verbal Report

\_\_\_\_\_ Audio Tape

\_\_\_\_\_ Role Play

\_\_\_\_\_ Video Recording

\_\_\_\_\_ Other (Describe)\_\_\_\_\_

\_\_\_\_\_ Evaluate Trainee's Process and Progress Notes

**SECTION III ADDITIONS**

a. TERMINATION

The expectation of all parties is that this agreement will be honored mutually. Termination of this agreement *with cause* shall be in accordance with the academic policies of the qualifying degree program or the employment or volunteer policies of the supervised practicum setting. Any party may terminate this agreement *without cause* by giving all other parties 30 days’ notice of the intention to terminate. Termination of the trainee’s or supervisor’s employment under terms of this agreement must take into account the clinical necessity of an appropriate termination or transfer of psychotherapeutic clients. In any case, it is assumed that if there is an early termination of this agreement on the part of the trainee, the supervised fieldwork setting or the supervisor, such a decision must include prior consultation with the qualifying degree program.

b. CHANGES IN THE AGREEMENT

This agreement must be amended in writing and signed by each party.

c. INDEMNIFICATION

The qualifying degree program requires that each student trainee procure individual professional liability malpractice insurance coverage before working with clients in a supervised practicum setting. The supervised practicum setting assumes all risk and liability for the student’s performance of services while at the supervised practicum setting.

**SECTION IV ADDITIONAL TERMS AND COMMENTS**

(This space is to be used for additional notes on the student’s clinical training experience.)

**SECTION V TERM OF THE AGREEMENT**

**Note to Agency:** Please review with the trainee their time commitment to your agency. Fill in the dates below, using the date you and the trainee entered into this agreement and the approximate date you expect the trainee to leave. **Important:** Agency Director, please initial agreement next to commitment dates.

FROM \_\_\_\_\_ (Date this agreement is valid) \_\_\_\_\_ (Initials) TO \_\_\_\_\_ (Date trainee expected to leave agency) \_\_\_\_\_ (Initials)

**SECTION VI SIGNATURES**

By signing this form, you are indicating that you have read, understood, and agreed to the terms specified.

<b>I. Representative of the Placement Site:</b>	
_____	
Name (please print)	Title
_____	
Signature	
_____	
<b>II. Primary Site Supervisor:</b>	<b>Initials of other supervisors:</b> _____
_____	
Name (please print)	Title
_____	
Signature	Date
_____	
<b>Note:</b> Write license number for each license held:	
License(s) held: #	
_____ LMFT	_____ Psychologist*
_____ LCSW	_____ Psychiatrist (M.D.)
_____ LPCC	
_____	
<b>III. Trainee:</b>	
_____	
Name (please print)	CWID#
_____	
Signature	Date
_____	
<b>IV. For qualifying degree program: CSUF Clinical Training Director</b>	
_____	
Name (please print)	
_____	
Signature	Date
_____	

\*Please note that Licensed Educational Psychologists (LEPs) cannot supervise MFT or CC Trainees.  
**REMINDER to the Trainee:** Please distribute signed photocopies to those who sign above, filing the original with the Department of Counseling, Clinical Training office. **The Original "4-Way Agreement" must be kept on file with the Department of Counseling, Clinical Training office, for practicum hours to count.**

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

**To:** Exempt Setting Committee Members                      **Date:** February 21, 2018  
**From:** Christy Berger  
Regulatory Analyst    **Telephone:** (916) 574-7817  
**Subject: Report on Meeting with Nonprofit and Charitable Organizations Providing  
Clinical Mental Health Services**

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On January 25, 2018, Kim Madsen, Steve Sodergren, Rosanne Helms and Christy Berger met with representatives from four nonprofit and charitable (501c3) organizations whose primary function is to provide clinical mental health services to the community. The purpose was for staff to learn more about how these settings function, the populations they serve, how they are funded, how they are staffed, and the challenges they face as well as their successes.

- Southern California Counseling Center – Serves 4,500 clients per year
- Open Paths Counseling Center – Serves over 800 clients per year
- The Maple Center – Serves 1,800 clients per year
- Airport Marina Counseling Service – Serves “hundreds of clients per week”

#### **Clients and Services Provided**

These agencies serve a range of clients who are typically from underserved communities. While the Affordable Care Act has expanded the availability of mental health services, some insurance plans have high deductibles and co-pays that are not affordable. In addition, agencies provide services to undocumented individuals who often do not have insurance. Some agencies have waiting lists for services. The agencies provide a variety of services, including individual, couple, family and group psychotherapy, school-based counseling and client education. Two clinics also have a psychiatrist available.

#### **Funding**

These agencies are primarily funded by:

- Client fees (sliding scale)
- Individual donations
- Corporate donations
- Government funding

Note that two of the agencies do not take government funding, as it allows for greater flexibility in how services are provided to clients.

### **Staffing**

All of the agencies have an extensive training program for pre-licensed students and registrants. The training programs focus in-depth on clinical topics beyond what is covered in the schools. Most of the licensed supervisors are off-site volunteers.

Two of the agencies also have peer counselors in addition to students and registrants, who are critical to their programs because they are often better able to reach clients that traditional therapy/therapists are unable to reach. There is often a lack of trust that peer counselors are able to bridge because they typically come from a similar background/culture, have similar life experiences, or speak their language. These agencies have an extensive training process for their peer counselors, as well as supervision.

All of the agencies perform a background check on their counselors, including fingerprinting.



Board of Behavioral Sciences

# Memo

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Sacramento, CA 95834  
(916) 574-7830, (916) 574-8625 Fax  
[www.bbs.ca.gov](http://www.bbs.ca.gov)

**To:** Exempt Setting Committee Members      **Date:** February 20, 2018  
**From:** Christy Berger  
Regulatory Analyst      **Telephone:** (916) 574-7817  
**Subject: Survey Results: Exempt and Private Practice Settings**

The survey regarding exempt and private practice settings received 1,383 total responses as of February 1, 2017. This survey was voluntary and anonymous. The Board requested the participation of its licensees and registrants, as well as exempt setting agency directors. A link to the survey was provided on the home page of the BBS website and promoted via the BBS listserv. Each of the professional associations, as well as the California Council of Community Behavioral Health Agencies (CCCBHA) assisted in promoting the survey. Staff also performed a search using GuideStar<sup>1</sup>, which is a database of non-profits, and contacted those agencies directly to ask them to respond.

## **Survey Results**

The full survey results are provided in the Attachment. The first few questions of the survey were aimed at obtaining more information about work settings in general. The remainder of the survey was specific to “exempt” settings. Notable findings are as follows:

### **Survey Results Re: General Work Settings**

1. The majority of survey respondents are LCSW and LMFT licensees (68%).
2. The majority of the survey respondents were currently and primarily working in either a nonprofit and charitable entity (28%), a private practice (23%), or a County/City agency (14%) (*Question 2*).
3. The main focus or purpose of the vast majority of settings where the respondents work is a mental health clinic/counseling center. Other settings in the top 5 were: a family and/or children’s services program; a case management program; or, a school setting (*Q5*).
4. The vast majority of funding for exempt settings comes from state, federal and local government. The #2 funding source was private payment. (*Q6*)

<sup>1</sup> *Criteria used were a minimum revenue of \$5,000, a Federal Tax Form 990 (an IRS form for tax-exempt organizations), and that the organization provides mental health services.*

5. 36% of respondents currently work in an exempt setting that allows “clinical services” (*defined as assessment, diagnosis and/or treatment*) to be provided by employees or volunteers who are NOT seeking licensure as a mental health professional (Q8).
  - Note: Several respondents indicated that the definition of an individual “not seeking licensure as a mental health professional” could be interpreted as including an already licensed mental health professional, or a credentialed school psychologist/counselor. This may have affected survey responses for a small number of individuals.

**Only those who responded that they currently work in an exempt setting were asked to complete the remainder of the survey. 244 respondents continued on.**

**The remainder of this memo will use the term “paraprofessional counselors” to refer to *individuals who provide clinical services who may not be seeking licensure.***

### Survey Results Re: Exempt Settings

6. 38% of respondents work in a region where there is a shortage of licensed mental health providers (Q10).
7. 67% of respondents work in a setting that requires paraprofessional counselors to be “license-eligible” (e.g., *have completed a degree program eligible for licensure*) (Q11).
8. 17% of respondents work in a setting that requires paraprofessional counselors to have personal experience either as a mental health consumer or as a family member of a consumer (Q11).
9. For the settings that specify educational requirements for paraprofessional counselors, 46% require either a Master’s or Bachelor’s degree at minimum (Q12).
10. 54% of respondents felt that the clinical services provided by paraprofessional counselors typically do meet the same basic minimum standards as the clinical services provided by a licensee (Q13).
11. 84% of settings where the respondents work require a fingerprint check for all individuals performing clinical services (Q15).
12. 66% of settings where the respondents work require a licensed mental health professional to provide supervision to paraprofessional counselors. In 61% of the settings, those supervisors are required to work on site (Q16/17).
13. 56% of settings where the respondents work assign a maximum of five (5) paraprofessional counselors to each clinical supervisor (Q18).



14. 85% of settings where the respondents work provide a formal mechanism for consumers to submit complaints about the therapist or clinical services received. 70% believe that complaints are addressed appropriately. (Q19/21).
15. 37% of respondents indicated that they believe certain settings should NOT continue to be exempted from mental health professional licensure requirements, and 31% were not sure. A significant amount of insight can be gleaned on both sides of the issue by reading the written responses to this question (Q22). The written responses can be loosely categorized into the following themes (listed in order of frequency):
- NO - Settings should not be exempt due to a lack of clinical competence/lacking standards of care and the resulting risk to consumers **(29 comments)**
  - YES – Settings should remain exempt due to a lack of funding for exempt settings/cost to become licensed **(17 comments)**
  - YES – Settings should remain exempt because it is important to have peer counselors who are from the client’s community (culture, language, life experiences) **(12 comments)**
  - YES – Settings should remain exempt due to a shortage of licensed mental health professionals willing/able to work in the setting or region **(11 comments)**
  - YES, BUT – Settings should remain exempt, but there should be clinical supervision, training and/or ethical standards for unlicensed staff. **(10 comments)**
  - NO - Settings should not be exempt because most legal and ethical standards only apply to licensed/registered clinicians. **(9 comments)**

Note: 15 respondents who wrote a “NO” comment expressed concerns about the exemption of school settings.

### **Recommendation**

Based on the results of the survey, the Committee may wish to discuss whether there is a need to develop standards regarding the provision of clinical services by unlicensed/unregistered individuals in exempt settings, and the possible impacts of those options.

### **Attachment**

Exempt and Private Practice Settings Survey Results

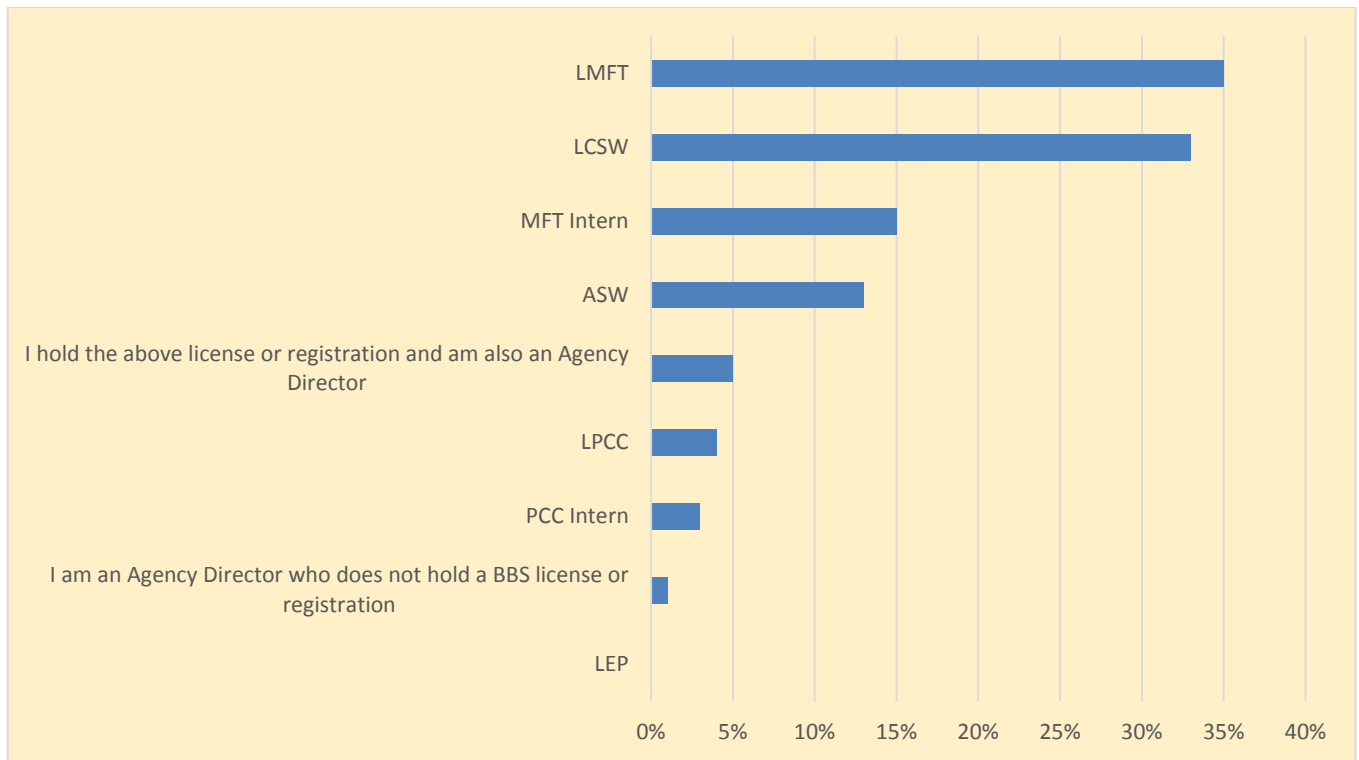
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# BBS EXEMPT SETTINGS SURVEY RESPONSES

1,383 Total Respondents  
as of 02/15/2018

## 1. What type of license or registration do you hold with the BBS? *(Mark all that apply)*

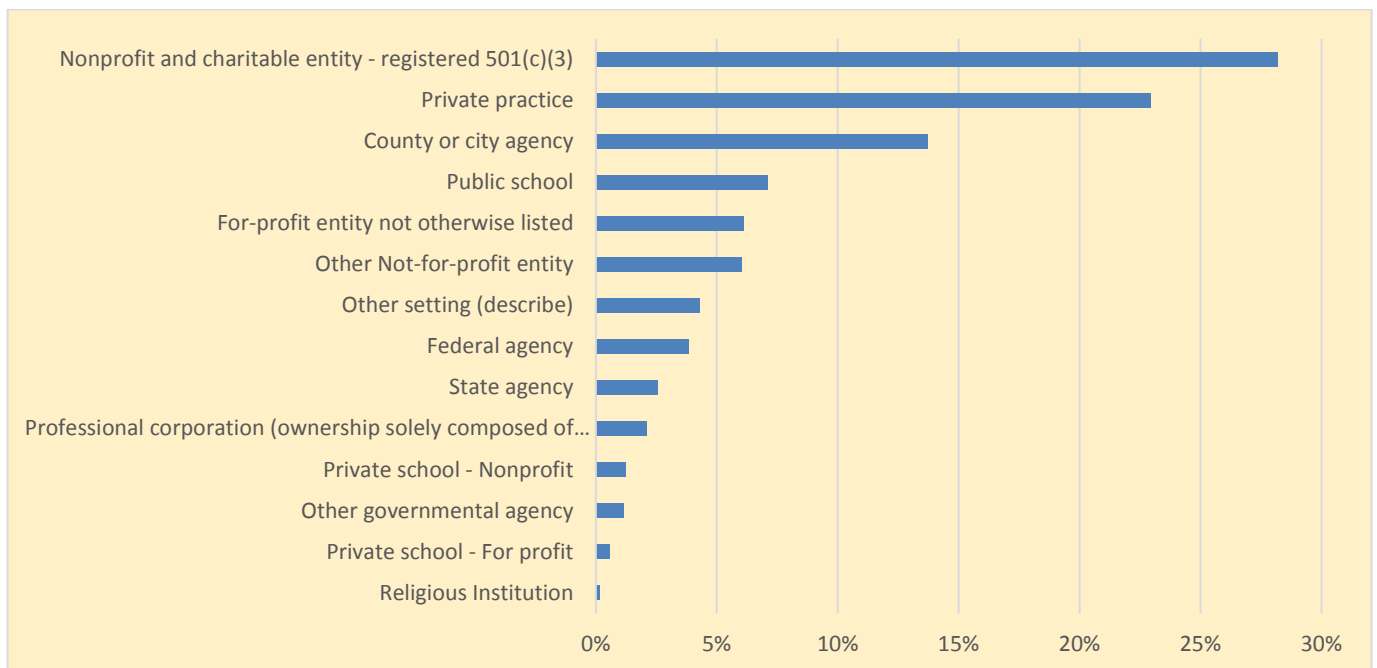
Answer Choices	Percent	Number
LMFT	35%	485
LCSW	33%	461
MFT Intern	15%	206
ASW	13%	181
I hold the above license or registration and am also an Agency Director	5%	64
LPCC	4%	60
PCC Intern	3%	43
I am an Agency Director who does not hold a BBS license or registration	1%	12
LEP	0%	4



**2. Which of the following best describes the CURRENT, PRIMARY setting in which you perform one or more of the following?**

- Provide clinical services (defined as assessment, diagnosis, and/or treatment);
- Provide clinical supervision; and/or
- Serve as an agency director.

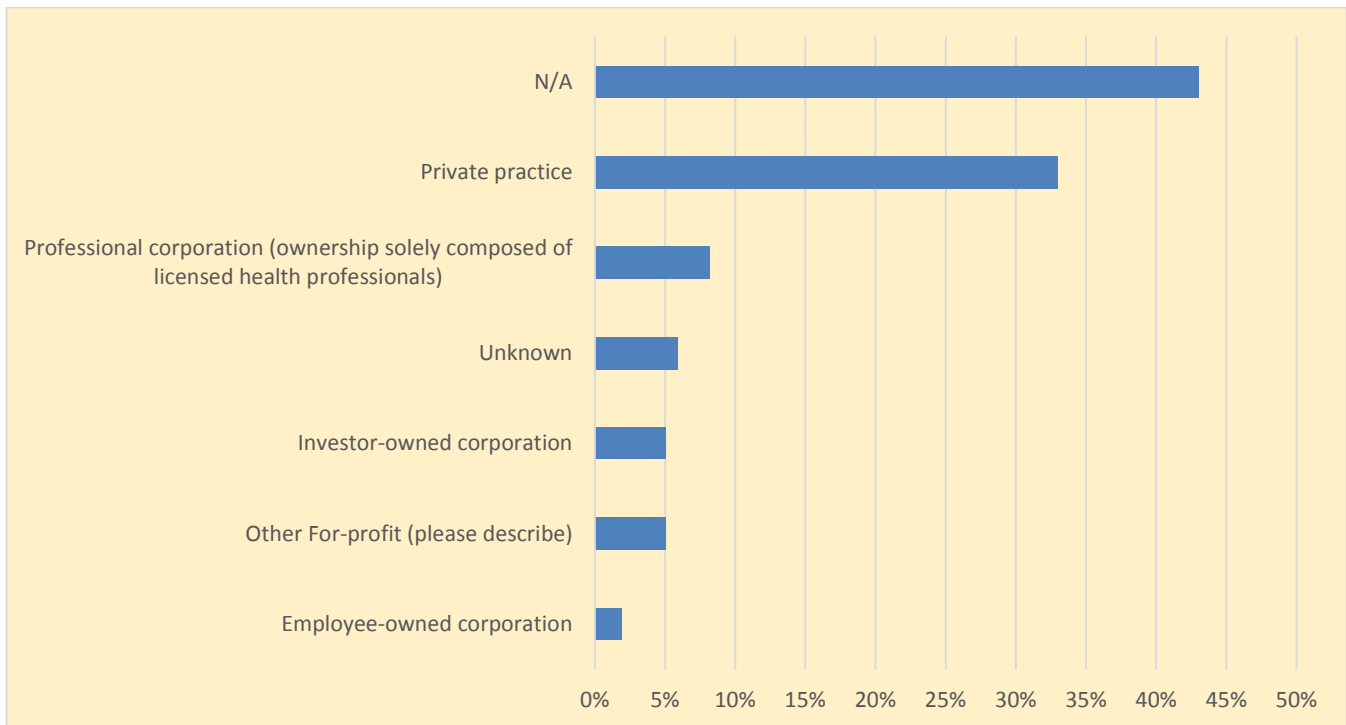
Answer Choices	Percent	Number
Nonprofit and charitable entity - registered 501(c)(3)	28%	388
Private practice	23%	316
County or city agency	14%	189
Public school	7%	98
Other Not-for-profit entity	6%	83
For-profit entity not otherwise listed	6%	84
Federal agency	4%	53
Other setting (describe)	4%	59
State agency	3%	35
Professional corporation (ownership solely composed of licensed health professionals)	2%	29
Private school - For profit	1%	8
Other governmental agency	1%	16
Private school - Nonprofit	1%	17
Religious Institution	0%	2



**3. Question Omitted** – The question appears to have been misunderstood. It asked, “If you answered “Other Not-for-profit entity” in question 2, please describe the type of nonprofit structure, if known.” Nearly all respondents described the purpose of the setting or the client population, rather than the nonprofit “structure.”

**4. If the setting is a for-profit entity, what is the ownership structure? (Mark all that apply)**

Answer Choices	Percent	Number
N/A	43%	350
Private practice	33%	268
Professional corporation (ownership solely composed of licensed health professionals)	8%	68
Unknown	6%	49
Other For-profit (please describe)	5%	37
Investor-owned corporation	5%	42
Employee-owned corporation	2%	16

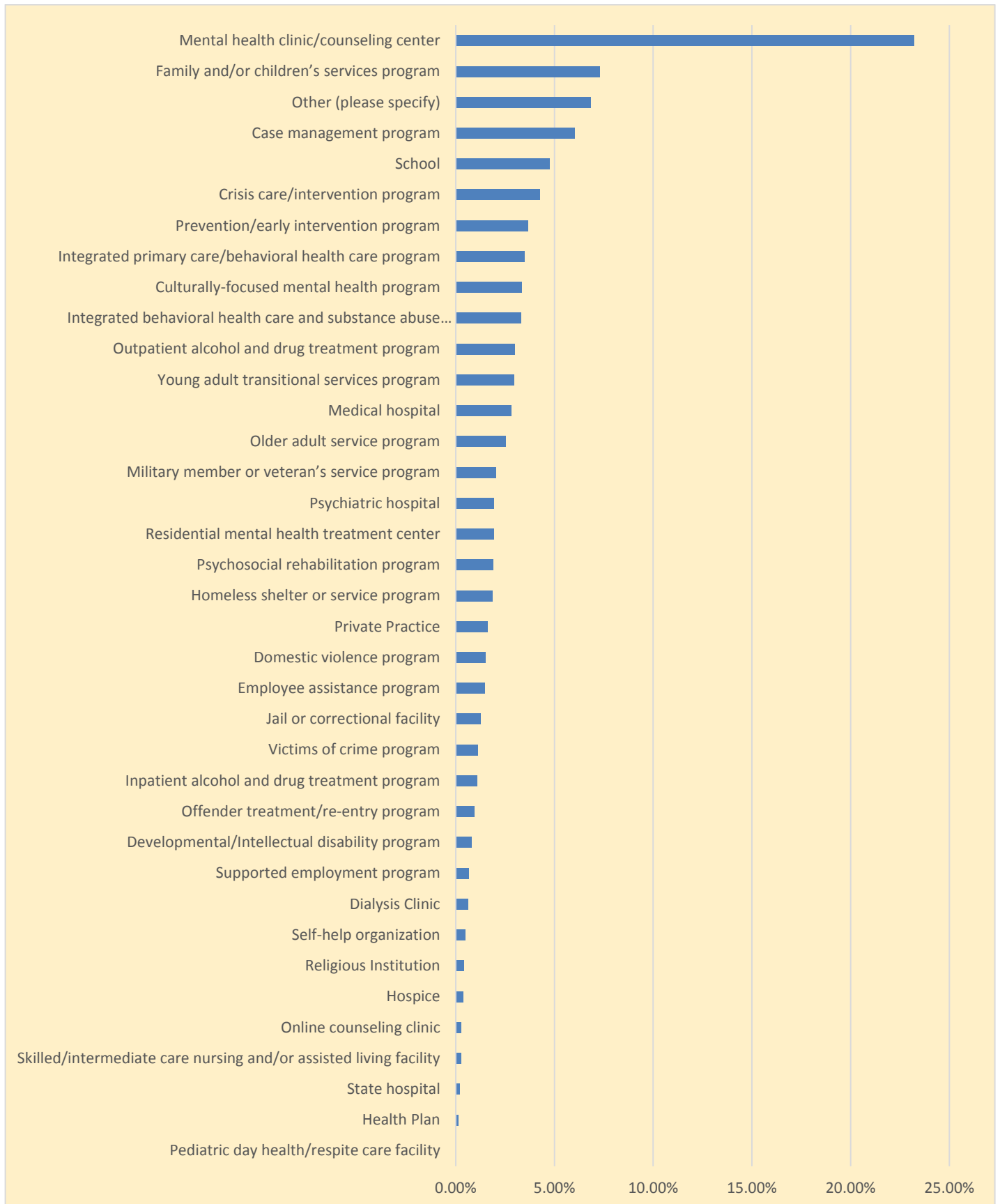


## 5. What is the main focus/purpose of this setting? (Mark all that apply)

Answer Choices	Responses	
Mental health clinic/counseling center	23.22%	719
Family and/or children's services program	7.30%	226
Other (please specify)	6.85%	212
Case management program	6.01%	186
School	4.75%	147
Crisis care/intervention program	4.26%	132
Prevention/early intervention program	3.65%	113
Integrated primary care/behavioral health care program	3.49%	108
Culturally-focused mental health program	3.33%	103
Integrated behavioral health care and substance abuse treatment program	3.29%	102
Outpatient alcohol and drug treatment program	2.97%	92
Young adult transitional services program	2.94%	91
Medical hospital	2.81%	87
Older adult service program	2.52%	78
Military member or veteran's service program	2.03%	63
Residential mental health treatment center	1.91%	59
Psychiatric hospital	1.91%	59
Psychosocial rehabilitation program	1.87%	58
Homeless shelter or service program	1.84%	57
Private Practice	1.61%	50
Domestic violence program	1.49%	46
Employee assistance program	1.45%	45
Jail or correctional facility	1.26%	39
Victims of crime program	1.10%	34
Inpatient alcohol and drug treatment program	1.07%	33
Offender treatment/re-entry program	0.94%	29
Developmental/Intellectual disability program	0.77%	24
Supported employment program	0.65%	20
Dialysis Clinic	0.61%	19
Self-help organization	0.48%	15
Religious Institution	0.42%	13
Hospice	0.36%	11
Skilled/intermediate care nursing and/or assisted living facility	0.26%	8
Online counseling clinic	0.26%	8
State hospital	0.19%	6
Health Plan	0.13%	4
Pediatric day health/respite care facility	0.03%	1

## 5. What is the main focus/purpose of this setting? (Mark all that apply)

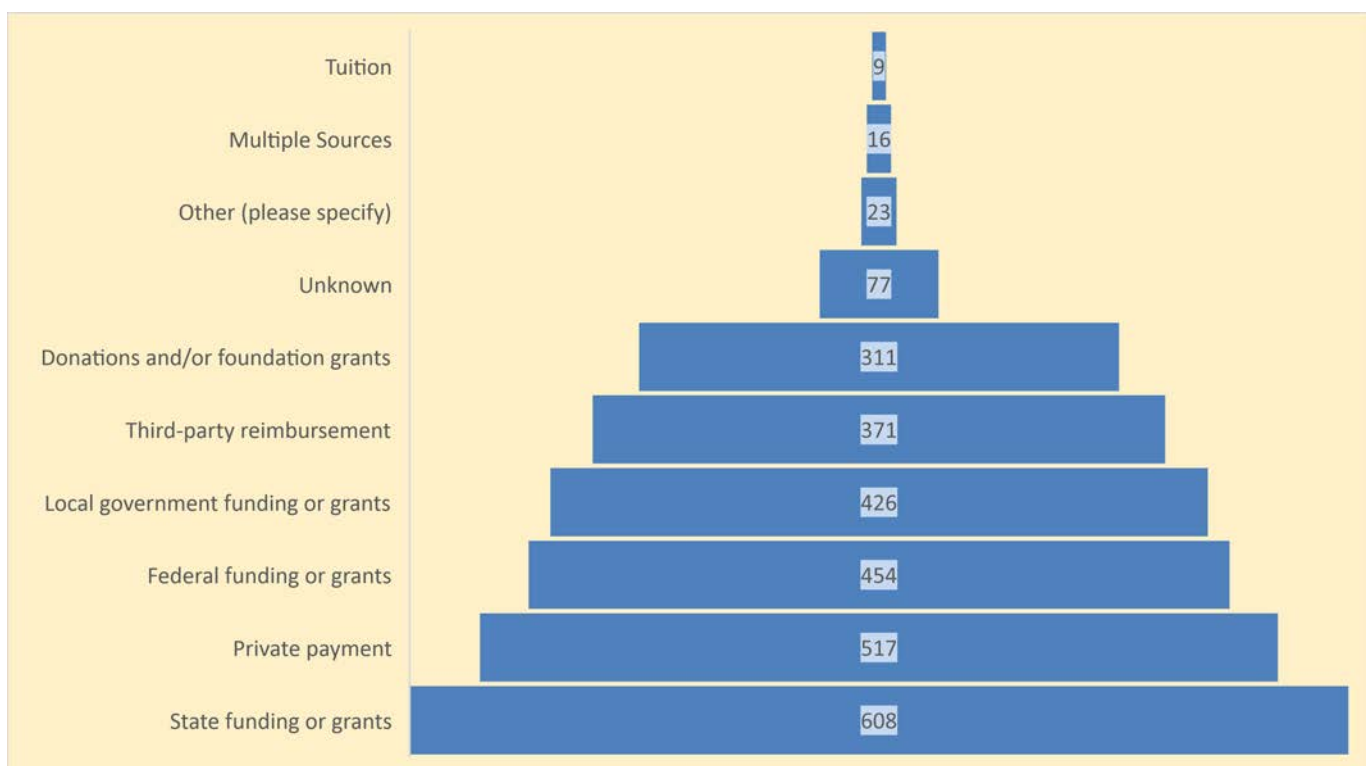
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## 6. How is this setting and/or program funded? (Mark all that apply)

Answer Choices	Responses	
Private payment	517	18%
Federal funding or grants	454	16%
Local government funding or grants	426	15%
Third-party reimbursement	371	13%
Donations and/or foundation grants	311	11%
Unknown	77	3%
Other (please specify)	23	1%
Multiple Sources	16	1%
Tuition	9	0%

*Note: There may be some overlap between the responses for government funding and “Third-party reimbursement” – for example, it was brought to our attention that Medi-Cal could fall under both “State funding” and “Third-party reimbursement”.*

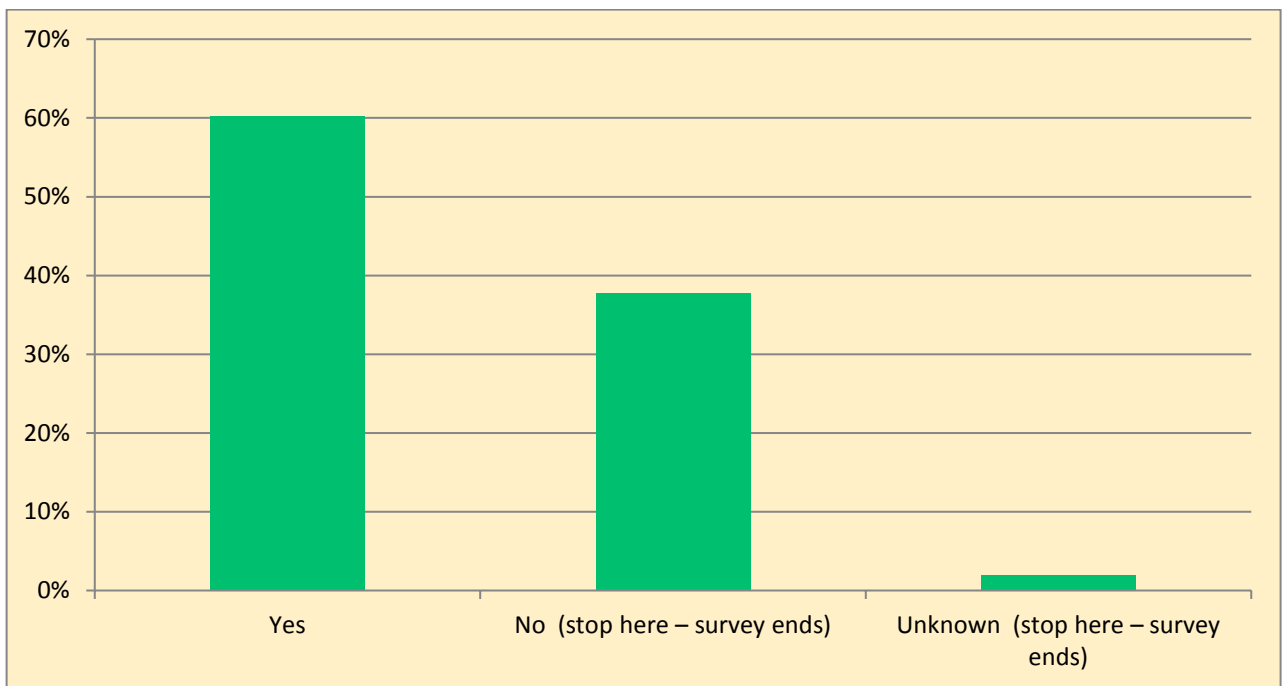




## 7. Is the setting any of the types listed below?

- Public school
- Private school
- Religious institution
- Federal agency
- State agency
- County or city agency
- Other governmental agency
- Nonprofit and charitable entity - registered 501(c)(3)

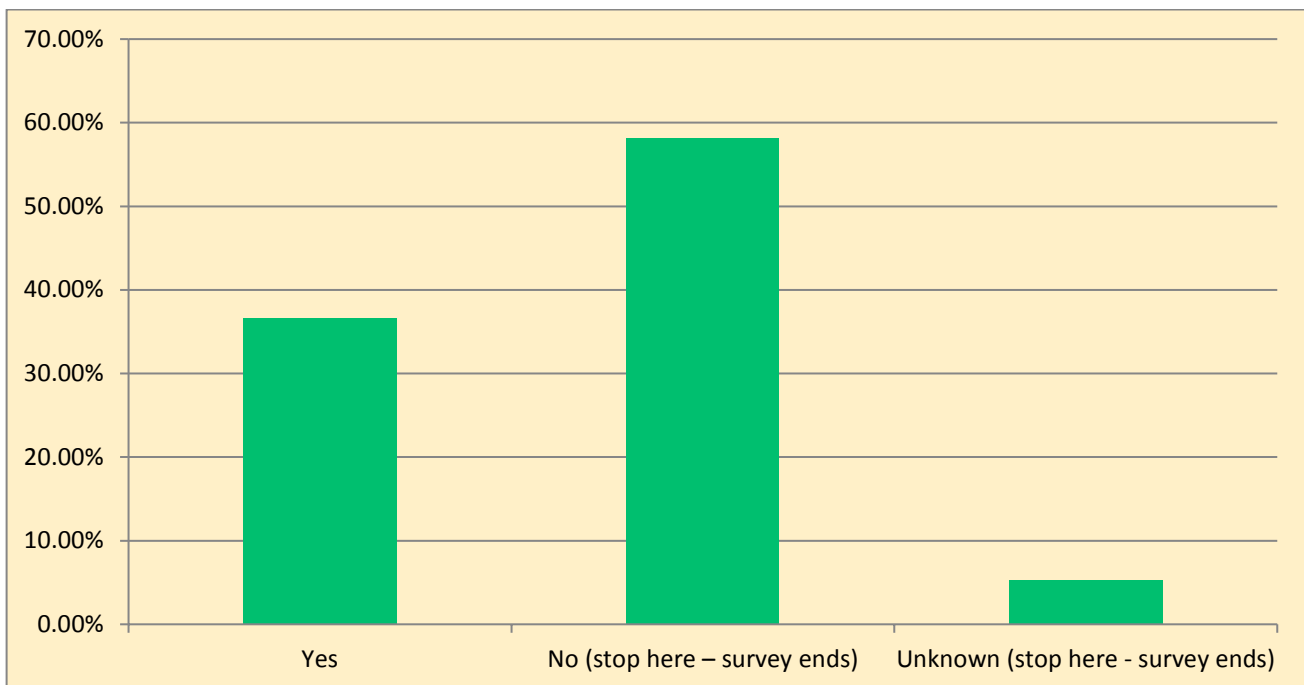
Answer Choices	Responses	
Yes	60%	821
No (stop here – survey ends)	38%	515
Unknown (stop here – survey ends)	2%	27
	<b>Answered</b>	<b>1363</b>



**812 respondents continued with the survey**

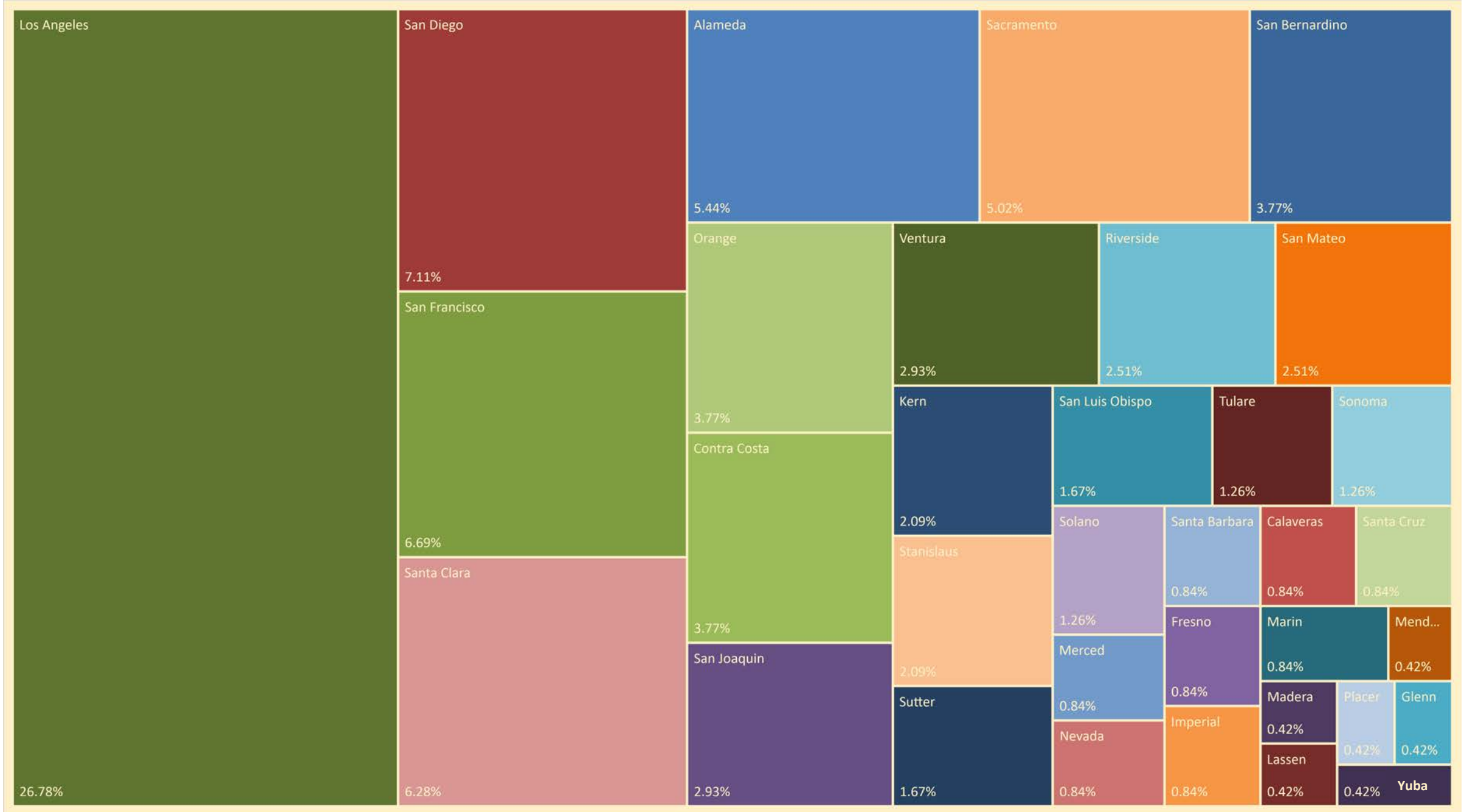
**8. If YES to #7: Does the setting or program allow clinical services (assessment, diagnosis and/or treatment) to be provided by employees or volunteers who are not seeking licensure as a mental health professional?**

Answer Choices	Responses	
Yes	36%	295
No (stop here – survey ends)	58%	473
Unknown (stop here - survey ends)	5%	44
	<b>Answered</b>	<b>812</b>



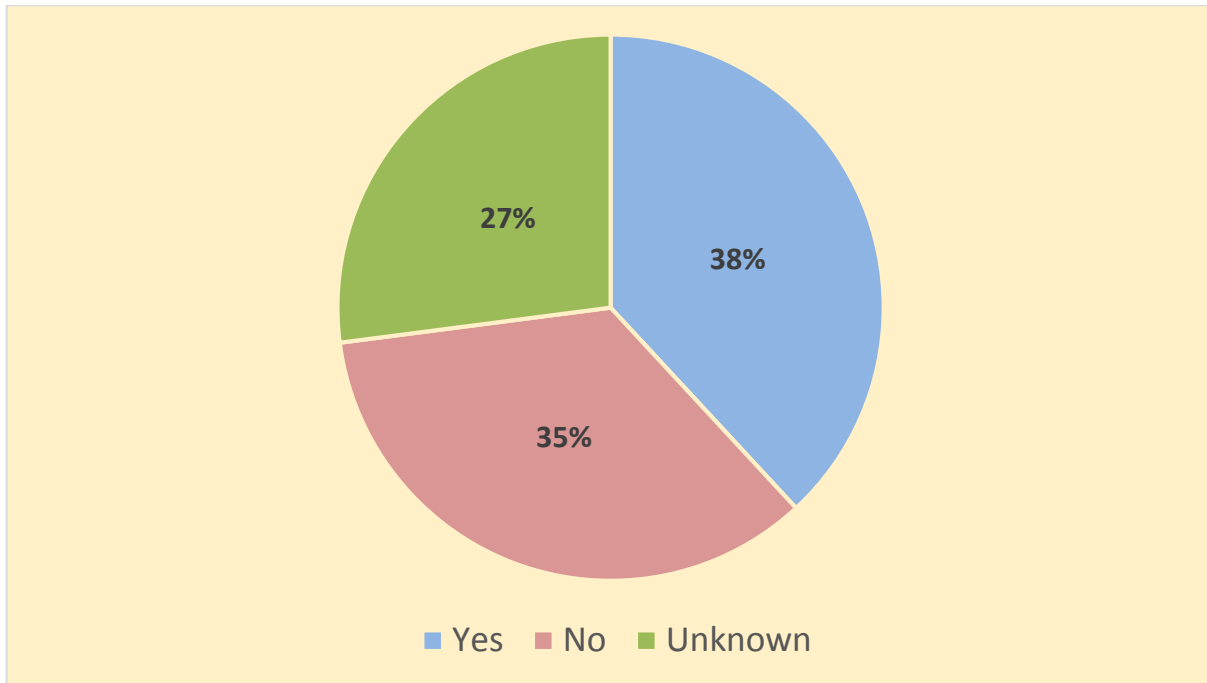
**244 respondents continued with the survey**

9. In what county is this facility located?



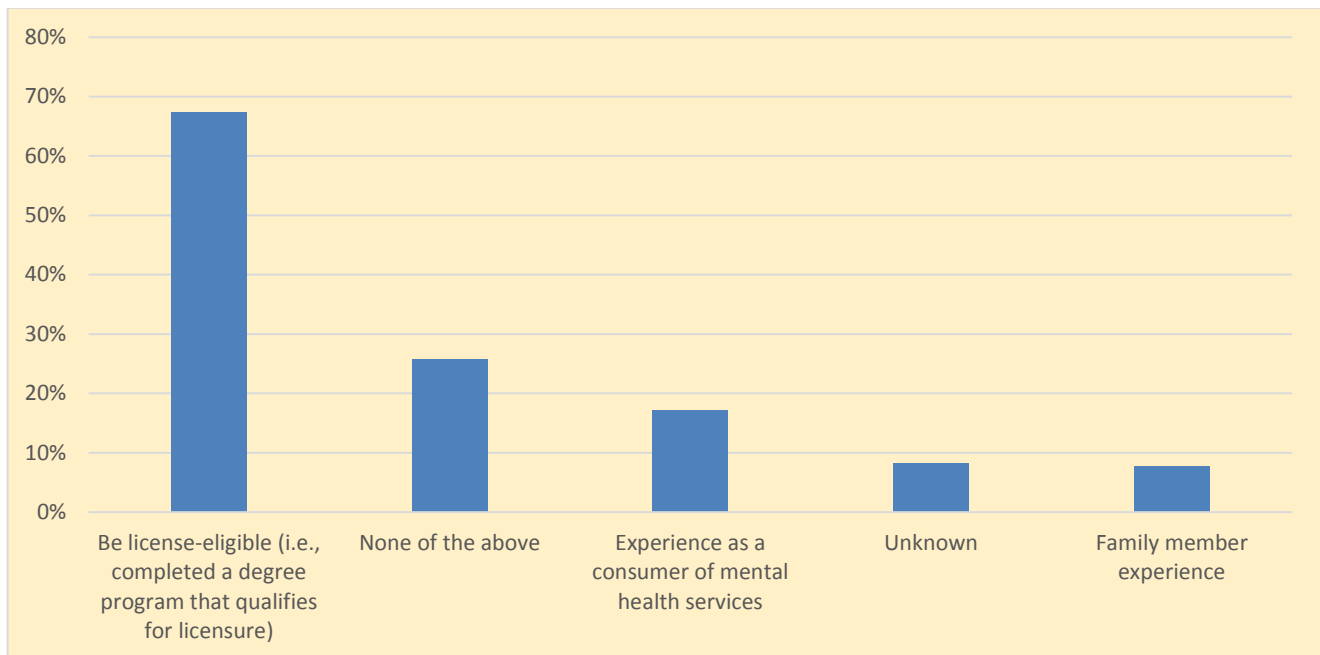
**10. Is there a shortage of licensed mental health providers in the region where the setting is located?**

<b>Answer Choices</b>	<b>Responses</b>	
Yes	38%	93
No	35%	85
Unknown	27%	66
	<b>Answered</b>	<b>244</b>



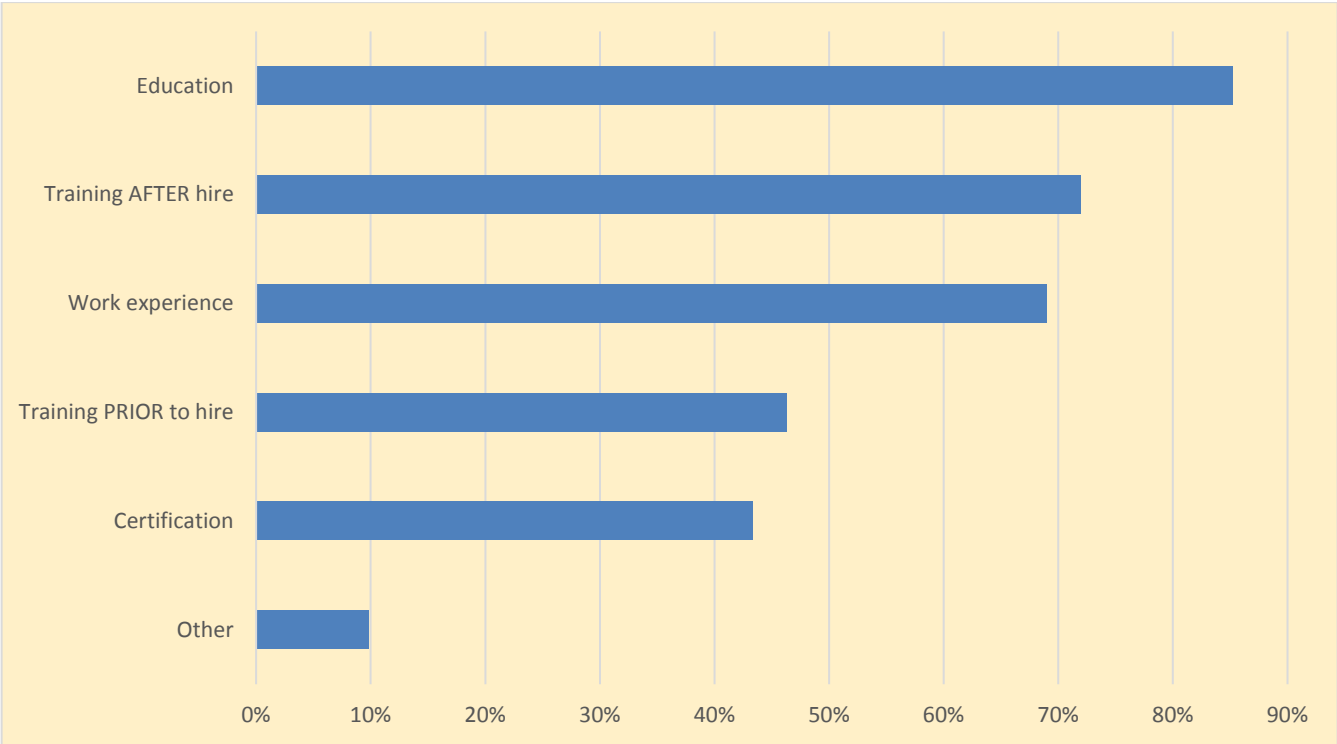
**11. What qualifications are required of staff members (including volunteers) who are providing clinical services (assessment, diagnosis and/or treatment) but who may not be seeking licensure as a mental health professional? (Mark all that apply)**

Answer Choices	Responses	
Be license-eligible ( <i>i.e.</i> , completed a degree program that qualifies for licensure)	67%	157
None of the above	26%	60
Experience as a consumer of mental health services	17%	40
Family member experience	8%	18
Unknown	8%	19



**12. What other qualifications are required of staff members (including volunteers) who are providing clinical services, but who may not be seeking licensure as a mental health professional? (Indicate all that apply)**

Answer Choices	Responses	
Education	85%	173
Work experience	69%	140
Training AFTER hire	72%	146
Training PRIOR to hire	46%	94
Certification	43%	88
Other	10%	20
	<b>Answered</b>	<b>203</b>

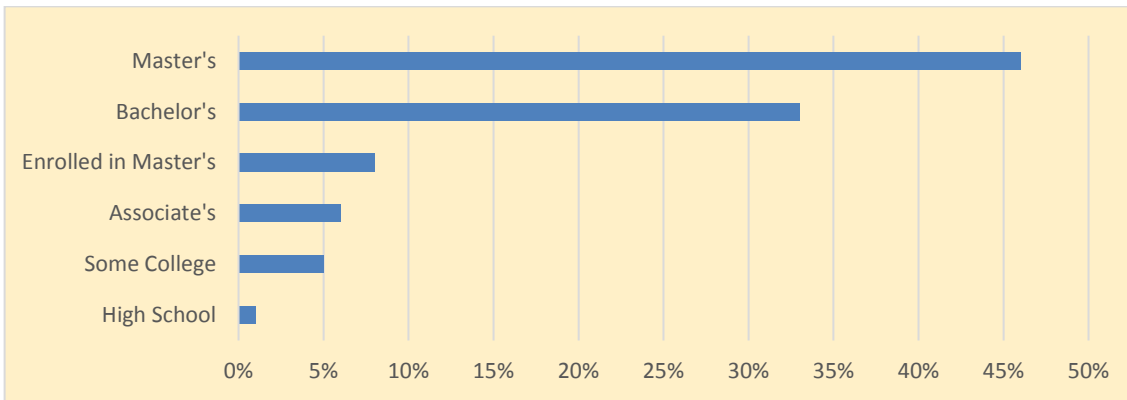


**Additional breakdown of responses on next page** ➔

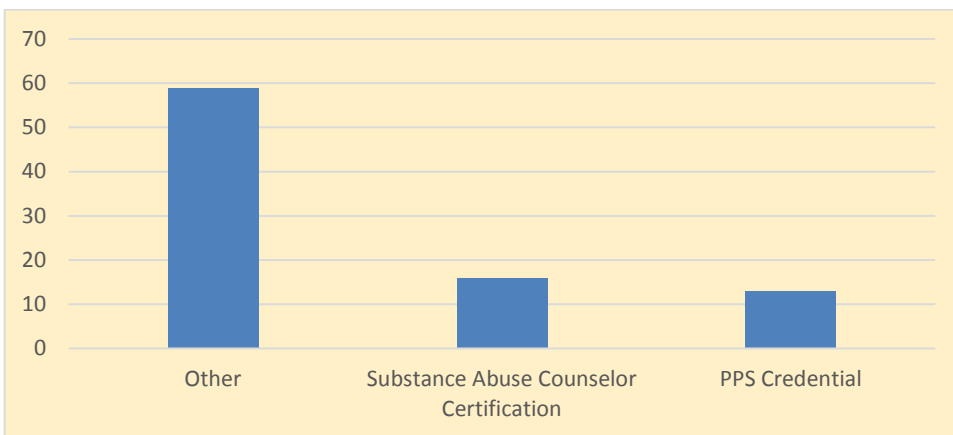
**12. What other qualifications are required of staff members (including volunteers) who are providing clinical services, but who may not be seeking licensure as a mental health professional?**

*(continued)*

<b>MINIMUM EDUCATION REQUIRED</b>		
<b>Of the 180 respondents who indicated that education was required as a qualification, 113 specified the following requirements:</b>		
Master's	46%	52
Bachelor's	33%	37
Enrolled in Master's	8%	9
Associate's	6%	7
Some College	5%	6
High School	1%	2

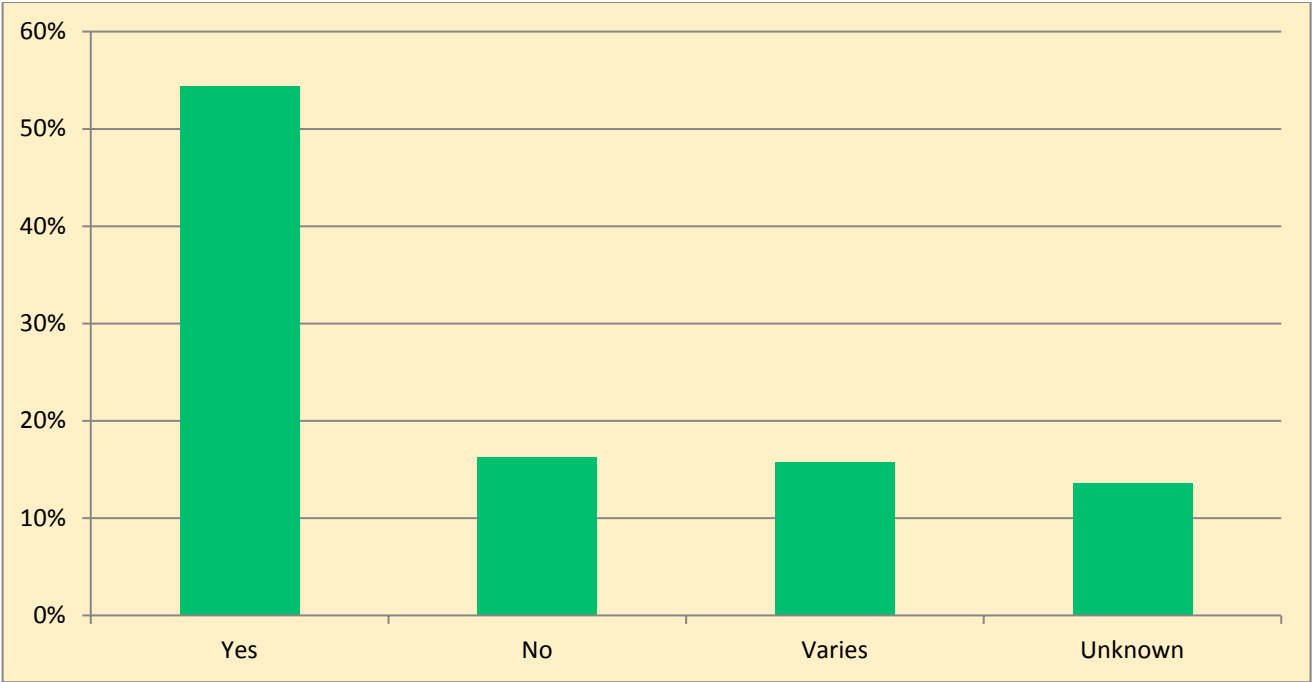


<b>CERTIFICATION REQUIRED</b>	
<b>Of the 130 respondents who indicated that certification was required as a qualification, 88 specified the following requirements:</b>	
Other	59
Substance Abuse Counselor Certification	16
PPS Credential	13



**13. Do the clinical services provided by individuals in this setting who may not be seeking licensure as a mental health professional, typically meet the same basic minimum standards as the clinical services provided by licensed mental health professionals? This includes acceptable interventions, compliance with statutory and regulatory requirements, compliance with ethical codes, etc.**

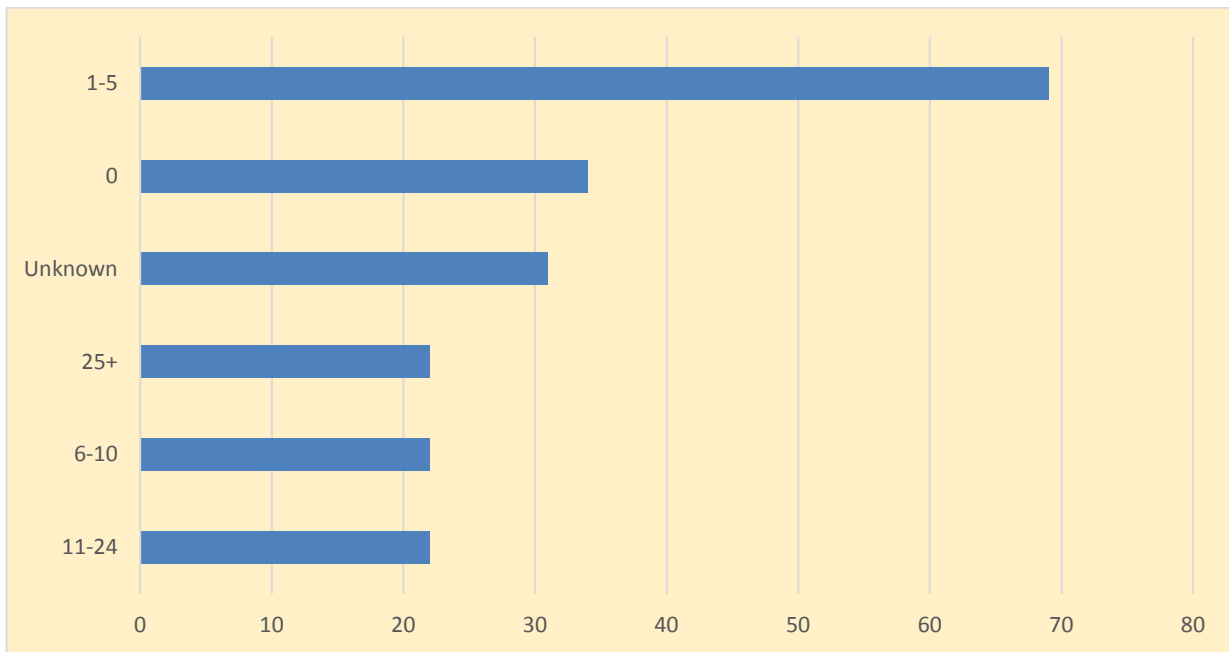
Answer Choices	Responses	
Yes	54%	124
No	16%	37
Varies	16%	36
Unknown	14%	31





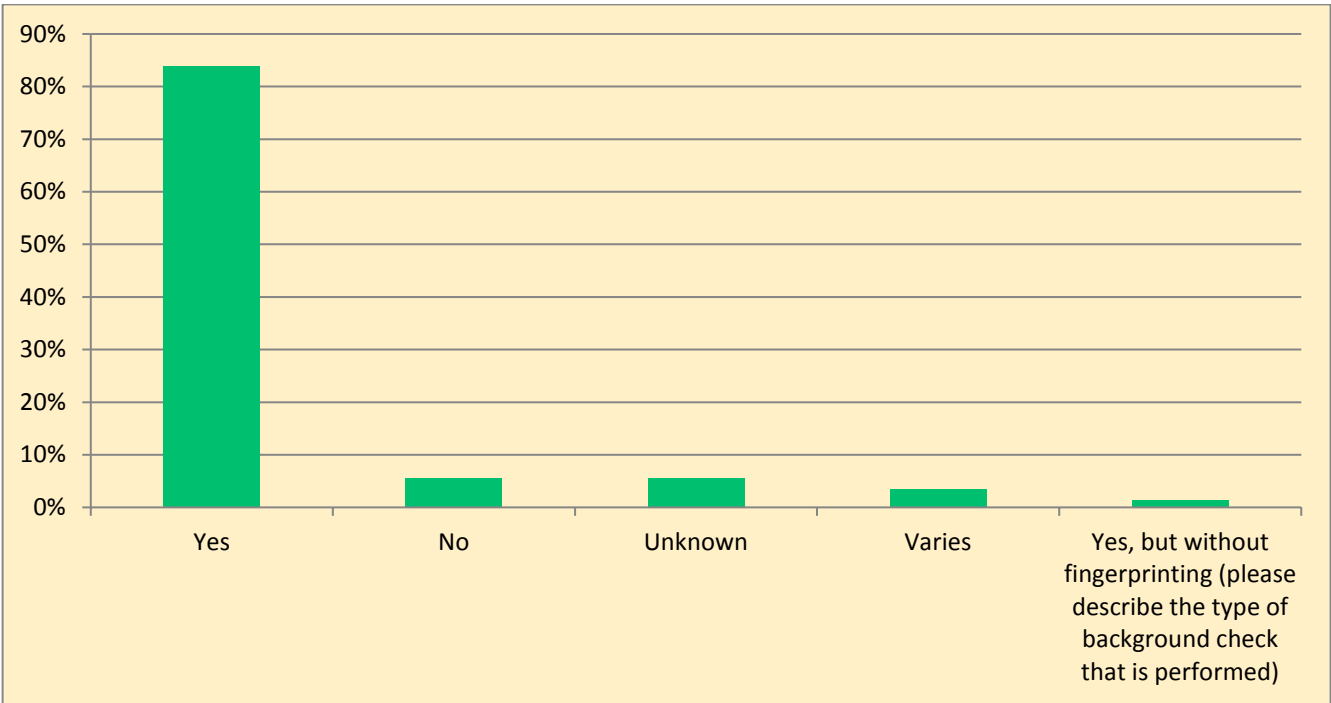
**14. Approximately how many individuals who may not be seeking licensure as a mental health professional are providing clinical services in this setting?**

Answer Choices	Responses	
25+	11%	22
11-24	11%	22
6-10	11%	22
1-5	35%	69
0	17%	34
Unknown	16%	31



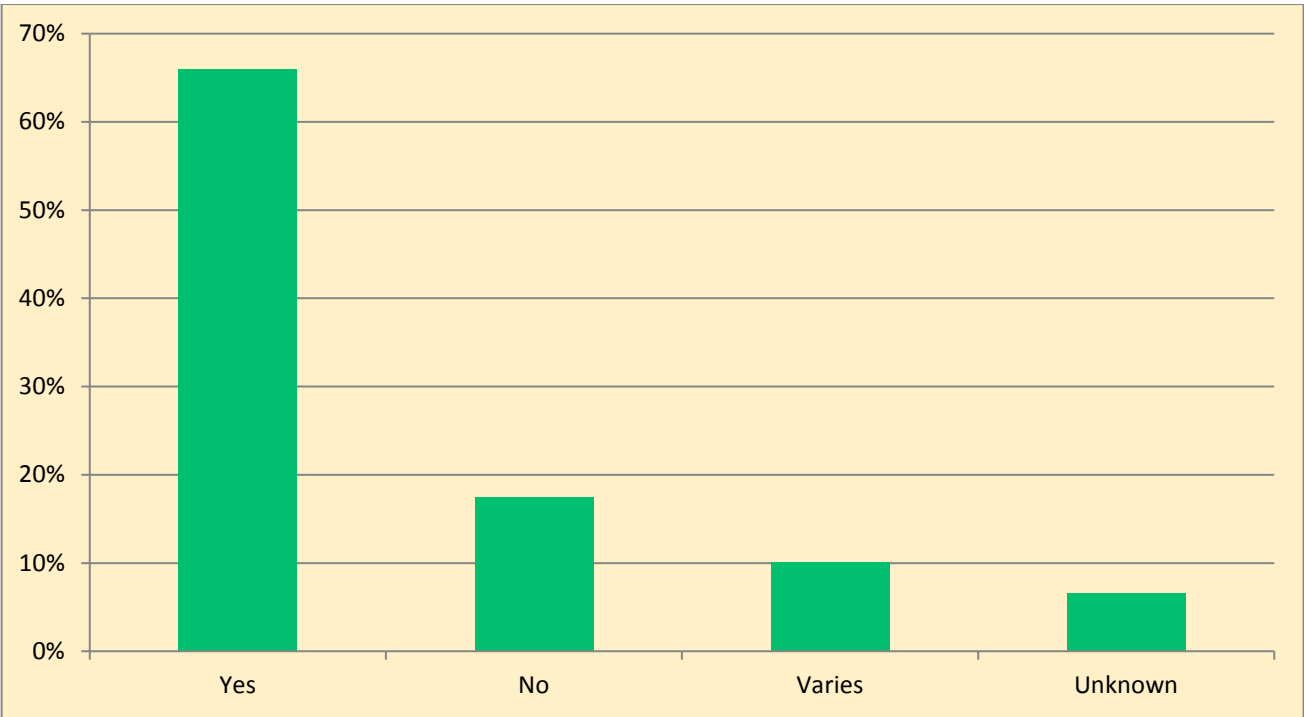
**15. Is a background check that includes fingerprinting performed on all individuals who perform clinical services in this setting?**

Answer Choices	Responses	
Yes	84%	194
No	6%	13
Unknown	6%	13
Varies	3%	8
Yes, but without fingerprinting ( <i>please describe the type of background check that is performed</i> )	1%	3
	<b>Answered</b>	<b>231</b>



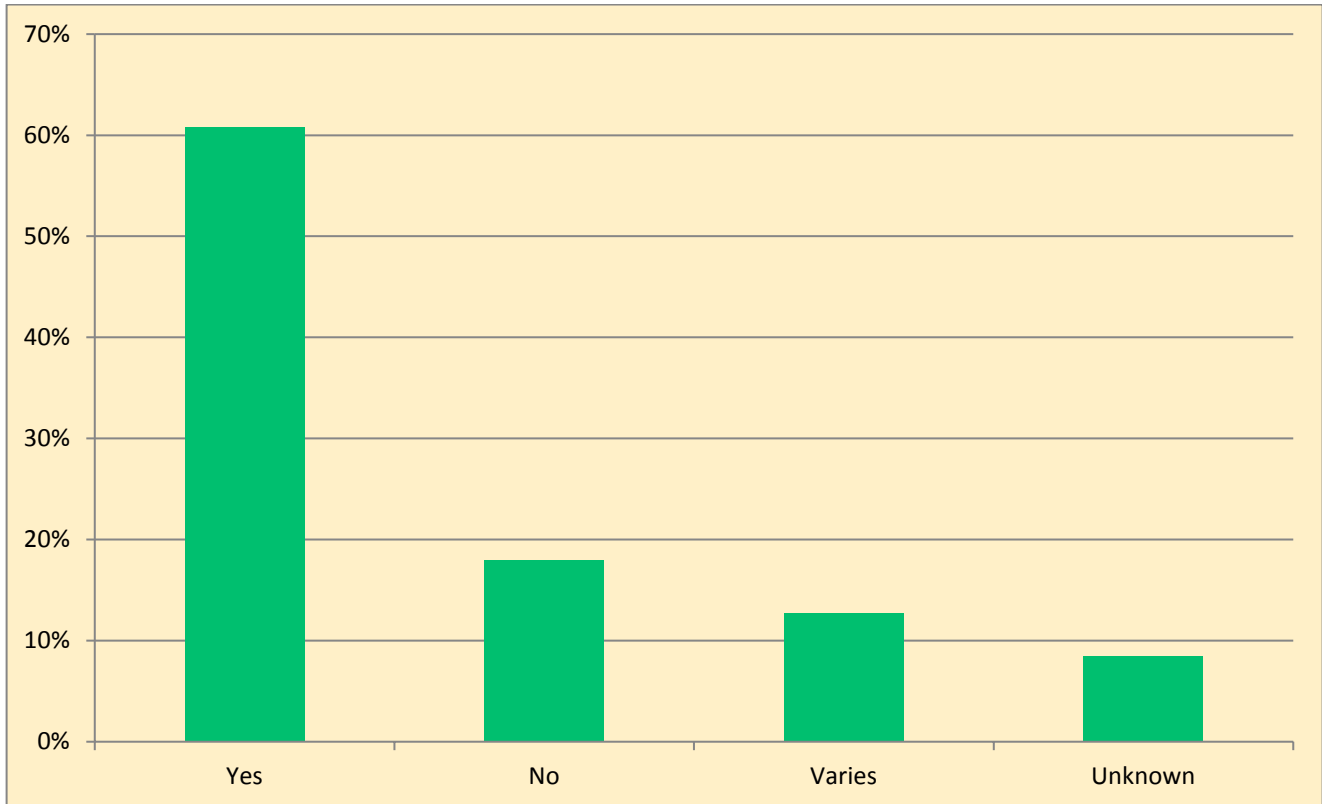
**16. Does the setting require a licensed professional (LCSW, LMFT, LPCC, Psychologist, Psychiatrist or Psychiatric Nurse Practitioner) to provide supervision to staff who are performing clinical services, but who may not be seeking licensure as a mental health professional?**

Answer Choices	Responses	
Yes	66%	151
No	17%	40
Varies	10%	23
Unknown	7%	15



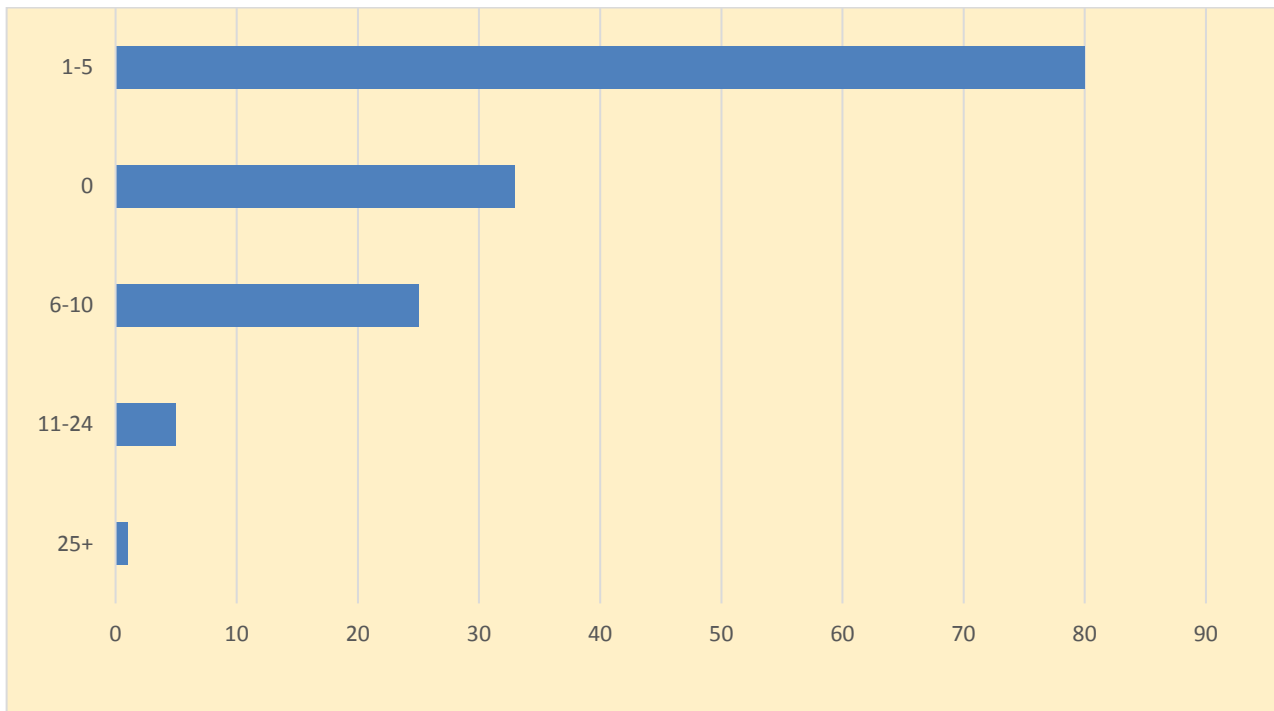
**17. If YES to #16: Are the licensed supervisors required to work on site?**

Answer Choices	Responses	
Yes	61%	115
No	18%	34
Varies	13%	24
Unknown	8%	16



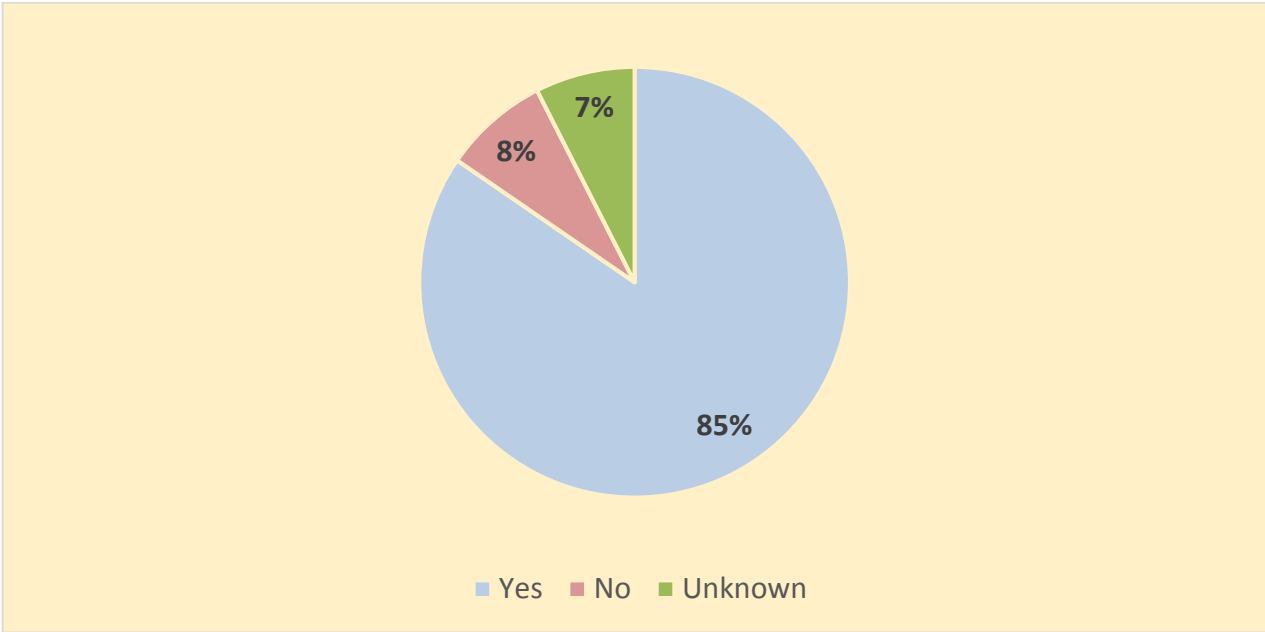
**18. Approximately how many individuals who are performing clinical services, but who may not be seeking licensure as a mental health professional, are assigned to each clinical supervisor?**

Answer Choices	Responses	
<b>1-5</b>	80	56%
<b>0</b>	33	23%
<b>6-10</b>	25	17%
<b>11-24</b>	5	3%
<b>25+</b>	1	1%



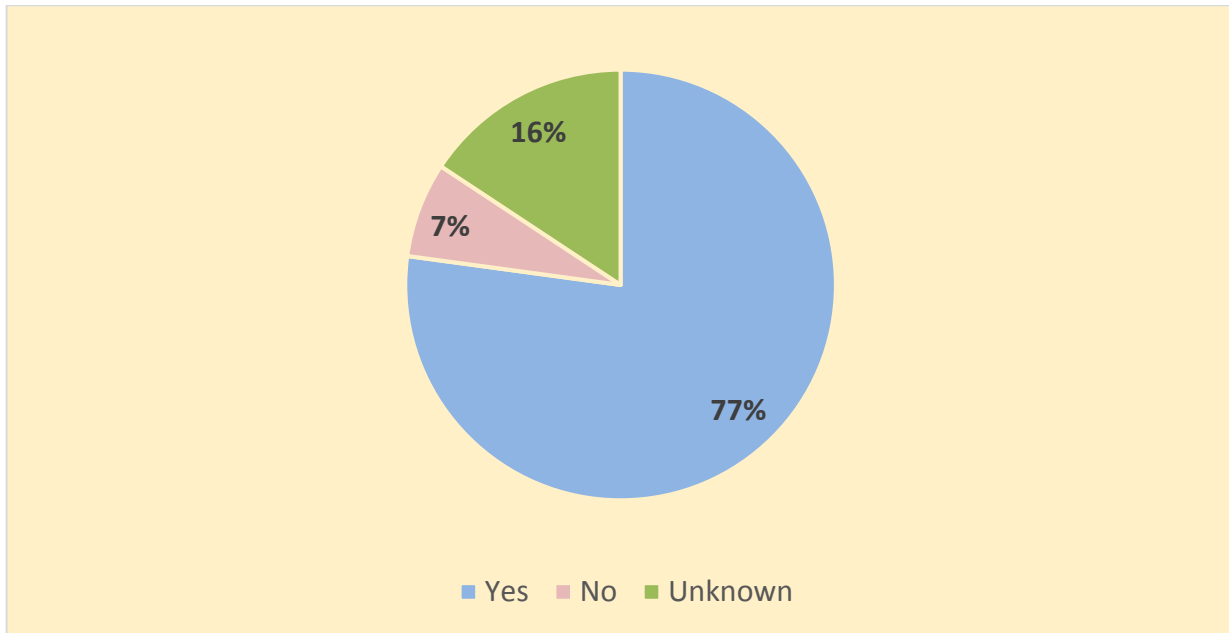
**19. Do consumers have a formal mechanism at this setting to have complaints or concerns about the clinical services received or about the therapist addressed?**

Answer Choices	Responses	
Yes	85%	192
No	8%	18
Unknown	7%	17
	<b>Answered</b>	<b>227</b>



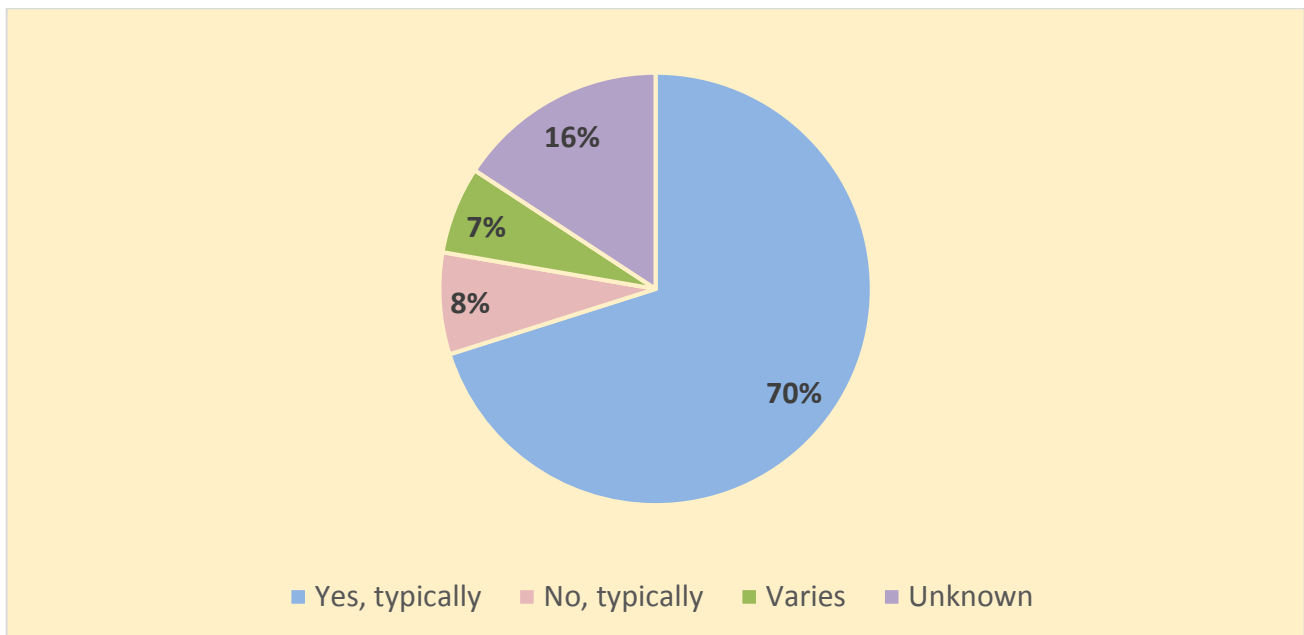
**20. If YES to #19: Are all consumers informed about the complaint process?**

Answer Choices	Responses	
Yes	77%	162
No	7%	15
Unknown	16%	33



**21. If YES to #19: Do you feel that consumer complaints are addressed appropriately?**

Answer Choices	Responses	
Yes, typically	70%	147
No, typically	8%	15
Varies	7%	17
Unknown	16%	30

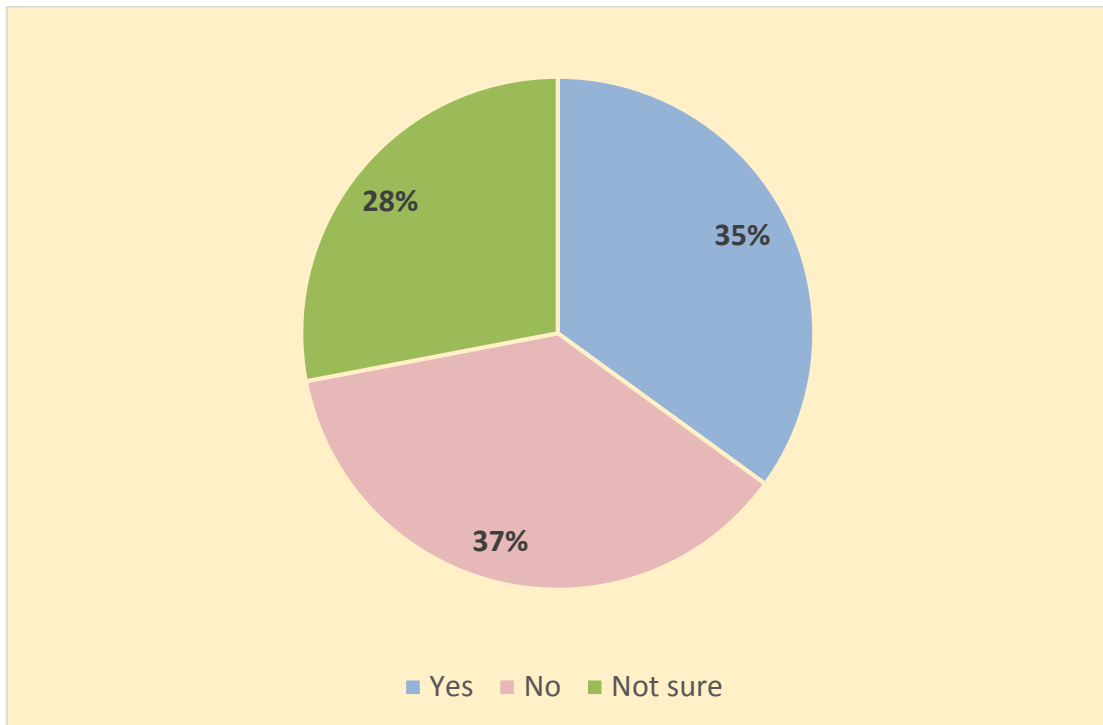




**22. Do you believe that certain settings should continue to be exempted from mental health professional licensure requirements? Please explain the reason(s) you selected this answer.**

*(Note: Exempt settings are defined in BBS law as a school, a governmental entity, or a nonprofit and charitable entity (501(c)(3))*

Answer Choices	Responses	
No	37%	82
Yes	35%	79
Not sure	28%	62
	<b>Answered</b>	<b>223</b>



22. Do you believe that certain settings should continue to be exempted from mental health professional licensure requirements? Please explain the reason(s) you selected this answer. (*continued*)

### WORD CLOUD BASED ON OPEN-ENDED RESPONSES

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Untrained Solid Proper Training Capacity  
Quality of Care Appropriately Role Means Clients  
Employ Settings Prelicensed and Licensed  
Mental Health Low Salaries Licensure  
MSW Staff Makes Clinical Applied Pay Aware  
Peer Counselors Committed Serve Vulnerable  
Credentialed

### SELECTED COMMENTS “YES” (settings should continue to be exempted):

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1. I think it is ok for some settings to be exempted from licensure requirements, but we have learned through many decades of providing services that it is important that all staff providing mental health services are overseen by licensed mental health professionals. There is too much legal, ethical and clinical risk associated with a lack of professional supervision.
2. Because a lot of the important work is being done by our peer advocates/leaders who have lived experience, but can not afford to or wish not to further their education, and advanced education is a requirement for licensure.
3. Medi-Cal regulations allow for non-licensed, non-registered staff to provide assessment and case management. It is important to allow peer counselors to be part of our system of care. They contributed an important treatment voice in the array of services in the mental health treatment system and will now also be able to contribute in the substance use system of care under the Organized Delivery System.
4. The cost is too high to supervise the requirements for individuals seeking license. The volunteer trainees require 1:5 ratio of supervision the cost for supervisors salary is so high that we can't even break even with volume there help. Certified Counselor's work in conjunction with our mental health professionals - this aides the clients in a balance of experience and education.
5. As long as they are appropriately supervised.

6. Some roles do not require as much clinical expertise and this allows clinicians who are not moving toward licensure a role to play in the profession
7. Unless we create a non-clinical licensure track in California, like many other states have done, I'm thinking specifically of my experience as an LMSW in New York, then we need to allow exempted settings.
8. There is overwhelming need for support services in low income communities and there is not enough funding to meet the needs. 2.) The majority of our licensure track counselors are from more privileged backgrounds (therefore they can afford to attend college and graduate school and complete a lengthy internship). By training paraprofessional counselors we have been able to provide clients with counselors who look like them and have first hand experience and understanding of their communities and cultures. Clients are more comfortable receiving services when they see we employ people from their community. We have better client retention and outcomes and our licensure track counselors receive invaluable knowledge from working side by side with our paraprofessional counselors.
9. Services provided by staff not seeking licensure are invaluable to both client and therapist as in our setting, caseloads are high. With the help of the paraprofessional clients/families learn skills to address symptoms and improve functioning. Many cases do not necessitate therapy but instead rehab services including social skill development, anger management skills, etc which are provided by the rehab staff and allow clinicians to provide more time to high risk clients. The cases rehab provide services to are still assigned to a clinician. Although the clinician does not provide supervision to the rehab staff they do direct treatment interventions and monitor progress of client. Further, clinician and rehab staff are required to consult regarding case a minimum of 1x per quarter but generally this happens more frequently.
10. Credentialed and Certified counselors are well able to provide psycho-education, case management and other services. We cannot fill current openings here due to cost of living and competition with Kaiser (pays approx. 19% more) and other large facilities.
11. There is a shortage of qualified mental health professionals in diverse communities- the need from communities far exceeds the availability of staff that we have available
12. Value if senior peer counseling for some clients in certain circumstances. Most of our services provided by individuals working toward licensure.
13. Some settings are very hard to attract/hire/retain staff. If the staff education level, experience level, and supervision matches those of other employees, it makes perfect sense to help meet the shortage. I tend to self-limit these hires anyway as they are more work (require extra co-signatures and documentation oversight)
14. The county will not pay for licensed professionals or at least nowhere near competitively do there would always be a shortage of people willing to fulfill the role
15. I live in a rural county where it is difficult to find qualified individuals to work with challenging clients
16. Many clinicians have years of experience on the job and are providing excellent services. Moreover, they usually receive the same employer sponsored training as licensed social workers to practice skills in a group setting and to stay current in efficacious treatment modalities. If the laws change, it should be to mandate non profits and government agencies to provide a certain amount of coursework or training to their employees each year, regardless of licensure. What is more concerning is people in

private practice that may be licensed, but have very little oversight. We frequently hear from our patients stories about their interactions with therapists that seem to personal, such as therapists not allowing to end therapy when the client is ready or talking about their own personal problems during the session.

17. Our paraprofessional counselors live in their communities and know the population they serve. They are trusted, well trained and supervised
18. Staffing would be impossible if all staff were required to be licensed; 2) Peer staff provide a very important and valuable component of the program -- particularly offering service provision that is relevant and important to clients
19. We have been operating for over 46 years and have been able to provide services to so many people who might otherwise not be able to afford care. For many years, all counseling was provided by paraprofessionals (peer counselors). Along with the trainees and interns, they serve a vital role in the operation of our agency.
20. Getting licensed is an expensive and a long process that takes the average person 6 years. This field needs more licensed mental health workers but graduate school is not accessible to everyone particularly people of color. In part I am glad that you don't need a graduate degree to work in mental health but I do think in our current system pairs often the most acute clients are treated by the least trained professionals. Licensed therapists in community mental health like myself become directors and the client work is done by those without a license. Low salaries keep this pattern in place.

#### **SELECTED COMMENTS “NO” (settings should NOT continue to be exempted):**

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1. No I do not believe so especially in school settings. License professionals are required to have more experience and training especially the clinical skill set to handle psychosis, eating disorders, alcohol and drug addiction which are becoming even more present in the school settings.
2. We are providing intensive counseling services to students with severe mental health symptoms that are significantly impacting their functioning at school. The individuals that are completing "mental health assessments" are not clinically trained. The individuals running the ERICS program are also not clinically trained and are unaware of legal/ethical/safety implications that come with running a mental health program in the schools. It should be required that anyone working in this program should be clinically trained and hold a current license to provide such services.
3. Clients deserve consistent standard of care, regardless of setting which is related to their ability to pay.
4. Licensure requirements ensure that basic standards and procedures are in place so that clients are able to obtain a certain level of care that are not instituted for non-professionals.
5. Public-consumer protection, quality assurance. We are serving the absolute most vulnerable people when fulfilling our role as clinicians. Direct harm is done to consumers by unprepared well-meaning workers. The client/patient and family thinks they were served by a clinician but in fact their challenges were not addressed by the untrained staff.
6. At least one or more licensed or license eligible person working towards licensure should be required per site if social services, therapy, or counseling is provided.

7. This population deserves the highest quality of care and often lack of education in therapy techniques, intervention and how to ethically engage clients taints the and hinders the process of recovery.
8. The risk of providing ineffective treatment may be greater when the clinicians are not properly trained.
9. I feel that if you are working with individuals (especially children) who are experiencing severe emotional/mental issues you need to have the proper training and experience
10. those without a license are not trained or capable to conduct psychotherapy, group therapy, psychosocial assessments, diagnose, or 5150 when necessary. Those who have an MSW and are being weekly supervised and working toward their license have been trained in theory and practice, abnormal psych., etc. and are competent. Without supervision and at least an MSW they are not competent to conduct ethical, sound clinical treatment. In my setting older employees without an MSW are limited in their scope of practice and do case management only.
11. I believe that all mental health providers should be registered to ensure an adequate level of care
12. Having mixed groups of some non professionals, trainees, interns, and licensed staff has created problems in my school district because the non professionals are not held to the same legal and ethical standards as the prelicensed and licensed staff.
13. Services rendered by untrained employees are vastly different and subpar than those with education and experience
14. No. I think the unlicensed person working in a \*clinical\* role where \*any\* personal information is being assessed, evaluated, or utilized within the setting should NOT be permitted. That is, unless the role (such as an "academic counselor" has its OWN code of law and ethics under the entity (such as FERPA). TRAINING needs to address where laws and ethics, including reporting overlap with organizational/entity requirements, and how these are prioritized an implemented.
15. I believe a license should be a requirement for all mental health professionals. It is a certification that shows the minimum standards to practice. Our profession should thrive to reach the highest standards as possible. We are similar to physicians; a physician is not allowed to practice if he/she is not licensed. Why should we be different?
16. I believe that if mental health services are being provided then the people providing those services should meet the industry standard which would include a license. Providing school-based counseling has increasingly become the defacto setting where many children and families are receiving mental health services. It is important that these services be provided by knowledgable, qualified and experienced mental health providers. Unfortunately, the funding for mental health services in the school setting is somewhat limited and these services are provided free of charge to families. This provides wonderful access to mental health services to children and families, but greatly limits what can be provided. If it is mandated that school-based counseling services be provided by licensed professionals, then the way schools are funded for mental health services should also be addressed
17. Its imperative that services provided to consumers are effective and professionally sound. Agencies such as violence intervention program in LA take advantage of underpaid staff and assign unmanageable workloads that lack supervision and ethically sound management and direction without maintaining the sole focus on prioritizing the wellbeing of there consumers. These exemptions propel an ongoing problem with improperly trained and educated individuals causing more harm than good to

consumers, and supervisors that continue to hold licenses despite engaging in illegal unethical and unprofessional clinical practices

18. Licensure assumes an ethical standard and clinical competence
19. Provision of clinical services should be by those who can be held accountable, who have malpractice insurance, are regularly training in ethics, and required to obtain CEU's to remain current in best practices.
20. Quality of care is paramount and can vary widely per families previous reports of experiences in services.

### **SELECTED COMMENTS “NOT SURE”:**

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1. I think ensuring quality of care and supervision are the important things to focus on when determining whether or not certain settings should continue to be exempt.
2. There are not enough funds likely to provide all the needed help in county for services. However, there does seem to be a 'lack of demand' for clinical services as when a volunteer or BS/BA degree is doing somewhat equivalent work which depreciates our value. Therefor weakens the need for therapists and decreases wages.
3. I believe that people may be qualified to perform at least some level of clinical services (e.g. case management) without licensure but with relevant training and supervision. If not already present, maybe there should be guidelines or recommendations around training and supervision for staff and volunteers in these exempt settings? I also think it would be important for staff and volunteers in the exempt settings to be aware of the laws and ethics that are the foundation of our work (e.g. NASW Code of Ethics).
4. I think this has created a significant wage gap between licensed and unlicensed professionals, which results in clinicians who are accruing hours towards licensure being almost exclusively limited to working in nonprofit settings as there are very few other job options for clinicians who are not yet licensed (primarily due to the additional supervision requirements for registered but unlicensed staff). However, this allows agencies to provide services at a lower cost than they otherwise would be able to, which allows more clients in need to access services.

## 23. Is there anything else you would like to add?

Answered	71
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### SELECTED RESPONSES PERTINENT TO SURVEY TOPICS

1. Require Master's level training for any clinical work that indicates need for assessment through management of psychosocial issues. Bachelor level staff for supportive roles
2. When services are provided by unlicensed, untrained professionals it often does more harm than good for the clients.
3. Again, if you were to make a mandatory requirement for masters level clinicians only to perform services, then you must also increase the reimbursement rates for non profits.
4. Paraprofessional counselors are doing very important work in some of our most underserved communities and in many cases they are doing work that licensure track counselors cannot do. Paraprofessional counselors are a vital resource to the neediest members of our society.
5. I believe there needs to be a mandate for supervision to be provided for both licensed and unlicensed staff. Too often newbies are left to learn everything the hard way.
6. I have worked in a diverse range of settings such as PHF's, OP MH clinics, with children, adults, families, at risk youth, chronically mentally ill, & substance abusers. In many settings it is an invaluable contribution that is provided by people with a long experience, understanding of the people served in different settings, as well as personal experience as a consumer of MH services. While a license speaks volumes about the hard work required to be designated as a "professional" at times I have witnessed better ideas for treatment from unlicensed individuals in the field. I would go so far as to say the unlicensed professional is a major part of service delivery in the mental health profession that can't be replaced.
7. There is a need to develop standards and training for peer staff. And to train clinical staff on the value and usefulness of using peer staff who often feel devalued. Also, clinical staff often do not understand how to support, train and provide ethical standards for peer staff.

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**To:** Exempt Setting Committee Members      **Date:** February 21, 2018  
**From:** Christy Berger  
Regulatory Analyst      **Telephone:** (916) 574-7817  
**Subject:** **Discussion and Possible Recommendation Regarding Registrant  
Employment by Temporary Staffing Agencies**

At its June 2017 meeting, the Exempt Committee discussed the topic of registrants (often Associate Clinical Social Workers (ASWs)), who are gaining hours of experience while employed by a temporary employment/staffing agency (temporary agency). This type of arrangement has often been seen with registrants placed at the Veteran's Administration (VA). Current law for all three professions does not address a temporary agency as an employer of individuals gaining hours of experience toward licensure, and certain provisions of existing law are a poor fit for this situation.

The issues discussed were as follows:

**1. Employment as an Independent Contractor**

Temporary agencies sometimes employ BBS registrants as independent contractors (under a 1099). In this case, any hours of experience would be denied as this is explicitly prohibited by law.<sup>1</sup> The Committee directed staff to make efforts to educate supervisees and supervisors employment as an independent contractor is prohibited, and that any hours gained as a 1099 employee will not count toward licensure.<sup>2</sup>

**2. Location of Services Performed**

LMFT and LPCC law<sup>3</sup> requires trainees, associates and applicants to perform services "at the place where their employer regularly conducts business." LCSW will contain this same provision with the passage of currently pending legislation (AB 93). Because services are never performed at a temporary agency, the Committee determined that the law should specify that in the case of a temporary agency employer, registrants must perform services at the agency where they have been placed.

<sup>1</sup> Business and Professions Code (BPC) sections 4980.43(c), 4996.23(j) and 4999.47(a)

<sup>2</sup> LMFT and LPCC law, BPC sections 4980.43(k) and 4999.47(d) make minor exceptions for volunteers receiving reimbursement of expenses

<sup>3</sup> BPC sections 4980.43(j) and 4999.47(f)

LMFT and LPCC law<sup>4</sup> goes on to specify that services may be performed at other locations, so long as the services are performed “*under the direction and control of the employer and supervisor*” and “*in compliance with the laws and regulations pertaining to supervision.*” The Committee had originally directed staff to specify that, in the case of a registrant employed by a temporary agency, that agency where the individual has been placed should have these responsibilities. However, AB 93 is deleting this language due to other changes that make it unnecessary.

### 3. **Written Agreement Between Employer and Supervisor**

For the purposes of this section, the term “outside supervisor” will describe a supervisor who is either not employed by the supervisee’s employer (LCSW law<sup>5</sup>) or who serves as a volunteer in a non-private-practice setting (LMFT and LPCC law<sup>6</sup>). Note that the law for all three professions is being amended via AB 93 to include a supervisor who is either not employed by the supervisee’s employer or is a volunteer.

The law requires “outside supervisors” to sign a written agreement (see examples in **Attachments B and C**) with the employer to take supervisory responsibility for the supervisee’s services. LMFT and LPCC law also require the agreement to ensure the supervisor has access to client records and to prohibit the employer from interfering with the supervisor’s legal and ethical obligations to ensure compliance with licensure requirements (LCSW regulations are proposed to be amended to also include these provisions after the passage of AB 93).

In the case of a temporary agency employer, the Committee determined that the written agreement should instead be between the agency that has responsibility for the clients and the supervisor.

In addition, current LCSW law<sup>4</sup> (and proposed regulation amendments planned for LMFT and LPCC law after the passage of AB 93) requires a written agreement when the supervisor and supervisee have different employers. This means that the agreement, in the case of a registrant having a temporary agency employer, would still be required even when the supervisor is an employee of the setting where the registrant has been placed.

In the situation described, the supervisor is already employed by the agency responsible for the clients and therefore the Committee determined that the written agreement is unnecessary.

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<sup>4</sup> BPC sections 4980.43(j) and 4999.47(f)

<sup>5</sup> BPC section 4996.23(o)

<sup>6</sup> Title 16, California Code of Regulations sections 1820(e)(3) and 1833(b)(4)

Because pending legislation affects all of the above referenced law sections, exact language cannot be drafted at this point. The concepts for draft language once AB 93 passes is provided in **Attachment D**.

**Recommendation**

Conduct an open discussion about the conceptual amendments. Direct staff to make any discussed changes, and bring fully drafted proposed language back to the Committee for recommendation to the Board.

**Attachments**

**Attachment A:** Related Amendments Proposed in AB 93 and Proposed Follow-Up Regulations Re: Written Agreement Between Supervisor/Employer

**Attachment B:** Sample Written Agreement – LCSW law

**Attachment C:** Sample Written Agreement – LMFT law (LPCC uses same language)

**Attachment D:** Conceptual Draft Language

**ATTACHMENT A**  
**PENDING LAW CHANGES**

**Re: Written Agreement Between Supervisor/Employer**

**PROPOSED AMENDMENTS IN AB 93 (Business and Professions Code)**

**LMFT - §4980.43.5:**

(a) A trainee, associate, or applicant for licensure shall only perform *mental health and related services* at the ~~place~~ *places* where his or her employer regularly conducts business and services, which may include performing services at other locations as long as the services are performed under the direction and control of his or her employer and his or her supervisor and in compliance with the laws and regulations pertaining to supervision. ~~services.~~

(d) In a setting that is not a private ~~practice~~, ~~a written practice~~:

(1) A *written oversight* agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer.

**LCSW - §4996.23:**

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

**LCSW - §4996.23.3:**

(a) An *associate clinical social worker or an applicant for licensure* shall only perform *mental health and related services* ~~places~~ where his or her employer regularly conducts business and services.

(d) In a setting that is not a private ~~practice~~, ~~a written practice~~:

(1) A *written oversight* agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer.

**LPCC - §4999.46.4:**

(a) A clinical counselor trainee, associate, or applicant for licensure shall only perform *mental health and related services* at the ~~place~~ *places* where his or her employer regularly conducts business and services, which may include performing services at other locations, as long as the services are performed under the direction and control of his or her employer and his or her supervisor and in compliance with the laws and regulations pertaining to supervision. ~~services.~~

(d) In a setting that is not a private ~~practice~~, ~~a written practice~~:

(1) A *written oversight* agreement, as specified by regulation, shall be executed between the supervisor and employer when the supervisor is not employed by the supervisee's employer or is a volunteer.

## **PROPOSED FOLLOW-UP REGULATIONS TO AB 93 (Title 16, California Code of Regulations)**

### **LPCC - §1821**

~~(3)~~(a) Pursuant to Section 4999.46.4 of the Business and Professions Code, ~~in~~ a setting which is not a private practice, ~~the authorized supervisor may be employed by the applicant's employer on either a paid or a voluntary basis. If such employment is on a voluntary basis,~~ a written agreement ~~must~~shall be executed between the supervisor and the ~~organization,~~employer when the supervisor is not employed by the supervisee's employer or is a volunteer.

(1) The written agreement shall be executed prior to commencement of supervision.

~~(2), in which the supervisor agrees~~ The written agreement shall contain a declaration from the supervisor agreeing to ensure that the extent, kind, and quality of counseling performed by the ~~intern~~supervisee is consistent with the ~~intern's~~supervisee's training, education, and experience, and is appropriate in extent, kind, and quality.

(3) The agreement shall contain an acknowledgment by the employer that the employer:

~~(4)~~(i) Is aware of the licensing requirements that must be met by the ~~intern~~supervisee and ~~that the employer agrees not to interfere with the supervisor's legal and ethical obligations to ensure compliance with those requirements; and~~

~~(2)~~(ii) Agrees to provide the supervisor access to clinical records of the clients counseled by the ~~intern~~supervisee; and

(iii) Is aware that the supervisor will be providing clinical guidance to the supervisee in order to ensure compliance with the standards of practice of the profession, and agrees not to interfere with this process.

### **LMFT - §1833**

~~(4)~~(a) Pursuant to Section 4980.43.5 of the Business and Professions Code, ~~in~~ a setting which is not a private practice, ~~the authorized supervisor may be employed by the applicant's employer on either a paid or a voluntary basis. If such employment is on a voluntary basis,~~ a written agreement ~~must~~shall be executed between the supervisor and the ~~organization,~~employer when the supervisor is not employed by the supervisee's employer or is a volunteer.

(1) The written agreement shall be executed prior to commencement of supervision, ~~in which the supervisor agrees~~

(2) The written agreement shall contain a declaration from the supervisor agreeing to ensure that the extent, kind, and quality of counseling performed by the ~~intern or trainee~~supervisee is consistent with the ~~intern or trainee's~~supervisee's training, education, and experience, and is appropriate in extent, kind, and quality.

(3) The agreement shall contain an acknowledgment by the employer that the employer:

~~(1)(i)~~ Is aware of the licensing requirements that must be met by the intern or trainee supervisee and that the employer agrees not to interfere with the supervisor's legal and ethical obligations to ensure compliance with those requirements; and

~~(2)(ii)~~ Agrees to provide the supervisor access to clinical records of the clients counseled by the intern or trainee supervisee, and

(iii) Is aware that the supervisor will be providing clinical guidance to the supervisee in order to ensure compliance with the standards of practice of the profession, and agrees not to interfere with this process.

### **LCSW - §1869**

(a) Pursuant to section 4996.23.3 of the Business and Professions Code, in a setting which is not a private practice, a written agreement shall be executed between the supervisor and the employer when the supervisor is not employed by the supervisee's employer or is a volunteer.

(1) The written agreement shall be executed prior to the commencement of supervision.

(2) The written agreement shall contain a declaration from the supervisor agreeing to ensure that the extent, kind, and quality of counseling performed by the supervisee is consistent with the supervisee's training, education, and experience, and is appropriate in extent, kind, and quality.

(3) The agreement shall contain an acknowledgment by the employer that the employer:

(i) Is aware of the licensing requirements that must be met by the supervisee and that the employer agrees not to interfere with the supervisor's legal and ethical obligations to ensure compliance with those requirements;

(ii) Agrees to provide the supervisor access to clinical records of the clients counseled by the supervisee; and

(iii) Is aware that the supervisor will be providing clinical guidance to the supervisee in order to ensure compliance with the standards of practice of the profession, and agrees not to interfere with this process.



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**Associate Clinical Social Workers**  
**SAMPLE LETTER OF AGREEMENT FOR SUPERVISION**  
*Required when the supervisor is not employed by the ASW's employer*

Date:  
 ASW name:  
 Supervisor name:  
 Employer name:

**SAMPLE**

This letter serves as an agreement between the employer, (*Employer's name*), the associate clinical social worker, (*ASW's name*), and the associate clinical social worker's supervisor, (*Supervisor's name*).

(*Supervisor's name*) is not employed by (*Employer's name*). However, (*Employer's name*) agrees to allow (*Supervisor's name*) to supervise (*ASW's name*). (*Supervisor's name*) agrees to supervise (*ASW's name*) for (*Employer's name*).

(*Supervisor's name*) agrees to take supervisory responsibility for the social work services provided by (*ASW's name*) as required by Chapter 14 of the California Business and Professions Code and Title 16, Division 18, Article 6 of the California Code of Regulations.

Supervisor's Signature	Date	ASW's Signature	Date
Employer's Authorized Representative Name	Employer's Authorized Representative Signature		Date

**NOTE:**

This is a SAMPLE letter. It should be written on the letterhead of the employer and signed and dated PRIOR to gaining hours of experience. The ASW is required to submit this letter with the application for licensure. See Business and Professions Code section 4996.23(o) and Title 16, California Code of Regulations section 1870.



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## Associate Marriage and Family Therapist / MFT Trainee SAMPLE LETTER OF AGREEMENT FOR SUPERVISION

*Required when the Associate's or Trainee's supervisor is working as a volunteer*

Date:  
 Associate Marriage and Family Therapist or MFT Trainee name:  
 Supervisor name:  
 Employer name:

This letter serves as an agreement between the employer, (Employer's name), the Associate Marriage and Family Therapist or MFT Trainee, (Associate's or Trainee's name), and the Associate's or Trainee's supervisor, (Supervisor's name).

(Supervisor's name) is employed by (Employer's name) on a VOLUNTARY basis. (Employer's name) agrees to allow (Supervisor's name) to supervise (Associate's or Trainee's name). (Supervisor's name) agrees to supervise (Associate's or Trainee's name) for (Employer's name).

(Supervisor's name) agrees to take supervisory responsibility for the marriage and family therapy services provided by (Associate's or Trainee's name) as required by Chapter 13 of the California Business and Professions Code and Title 16, Division 18, Article 4 of the California Code of Regulations. (Supervisor's name) shall ensure that the extent, kind and quality of services performed is consistent with (Associate's or Trainee's name) training, education, and experience and is appropriate in extent, kind and quality.

(Employer's name) is aware of the licensing requirements that must be met by (Associate's or Trainee's name) and agrees not to interfere with the supervisor's legal and ethical obligations to ensure compliance with those requirements; and agrees to provide the supervisor access to clinical records of the clients counseled by (Associate's or Trainee's name).

\_\_\_\_\_  
 Supervisor's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Associate's or Trainee's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Employer's Authorized Representative Name

\_\_\_\_\_  
 Employer's Authorized Representative Signature

\_\_\_\_\_  
 Date

### NOTE:

**This is a SAMPLE letter.** It should be written on the letterhead of the employer and signed and dated prior to gaining hours of experience. See Title 16, California Code of Regulations section 1833(b)(4).



**ATTACHMENT D**  
**CONCEPTUAL DRAFT LANGUAGE**  
**TEMPORARY AGENCY EMPLOYERS**

(a) A “temporary employment agency” is defined as agency that locates positions for individuals seeking temporary work, and fills vacancies for agencies seeking to employ individuals on a temporary basis.

(b) A “contracting agency” is defined as the agency where a trainee, registrant, or applicant for licensure has been placed by a temporary employment agency.

(c) The following provisions apply to a trainee, registrant, or applicant for licensure whose employer is a temporary employment agency:

(1) Notwithstanding BPC sections 4980.43.5, 4996.23.3, and 4999.46.4, the trainee, associate or applicant for licensure shall only perform mental health and related services at the places where the contracting agency regularly conducts business.

(2) Notwithstanding Title 16, CCR sections 1821, 1833 and 1869, the written agreement shall be between the contracting agency and the supervisor; and, in cases where the supervisor is an employee of the contracting agency, no written agreement shall be required.



Board of Behavioral Sciences

# Memo

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**To:** Exempt Setting Committee Members      **Date:** February 20, 2018  
**From:** Christy Berger  
Regulatory Analyst      **Telephone:** (916) 574-7817  
**Subject:** **Discussion Regarding Unlicensed Masters of Social Work Employees  
Billing as Psychotherapists**

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A concern has been raised about the billing practices of some exempt setting agencies that employ pre-licensed social work students who are enrolled in a master's degree program (social work "interns").

Agencies sometimes bill for the student as a "psychotherapist." Sometimes, the bill includes the supervisor's name but not the student's name, and sometimes the bill does list the student's name but does not indicate that the provider was a student. Agencies commonly bill for student-provided services such as assessment, diagnosis and treatment planning at the same rate as for a licensed individual. The concern is whether this may imply to the client and/or the third-party payor that the person is a licensed psychotherapist.

Business and Professions Code section 4996.15 states (emphasis added):

*Nothing in this article shall restrict or prevent activities of a psychosocial nature on the part of persons employed by accredited academic institutions, public schools, government agencies, or nonprofit institutions engaged in the training of graduate students or social work interns pursuing the course of study leading to a master's degree in social work in an accredited college or university, or working in a recognized training program, provided that these activities and services constitute a part of a supervised course of study and that those persons are designated by such titles as social work interns, social work trainees, or other titles clearly indicating the training status appropriate to their level of training.*

Note that similar law exists in the LMFT and LPCC statutes. This law does not specifically address billing, but does imply that any time a title is used, it must clearly designate the student's status.

As this is occurring in exempt settings and involves students, the Board does not have jurisdiction. The committee may wish to discuss whether this is a public protection issue that the Board should somehow address.

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