May 27, 2022

Board of Behavioral Sciences
1625 N Market Blvd S-200
Sacramento, CA 95834

RE: Practicum Face-to-Face Requirements

Dear Members of the Behavioral Sciences Board and Telehealth Committee:

The California Association of Marriage and Family Therapists (CAMFT) and the California Association of Licensed Professional Clinical Counselors (CALPCC), would like to express our serious concerns on the sweeping changes that the Board of Behavioral Sciences (BBS) is considering on how a California Licensed Marriage and Family Therapist (LMFT) and Licensed Professional Clinical Counselor (LPCC) are trained to become a qualified, competent, and safe health care provider.

CAMFT and CALPCC appreciate the hard work of the BBS staff, the Telehealth Committee, and the BBS Board in addressing and discussing telehealth and its impact on the future of psychotherapy and the psychotherapist. We recognize determining how prelicensees provide services via telehealth in post-pandemic California is complicated, and there are important considerations to be taken into account.

In March 2022, the Telehealth Committee directed staff to draft legislative language redefining the concept of "face to face" and in essence, eliminating any requirement that LMFT and LPCC applicants in California have any training with a patient in person. We find this very concerning for the proficiency of the provider, and safety of the patient.

Currently, licensing laws require LMFT trainees to obtain 150 hours of "face-to-face" counseling experience[1] and LPCC applicants to obtain 280 hours of "face-to-face" counseling experience in their practicum.[2] During the COVID-19 state of emergency, BBS staff allowed "face-to-face" to include videoconferencing counseling to help continued access to mental health services during the crisis. That was a reasonable and appropriate allowance given the health and safety of both the provider and the patient. Now, as the state of California move out of the pandemic, we need to assess what worked, what did not, and make intentional and well-reasoned decisions on where to make policy change.

Apart from the required "face-to-face" practicum, there is no requirement in statute or regulations that ensures the therapist/counselor in training has any in-person interaction with their patients. Removing this requirement without substantially more research is problematic, and places harmful risks on consumer protection, as well as the integrity of the license.

[1] BPC §§4980.36(d)(1)(B)(ii)
[2] BPC §4999.33(c)(3)(L)

All modifications to education and training will shape providers' skill sets moving forward, and this change would allow newly licensed providers to have no in-person clinical experience. Instead, there is a foreseeable and likely outcome where a provider would be seeing and interacting with a patient in-person for the first time *after* acquiring their license (and thus, without supervision and any relevant training).

To underscore the necessity to properly and effectively train future providers, the BBS in their wisdom determined it was necessary for providers to learn how to interact and work with patients via telehealth. Some providers may never use telehealth; yet, the BBS is ensuring training in this mode to establish sufficient knowledge regarding the use of technology, patient privacy, and ethical use of telehealth *in case* that provider does move forward with telehealth treatment. However, with this motion, the pendulum has swung in the opposite and will remove any guarantee that budding providers have any proficiency or skill with in-person treatment.

Telehealth was never intended to replace in-person care in its entirety but to improve access and provide an alternative option to in-person visits. If both modes of therapy are permitted, then training should be comprehensive to include requisite training in both modes of therapy.

CAMFT and CALPCC recommend that providers be educated and trained to ensure that they are proficient in providing therapy/counseling, *regardless of the mode of treatment*. **Legislation sponsored by the BBS this year requires all applicants and licensees under the BBS to have telehealth training. If telehealth training is going to be required, then in-person training should also be required.** An educational framework that requires in-person and telehealth experience is necessary to ensure providers are experienced and skilled in all treatment methods, including evaluating to determine if telehealth is appropriate for a patient.[3]

Concerns raised by association members include the lack of evidence that clinicians trained solely using telehealth are proficient in providing in-person care (anecdotal feedback indicating such things as physical cues are missed in telehealth.) Other feedback is that it is unclear how telehealth-only-trained clinicians will know how to assess patients and recognize that not all clients are suited for telehealth. If the clinician has only conducted telehealth services and has never provided in-person counseling, how would the clinician know what to look for when making this assessment?

The Pacific Southwest Mental Health Technology Transfer Center released the "Telehealth Clinical and Technical Considerations for Mental Health Providers,"[4] which was supported by the U.S. Department of Health and Human Services/the Substance Abuse and Mental Health Services Administration, which

[3] Standards of Practice for Telehealth, 16 CCR 1815.5(d)(2)

[4] *Telehealth Clinical and Technical Considerations for Mental Health Providers*, which can be accessed at: https://cars-rp.org/_MHTTC/docs/Telehealth%20Clinical%20Considerations.pdf

addressed our concerns regarding the assessment and training limited to telehealth. The document recognizes that in-person assessments of a patient may differ from those done via telehealth, and that a clinician's senses they use in diagnosing are limited in remote settings:

> "**The assessment process must be adjusted in the telehealth context. Several of the clinician's senses that they often use in diagnosis (e.g., visual, auditory, olfactory) are limited in remote settings. Be creative with the Mental Status Exam (MSE) assessment to ensure that no aspect of an in-person assessment is omitted in the telemedicine context**. Pay attention to volume, diction, and speech content. Ask a client to walk across the room in view of the camera to assess gait and appearance. **Beyond the MSE, there are many tools created for in-person assessments that require special consideration when conducted remotely.** Cognitive, neuropsychological, and autism assessments are informed by the manipulation of physical materials, standardized interactions between assessor and client, and clinical observation of the person in a physical environment may or may not be appropriate for telehealth."

The paper also mentions the risks associated with Telehealth that could be exacerbated if clinicians lack in-person experience:

- Difficulty developing therapeutic alliance across distance. For example, clients with psychosis and dementia may feel discomfort with technology and experience emotional distance from provider.
- Difficulties managing intense client emotions during remote sessions. For example, clinicians have fewer ways to provide comfort and containment from a distance when they cannot hand the client a tissue or look directly into someone's eyes.

CAMFT and CALPCC are in strong support of the allowance of telehealth and the usage of telehealth towards licensure hours, as well as the necessity of requisite in-person training. Without any experience of delivering clinical services in-person prior to licensure, would a provider recognize whether they or their patient is experiencing these difficulties addressed above?

We supported the BBS telehealth survey conducted in 2021 to gather information to inform the BBS before making changes to the telehealth policy framework. The survey results were intended to guide the discussions regarding training and supervision and should be included in the decision to remove the face-to-face clinical hour training requirements.

The Telehealth survey responses from supervisors regarding a cap on counting telehealth hours towards licensure were close, with 47% responding that there should be a cap on the number of telehealth hours that supervisees can count towards licensure.

Supervisor Survey Question 8: Cap on Telehealth Hours (TH) Supervisees Can Count Towards Licensure?

No Cap: 53.17%
Telehealth Capped at 75% of Hours: 12.34%
Telehealth Capped at 50% of Hours: 24.22%
Telehealth Capped at 25% of Hours: 9.37%
Telehealth Capped No hours counted: 0.90%

This close margin helps demonstrate *existing supervisors'* concerns regarding pre-licensed individuals' potential lack of in-person experience.

CAMFT and CALPCC recommend that a minimum of in-person experience hours be established, but are open to stakeholder input and BBS assessment as to what the minimum should be. A required minimum of in-person hours will help ensure applicants obtain requisite training in both modes of treatment. CAMFT and CALPCC support the use of telehealth, requirements to train providers in telehealth, and remote supervision of prelicensees because such requirements increase access and training opportunities. We also advocate strengthening the qualifications and maintaining high standards of professional ethics and accountability of LMFTs and LPCCs. The proposed change to "face-to-face" counseling requirements does not move the profession forward, nor does it maintain high educational standards for LMFTs and LPCCs.

For these reasons, CAMFT and CALPCC respectfully request the Committee to reject any proposal or language that eliminates a minimum requirement of in-person counseling experience during practicum.

Sincerely,

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