



**BOARD OF BEHAVIORAL SCIENCES**  
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## MEETING NOTICE

### Marriage and Family Therapist Education Committee October 27, 2006

Crowne Plaza Hotel SFO  
1177 Airport Blvd  
Burlingame, CA 94010  
(877) 252-1558  
(415) 398-8900

**10:00 a.m. – 2:30 p.m.**

- I. Introductions
- II. Gap Analysis of Curriculum Standards (BBS Occupational Analysis, DACUM Competencies, AAMFT Core Competencies for MFTs, AMFTRB Practice Analysis)
- III. Discussion Regarding MHSA Workforce Draft Strategic Plan and the Integration of MHSA Principles in Marriage and Family Therapist (MFT) Education
  1. What do schools and agencies do currently to train students to be Culturally Competent?
  2. Do schools and agencies use consumers to train students as to the experience of mental illness and to the experience of obtaining treatment?
  3. Are schools teaching the MHSA recovery model? What does this mean when someone has a chronic mental illness?
- IV. Solicitation for Responses from Stakeholders Regarding:
  1. Do the current curriculum requirements allow the schools the flexibility to incorporate the new research and core competencies as established by the AAMFT, the DACUM and the MHSA?
  2. Are there topics or types of training that need to be mandated in order to guarantee public safety when MFTs practice in private practice and public agencies?
  3. Is the 48 unit requirement sufficient to cover state mandated requirements that have accumulated the core competencies for both private and public practice? Should the state consider a 60 unit requirement for licensure as an MFT?
- V. Suggestions for Future Agenda Items

*Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Items will be considered in the order listed. Times 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 facilities are accessible to persons with disabilities. Please make requests for accommodations to the attention of Christina Kitamura at the Board of Behavioral Sciences, 1625 N. Market Boulevard, Suite S-200, Sacramento, CA 95834, or by phone at 916-574-7835, no later than one week prior to the meeting. If you have any questions please contact the Board at (916) 574-7830.

**State of California  
Board of Behavioral Sciences**

**Memorandum**

**To:** Marriage and Family Therapist Education Committee      **Date:** October 18, 2006

**From:** Christy Berger, Legislation Analyst      **Telephone:** (916) 574-7847

**Subject: Marriage and Family Therapist Education Gap Analysis**

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Background

A number of entities have evaluated the practice of Marriage and Family Therapy, that is, what Marriage and Family Therapists (MFT) do in actual practice. This has been done on both a state level and on a national level and using different methods.

The attached chart is the result of comparing the current California MFT educational requirements with the results of four different analyses of MFT practice to determine where current MFT law may be outdated. The following analyses were included in the comparison:

- Board of Behavioral Sciences MFT Occupational Analysis (2002)
- American Association for Marriage and Family Therapy (AAMFT) Core Competencies (2004)
- Developing a Curriculum (DACUM) Competency Profile for MFTs (Public or Community-Based Mental Health Services - 2005)
- Association of Marriage and Family Therapy Regulatory Boards (AMFTRB): Role Delineation Study of MFT Practice (1998)

This gap analysis could have been done several different ways, given the complexity of the subject matter. This is our best attempt to compare MFT education-related licensing laws with four different studies of practice.

Discussion

The Business and Professions Code (BPC) contains educational that range from very general to very specific. One example of a “general” requirement is, “the broad range of matters that may arise in marriage and family relationships” (BPC §4980.37(a)(2)). This type of general requirement will naturally have a larger number of tasks, knowledges, or competencies that are applicable, as is evident in the attached “Gap Analysis Chart.”

For requirements that are more specific, the opposite occurs - far fewer tasks, knowledges, and competencies apply. However, some are so very specific that it was a bit of a stretch to find any that apply. This especially is true of some of the “Additional Coursework” requirements such as Human Sexuality.

Another challenge was comparing certain tasks of the DACUM to MFT law. For example, the DACUM applies to treatment of individuals, couples, families, groups, etc., and does not specifically address children. The BPC requires “a variety of approaches to the treatment of children.” Though many facets of therapy are specifically tailored to children, this study did not address those specifics. Therefore, any task that **could** apply to children was included.

Another factor that affected the analysis is that the BPC has a number of overlapping requirements. One example is “applied psychotherapeutic techniques” (BPC § 4980.40(b)(1)) and “the application of marriage and family relationship counseling principles and methods” (BPC §4980.37(a)(3)). While the latter is more specific, there is a great deal of overlap with the former. One reason for some of the overlap is that some requirements are specified for practicum while others are coursework requirements. Practicum requirements have been specified in the chart.

**Results**

According to the analysis, MFT education law may be lacking in one major content area, which is public/community practice. Additionally, most of the statutory language needs some work in order to remove overlapping requirements and to make some fine distinctions where a requirement is either not clearly distinguishable from another requirement or is not fully developed. The Board welcomes suggestions about how to do this. The areas that may be in need of work are included on Attachment 1.

**Board of Behavioral Sciences MFT Occupational Analysis**

MFT educational law matches up well with the Board’s occupational analysis. It is interesting to note that the majority of respondents to the occupational analysis indicated their primary work setting is a private practice. This is likely why it compares so well to current educational requirements, also designed for private practice.

**(AAMFT) Core Competencies**

MFT education law does not include any of the competencies defined in AAMFT’s “Research and Program Evaluation” domain. This domain includes the competencies listed below. All of these competencies, while generally important, are not directly relevant to clinical practice, the purpose for which the Board is licensing professionals. Most of these types of competencies are gained through a practitioner’s continuing education efforts.

Number	Competence
6.1.1	Know the extant MFT literature, research, and evidence-based practice.
6.1.2	Understand research and program evaluation methodologies, both quantitative and qualitative, relevant to MFT and mental health services.
6.1.3	Understand the legal, ethical, and contextual issues involved in the conduct of clinical research and program evaluation.
6.2.1	Recognize opportunities for therapists and clients to participate in clinical research.
6.3.1	Read current MFT and other professional literature.
6.3.2	Use current MFT and other research to inform clinical practice.
6.3.3	Critique professional research and assess the quality of research studies and program evaluation in the literature.
6.3.4	Determine the effectiveness of clinical practice and techniques.
6.4.1	Evaluate knowledge of current clinical literature and its application.
6.5.1	Contribute to the development of new knowledge.

**DACUM Competency Profile for MFTs**

A list of the DACUM tasks that did not match up with any of the current MFT educational requirements is provided below. Of all of the practice analyses, the DACUM had the greatest number of tasks that did not fit. It is the most recent profile of all of the practice analyses, and focuses on public practice and includes aspects central to the Mental Health Services Act (MHSA). Some of the DACUM tasks are very specific and are even agency-specific, such as G-16 “Provide education on foster parenting skills.” Others are very general. However, a number

of these tasks should be considered because the MHSA will certainly impact future MFT practice.

Of the tasks that did not match up with current MFT educational law, most are under “Perform Administrative Functions” and “Promote Professional Development.” While these skills are important for a particular job, most are not directly relevant to clinical practice, the purpose for which MFTs are licensed. Those that are relevant are those where administration and clinical skills come together, such as H-12, “Write clinical reports.”

Here are the tasks that did not fit:

#### Provide Education

- G-1 Provide education to clients about client rights
- G-8 Educate law enforcement workers about mental illness and recovery
- G-9 Educate students & interns about adult and child systems of care and coordinated services
- G-13 Provide education to consumer providers about work in the mental health field
- G-15 Provide education to erase the stigma about mental illness
- G-16 Provide education on foster parenting skills
- G-17 Educate community about co-occurring and other mental illnesses and recovery

#### Perform Administrative Functions

- H-1 Adhere to agency policies and procedures
- H-2 Participate in quality assurance
- H-3 Attend staff meetings
- H-4 Perform weekly supervision
- H-5 Track productivity levels of staff
- H-6 Gather performance outcome data
- H-7 Review client service data reports
- H-8 Monitor agency contracts
- H-9 Handle consumer/family complaints and grievances
- H-10 Supervise consumer staff volunteers
- H-11 Triage new referrals / determine dispositions
- H-12 Write clinical reports
- H-13 Maintain all required documentation
- H-14 Participate in staff performance evaluations
- H-15 Monitor MediCal eligibility through MIS (Management Information Systems)
- H-16 Participate in program development and design
- H-17 Complete billing procedures and logs
- H-18 Write grants and contracts
- H-19 Participate in hiring panels
- H-20 Outreach to find new clients
- H-21 Develop referral and community resource manuals

#### Promote Professional Development

- I-4 Maintain CEU requirements
- I-5 Participate in and promote mandatory trainings
- I-9 Mentor potential mental health workers
- I-10 Promote development/use of systemic, relational interventions in public mental health systems
- I-11 Develop community mental health training programs
- I-12 Attend professional events.
- I-13 Participate in career development opportunities

#### Also:

- A-8 Discuss and obtain signatures on HIPAA disclosure forms
- D-5 Provide benefits counseling
- E-13 Report to supervisor
- F-4 Participate in case conferences or daily treatment team meetings
- F-8 Coordinate with point of authorization

### **AMFTRB: Role Delineation Study of MFT Practice**

MFT law was found to be lacking in just one knowledge statement, “History of the marital and family field.” This is probably foundational coursework, and is another item not directly relevant to clinical practice.

#### Attachments

Gap Analysis Attachment 1

Gap Analysis Chart

Pertinent B & P Code

# ATTACHMENT

Agenda Item II A

Gap Analysis Attachment 1

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### Gap Analysis Attachment 1

<b>B&amp;P Code Section</b>	<b>Topic</b>	<b>Comment</b>
4980.40 (a)	<i>Marriage and family child counseling / Marital and family systems approaches to treatment</i>	Overlapping items.
4980.40 (a)(1)	<i>Theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy and marital and family systems approaches to treatment</i>	
4980.37 (a)(3)	<i>Application of marriage and family relationship counseling principles and methods</i>	
4980.40 (a)(2)	<i>How theories of marital and family therapy can be used in order to intervene therapeutically with couples, families, adults, children and groups</i>	

<b>B&amp;P Code Section</b>	<b>Topic</b>	<b>Comment</b>
4980.37 (a)(1)	<i>General diagnosis, assessment, prognosis and treatment of mental disorders</i>	Does "Dysfunctions" overlap with "Diagnosis"?
4980.40 (b)(1)	<i>Assessment (practicum)</i>	The others are clearly overlapping, items, but are split between practicum and coursework.
4980.40 (b)(1)	<i>Diagnosis (practicum)</i>	
4980.40 (b)(1)	<i>Dysfunctions (practicum)</i>	
4980.40 (b)(1)	<i>Prognosis (practicum)</i>	
4980.40 (b)(1)	<i>Treatment of premarital, couple, family, and child relationships (practicum)</i>	
4980.40 (a)(4)	<i>A variety of approaches to the treatment of children.</i>	The statute states, "The board shall, by regulation, set forth the subjects of instruction required in this subdivision" (4980.40(a)(4)). However, this has not been done.
4980.37 (a)(5)	<i>A variety of effective psychotherapeutic techniques and modalities to improve, restore or maintain healthy individual, couple and family relationships</i>	Psychotherapeutic techniques are likely covered under "treatment."
4980.40 (b)(1)	<i>Applied psychotherapeutic techniques (practicum)</i>	

B&P Code Section	Topic	Comment
4980.37 (a)(7)	<i>Cross-cultural mores and values</i>	Though not completely overlapping, these requirements could be better distinguished from each other. Also, a clinical perspective can be inferred, but is not explicit. To make explicit, possibly need to include: <ul style="list-style-type: none"> <li>• Language/translation issues</li> <li>• Acculturation</li> <li>• Cultural competence in assessment, diagnosis and treatment</li> <li>• Other diverse groups such as disabled, gay/lesbian, socioeconomic status, and spiritual/religious</li> </ul> Also, should the last item, 4980.37(b), remain optional?
4980.37 (a)(7)	<i>A familiarity with the wide range of racial and ethnic backgrounds common among CA's population.</i>	
4980.37 (b)	<i>Low income and multicultural mental health settings (practicum, <b>optional</b>)</i>	

B&P Code Section	Topic	Comment
4980.37 (a)(2)	<i>Broad range of matters that may arise within marriage and family relationships</i>	All are somewhat overlapping, and the first (4980.37(a)(2)) is very general.
4980.40 (a)(3)	<i>Specific family life events and the psychological, psychotherapeutic and health implications that arise within couples and families including, but not limited to childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting and geropsychology (<b>optional</b>)</i>	
4980.40 (a)(3)	<i>Developmental issues and life events from infancy and old age and their effect upon individuals, couples, and family relationship.</i>	

B&P Code Section	Topic	Comment
4980.40 (b)(1)	<i>Healthy functioning, health promotion, illness prevention (practicum)</i>	May need to make it more explicit that this refers to <u>mental</u> health.
4980.37 (a)(4)	<i>Encourages development of personal qualities intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion and personal presence.</i>	Possibly missing handling personal reactions and bias.
4980.41 (d)	<i>Alcoholism and other chemical substance dependency</i>	
4980.41 (e)	<i>Spousal or partner abuse assessment, detection and intervention</i>	
4980.39	<i>Aging and long term care</i>	Long-term care component is not defined in law.
4980.41 (a)	<i>California law and professional ethics</i>	
4980.41 (b)	<i>Child abuse assessment and reporting</i>	
4980.41 (c)	<i>Human sexuality</i>	
4980.41 (f)	<i>Psychological testing</i>	
4980.41 (g)	<i>Psychopharmacology</i>	

# ATTACHMENT

Agenda Item II A

Gap Analysis Chart

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**GAP ANALYSIS  
of Marriage and Family Therapist (MFT) Educational Requirements**

**TABLE 1 – PROGRAM REQUIREMENTS**

<b>BPC Section</b>	<b>Topic Required by Law</b>	<b>BBS MFT Occupational Analysis Task and Knowledge Statements</b>	<b>AAMFT Core Competencies</b>	<b>MFT DACUM Tasks</b>	<b>AMFTRB Task and Knowledge Statements</b>
4980.40 (a)	<i>Marriage and family child counseling / Marital and family systems approaches to treatment</i>	T: 49, 62 K: 89, 114, 115, 116	1.1.1, 1.1.2, 1.1.4, 1.3.3, 1.3.9, 2.3.6, 2.4.2, 3.1.1, 3.3.1, 3.3.4, 3.3.7, 4.1.1, 4.1.2, 4.3.1, 4.3.3, 4.3.4, 4.3.5, 4.3.7, 4.3.8, 4.5.2, 4.5.3	C-10, E-10, E-11, E-12, F-5, G-3, G-10	T: 01.01, 01.02, 01.03, 02.02, 02.03, 02.04, 02.07, 02.10, 02.11, 02.16, 02.18, 03.12, 03.13, 03.16, 03.17 K: 01, 05, 06, 08, 09, 10, 11, 21, 27, 31
4980.40 (b)(1)	<i>Applied psychotherapeutic techniques (practicum)</i>	T: 40, 41, 42, 44, 58, 59, 61, 62, 64, 65, 66 K: 56, 57, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 99, 100, 103, 104, 106, 107, 112, 113, 115, 116, 119, 120, 121, 122, 123, 124, 125, 126	3.1.1, 3.2.1, 3.3.1, 3.3.2, 3.3.3, 3.3.4, 3.3.5, 3.3.6, 3.3.7, 3.3.8, 3.3.9, 3.4.1, 3.4.2, 3.4.3, 4.1.1, 4.1.2, 4.2.1, 4.2.2, 4.3.1, 4.3.2, 4.3.3, 4.3.4, 4.3.5, 4.3.6, 4.3.7, 4.3.8, 4.3.9, 4.3.10, 4.3.11, 4.3.12, 4.4.1, 4.4.6, 4.5.1, 4.5.3	C-1, C-2, C-3, C-4, C-5, C-6, C-7, C-8, C-9, C-10, C-11, C-12, C-13, C-14, C-15, C-16, C-17, C-18, C-19, C-20, C-21, C-22, C-23, C-24, C-25, C-26, C-27, C-28	T: 03.01, 03.06, 03.07, 03.08, 03.09, 03.12, 03.13, 03.15, 03.16, 03.17, 03.18, 03.19, 03.20 K: 01, 05, 06, 07, 15, 16, 28, 37, 38, 39, 40, 44, 56
4980.40 (b)(1)	<i>Assessment (practicum)</i>	T: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 33, 34, 35, 36, 37, 38, 39 K: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 41, 52, 53, 54, 55, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70	1.2.2, 1.2.3, 1.3.1, 1.3.2, 1.4.1, 2.1.4, 2.1.6, 2.1.7, 2.2.1, 2.2.2, 2.2.4, 2.2.5, 2.3.2, 2.3.3, 2.3.4, 2.3.6, 2.3.7, 2.3.8, 2.3.9, 2.4.1, 2.4.4	A-2, A-3, B-1, B-2, B-3, B-4, B-5, B-6, B-7, B-8, B-9, B-10, B-11, B-12, B-13, B-14, B-15, B-16, B-17	T: 02.01, 02.02, 02.03, 02.04, 02.05, 02.06, 02.07, 02.08, 02.09, 02.10, 02.11, 02.12, 02.13, 02.14, 02.15, 02.16, 02.17, 02.18, 02.19, 02.20, 02.21 K: 09, 10, 11, 12, 15, 16, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 29, 30, 41, 42, 43, 46, 47
4980.40 (b)(1)	<i>Diagnosis (practicum)</i>	T: 25, 26, 28, 29 K: 39, 40, 41, 42, 44, 45	2.1.2, 2.1.5, 2.1.6, 2.1.7, 2.2.3, 2.3.1, 2.4.3, 3.2.1	A-3, B-3, B-10	T: 02.05, 02.06, 02.08, 02.14, 02.15, 02.16, 02.17, 02.18, 02.19, 02.20 K: 06, 08, 09, 10, 11, 12, 13, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 41, 42, 43, 45, 46
4980.40 (b)(1)	<i>Prognosis (practicum)</i>	T: 3, 22, 25, 26, 28, 29, 30, 31, 32 K: 6, 39, 40, 41, 42, 44, 45, 46, 47, 48, 50	2.1.2, 2.1.5, 2.1.6, 2.1.7, 2.2.3, 2.3.1, 2.4.3, 3.2.1, 4.3.11, 4.4.3, 4.4.5	A-3, B-3, B-10, C-22, C-23, C-24, C-28, E-20	T: 02.05, 02.06, 02.08, 02.14, 02.15, 02.16, 02.17, 02.18, 02.19, 02.20, 03.21, 04.01, 04.02, 04.03, 04.04, 04.05 K: 06, 08, 09, 10, 11, 12, 13, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 41, 42, 43, 45, 46
4980.40 (b)(1)	<i>Treatment of premarital, couple, family, and child relationships (practicum)</i>	T: 30, 31, 32, 40, 41, 42, 44, 45, 46, 47, 48, 49, 51, 52, 53, 54, 55, 56, 57, 58, 59, 61, 62, 64, 65, 66 K: 9, 32, 46, 47, 48, 49, 50, 51, 56, 57, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 111, 112, 113, 114, 115, 116, 117, 119, 120, 121, 122, 123, 124, 125, 126	3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.2.1, 3.3.1, 3.3.2, 3.3.3, 3.3.4, 3.3.5, 3.3.6, 3.3.7, 3.3.8, 3.3.9, 3.4.1, 3.4.2, 3.4.3, 3.4.4, 3.4.5, 3.5.1, 3.5.2, 3.5.3, 3.5.4, 4.1.1, 4.1.2, 4.2.1, 4.2.2, 4.3.1, 4.3.2, 4.3.3, 4.3.4, 4.3.5, 4.3.6, 4.3.7, 4.3.8, 4.3.9, 4.3.10, 4.3.11, 4.3.12, 4.4.1, 4.4.2, 4.4.3, 4.4.4, 4.4.5, 4.4.6, 4.5.1, 4.5.2, 4.5.3	A-10, C-10, C-15, C-16, E-10, E-11, E-12, F-5, F-7	T: 01.01, 03.01, 03.02, 03.03, 03.04, 03.05, 03.06, 03.07, 03.08, 03.09, 03.10, 03.11, 03.12, 03.13, 03.14, 03.15, 03.16, 03.17, 03.18, 03.19, 03.20, 03.21, 04.01, 04.02, 04.03, 04.04, 04.05, 05.07 K: 01, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 44, 45, 46, 56
4980.40 (b)(1)	<i>Dysfunctions (practicum)</i>	T: 25, 26, 28, 29 K: 39, 40, 41, 42, 44, 45	2.1.2, 2.1.5, 2.1.6, 2.1.7, 2.2.3, 2.3.1, 2.4.3, 3.2.1	A-3, B-3, B-10	T: 02.05, 02.06, 02.08, 02.14, 02.15, 02.16, 02.17, 02.18, 02.19, 02.20 K: 06, 08, 09, 10, 11, 12, 13, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 41, 42, 43, 45, 46
4980.40 (b)(1)	<i>Healthy functioning, health promotion, illness prevention (practicum)</i>	T: 30, 32, 45, 46, 47, 52, 55, 57 K: 34, 44, 46, 47, 48, 50, 51, 59, 81, 82, 83, 86, 87, 93, 94, 95	2.2.5, 2.3.1, 2.3.8, 2.4.3, 3.1.4, 3.3.6, 4.1.2, 4.3.6, 4.3.9	B-12, C-19, C-20, C-21, C-23, C-26, D-14, D-23, E-11, G-2, G-3, G-4, G-5, G-6, G-7, G-10	T: 02.12, 03.01, 03.03, 03.15, 03.16, 03.18, 03.19, 03.20 K: 31, 39, 48
4980.37 (b)	<i>Low income and multicultural mental health settings (practicum, optional)</i>	T: 5, 14, 23, 24, 48 K: 10, 11, 24, 28, 35, 36, 37, 41, 88, 122, 141	1.2.1, 1.2.2, 1.3.1, 2.1.4, 2.1.6, 2.3.2, 3.5.1, 4.1.1, 4.1.2, 4.3.2, 4.4.1, 4.4.6, 4.5.1	A-4, B-4, B-13, C-3, D-2, D-7, D-10, G-12, I-1	T: 01.04, 01.05, 02.06, 02.08, 02.12, 02.19, 02.21, 03.03, 03.09, 03.11, 03.14, 04.02, 04.03, 05.04 K: 42, 44, 53, 55, 56

**LEGEND:** BPC = Business and Professions Code      T = Task      BBS = Board of Behavioral Sciences      DACUM = Developing A Curriculum      AMFTRB = Association of Marriage and Family Therapy Regulatory Boards  
K = Knowledge      AAMFT = American Association of Marriage and Family Therapists

**TABLE 1 – PROGRAM REQUIREMENTS (continued)**

BPC Section	Topic Required by Law	BBS MFT Occupational Analysis Task and Knowledge Statements	AAMFT Core Competencies	MFT DACUM Tasks	AMFTRB Task and Knowledge Statements
4980.37 (a)(1)	<i>General diagnosis, assessment, prognosis and treatment of mental disorders</i>	T:* 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 28, 29, 33, 34, 35, 36, 37, 38, 39 K:* 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 52, 53, 54, 55, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70	1.2.2, 1.2.3, 1.3.1, 1.3.2, 1.4.1, 2.1.2, 2.1.4, 2.1.5, 2.1.6, 2.1.7, 2.2.1, 2.2.2, 2.2.3, 2.2.4, 2.2.5, 2.3.1, 2.3.2, 2.3.3, 2.3.4, 2.3.6, 2.3.7, 2.3.8, 2.3.9, 2.4.1, 2.4.2, 2.4.3, 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.2.1, 3.3.1, 3.3.2, 3.3.3, 3.3.4, 3.3.5, 3.3.6, 3.3.7, 3.3.8, 3.3.9, 3.4.1, 3.4.2, 3.4.3, 3.4.4, 3.4.5, 3.5.1, 3.5.2, 3.5.3, 3.5.4, 4.1.1, 4.1.2, 4.2.1, 4.2.2, 4.3.1, 4.3.2, 4.3.3, 4.3.4, 4.3.5, 4.3.6, 4.3.7, 4.3.8, 4.3.9, 4.3.10, 4.3.11, 4.3.12, 4.4.1, 4.4.2, 4.4.3, 4.4.4, 4.4.5, 4.4.6, 4.5.1, 4.5.2, 4.5.3	A-3, A-10, B-3, B-10, C-10, C-15, C-16, E-10, E-11, E-12, E-15, E-20, F-5, F-7	T: 01.01, 02.05, 02.06, 02.08, 02.14, 02.15, 02.16, 02.17, 02.18, 02.19, 02.20, 03.01, 03.02, 03.03, 03.04, 03.05, 03.06, 03.07, 03.08, 03.09, 03.10, 03.11, 03.12, 03.13, 03.14, 03.15, 03.16, 03.17, 03.18, 03.19, 03.20, 03.21, 04.01, 04.02, 04.03, 04.04, 04.05, 05.07 K: 06, 08, 09, 10, 11, 12, 13, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 41, 42, 43, 45, 46
4980.37 (a)(2)	<i>Broad range of matters that may arise within marriage and family relationships</i>	T: 6, 7, 8, 9, 10, 12, 13, 16, 23, 24, 34, 36, 42, 66 K: 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 26, 28, 35, 37, 41, 54, 60, 61, 62, 63, 64, 67, 74, 75, 119, 120, 121, 122, 123, 124, 125, 126	2.1.1, 2.1.2, 2.1.3, 2.1.5, 2.2.3, 2.2.5, 2.3.1, 2.3.2, 2.3.5, 2.3.6, 2.3.7, 2.3.9, 3.3.6, 3.4.3, 4.3.7, 5.3.4	B-4, B-5, B-6, B-7, B-8, D-10, E-5, G-3, G-6, G-10, G-11, G-12, G-14	T: 01.01, 02.05, 02.06, 02.08, 02.14, 02.15, 02.16, 02.17, 02.18, 02.19, 02.20, 03.01, 03.02, 03.03, 03.04, 03.05, 03.06, 03.07, 03.08, 03.09, 03.10, 03.11, 03.12, 03.13, 03.14, 03.15, 03.16, 03.17, 03.18, 03.19, 03.20, 03.21, 04.01, 04.02, 04.03, 04.04, 04.05, 05.07 K: 03, 04, 08, 09, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 46, 56
4980.37 (a)(3)	<i>Application of marriage and family relationship counseling principles and methods</i>	T: 41, 42, 44, 49, 59, 62 K: 74, 75, 78, 79, 80, 89, 114, 115, 116	1.1.1, 1.1.2, 1.1.4, 1.3.3, 1.3.9, 2.3.6, 2.4.2, 3.1.1, 3.3.1, 3.3.4, 3.3.7, 4.1.1, 4.1.2, 4.3.1, 4.3.3, 4.3.4, 4.3.5, 4.3.7, 4.3.8, 4.5.2, 4.5.3	C-10, E-10, E-11, E-12, F-5, G-3, G-10	T: 01.01, 01.02, 01.03, 02.02, 02.03, 02.04, 02.07, 02.10, 02.11, 02.16, 02.18, 03.12, 03.13, 03.16, 03.17 K: 01, 05, 06, 08, 09, 10, 11, 21, 27, 31
4980.37 (a)(4)	<i>Encourages development of personal qualities intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion and personal presence.</i>	T: 45, 48, 56, 57, 72, 77, 78, 79 K: 88, 97, 98, 99, 101, 138, 140, 146, 147, 148, 149, 150	1.3.6, 1.3.7, 1.3.9, 2.4.4, 3.4.5, 4.3.1, 4.3.2, 4.4.6, 4.5.1, 4.5.2, 5.1.4, 5.2.2, 5.3.10, 5.4.2, 5.5.2, 5.5.3	C-3, C-22, I-2, I-3, I-6, I-7, I-8	T: 01.01, 01.04, 01.05, 01.06, 01.07, 03.09, 03.19, 05.04, 05.07, 05.08, 05.11 K: 53
4980.37 (a)(5)	<i>A variety of effective psychotherapeutic techniques and modalities to improve, restore or maintain healthy individual, couple and family relationships</i>	T: 40, 41, 42, 44, 58, 59, 61, 62, 64, 65, 66 K: 56, 57, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 99, 100, 103, 104, 106, 107, 112, 113, 115, 116, 119, 120, 121, 122, 123, 124, 125, 126	3.1.1, 3.2.1, 3.3.1, 3.3.2, 3.3.3, 3.3.4, 3.3.5, 3.3.6, 3.3.7, 3.3.8, 3.3.9, 3.4.1, 3.4.2, 3.4.3, 4.1.1, 4.1.2, 4.2.1, 4.2.2, 4.3.1, 4.3.2, 4.3.3, 4.3.4, 4.3.5, 4.3.6, 4.3.7, 4.3.8, 4.3.9, 4.3.10, 4.3.11, 4.3.12, 4.4.1, 4.4.6, 4.5.1, 4.5.3	C-1, C-2, C-3, C-4, C-5, C-6, C-7, C-8, C-9, C-10, C-11, C-12, C-13, C-14, C-15, C-16, C-17, C-18, C-19, C-20, C-21, C-22, C-23, C-24, C-25, C-26, C-27, C-28	T: 03.01, 03.06, 03.07, 03.08, 03.09, 03.12, 03.13, 03.15, 03.16, 03.17, 03.18, 03.19, 03.20 K: 01, 05, 06, 07, 15, 16, 28, 37, 38, 39, 40, 44, 56
4980.37 (a)(7)	<i>Cross-cultural mores and values</i>	T: 14, 23, 24, 48 K: 10, 11, 24, 28, 35, 36, 88, 92, 141	1.1.3, 1.2.1, 1.2.2, 1.3.1, 2.1.4, 2.1.6, 4.1.1, 4.1.2, 4.3.2, 4.4.1, 4.4.6, 4.5.1	B-4, C-3, D-2, I-1	T: 01.04, 01.05, 02.06, 03.03, 03.09, 05.04, 05.09 K: 53
4980.37 (a)(7)	<i>A familiarity with the wide range of racial and ethnic backgrounds common among CA's population.</i>	T: 5, 14, 23, 24, 48 K: 10, 11, 24, 28, 35, 36, 88, 92, 141	1.1.3, 1.2.1, 1.2.2, 1.3.1, 2.1.4, 2.1.6, 4.1.1, 4.1.2, 4.3.2, 4.4.1, 4.4.6, 4.5.1	B-4, C-3, D-2, I-1	T: 01.04, 01.05, 02.06, 03.03, 03.09, 05.04, 05.09 K: 53

**LEGEND:** BPC = Business and Professions Code      T = Task      BBS = Board of Behavioral Sciences      DACUM = Developing A Curriculum      AMFTRB = Association of Marriage and Family Therapy Regulatory Boards  
 K = Knowledge      AAMFT = American Association of Marriage and Family Therapists

**TABLE 2 – COURSEWORK REQUIRED AS PART OF DEGREE PROGRAM**

	<b>Topic Required by Law</b>	<b>BBS Occupational Analysis Task and Knowledge Statements</b>	<b>AAMFT Core Competencies</b>	<b>MFT DACUM Tasks</b>	<b>AMFTRB Task and Knowledge Statements</b>
4980.40 (a)(1)	<i>Theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy and marital and family systems approaches to treatment</i>	T:* 48, 49, 58, 59, 61, 62 K:* 32, 88, 89, 100, 102, 103, 104, 105, 106, 107, 108, 111, 112, 113, 114, 115, 116, 117	1.1.1, 1.1.2, 1.1.4, 1.3.3, 1.3.9, 2.3.6, 2.4.2, 3.1.1, 3.3.1, 3.3.4, 3.3.7, 4.1.1, 4.1.2, 4.3.1, 4.3.3, 4.3.4, 4.3.5, 4.3.7, 4.3.8, 4.5.2, 4.5.3	C-9, C-10, C-11, C-12, C-13	T: 01.01, 01.02, 01.03, 02.02, 02.03, 02.04, 02.07, 02.10, 02.11, 02.16, 02.18, 03.12, 03.13, 03.16, 03.17 K: 01, 05, 06, 08, 09, 10, 11, 21, 27, 31
4980.40 (a)(2)	<i>How theories of marital and family therapy can be used in order to intervene therapeutically with couples, families, adults, children and groups</i>	T: 48, 49, 58, 59, 61, 62 K: 32, 88, 89, 100, 102, 103, 104, 105, 106, 107, 108, 111, 112, 113, 114, 115, 116, 117	1.1.1, 1.1.2, 1.1.4, 1.3.3, 1.3.9, 2.3.6, 2.4.2, 3.1.1, 3.3.1, 3.3.4, 3.3.7, 4.1.1, 4.1.2, 4.3.1, 4.3.3, 4.3.4, 4.3.5, 4.3.7, 4.3.8, 4.5.2, 4.5.3	C-1, C-2, C-3, C-4, C-5, C-6, C-7, C-8, C-9, C-10, C-11, C-12, C-13, C-14, C-15, C-16, C-17, C-18, C-19, C-20, C-21, C-22, C-23, C-24, C-25, C-26, C-27, C-28	T: 01.01, 01.02, 01.03, 02.02, 02.03, 02.04, 02.07, 02.10, 02.11, 02.16, 02.18, 03.12, 03.13, 03.16, 03.17 K: 01, 05, 06, 08, 09, 10, 11, 21, 27, 31
4980.40 (a)(3)	<i>Developmental issues and life events from infancy and old age and their effect upon individuals, couples, and family relationship.</i>	T: 8, 65 K: 15, 16, 17, 27, 123, 124, 125	2.1.1, 2.1.5, 2.3.1, 2.3.2, 2.3.7	No tasks, but listed in "General Knowledge and Skills" section	T: 02.09, 02.10, 02.11 K: 11, 12, 13, 17
4980.40 (a)(3)	<i>Specific family life events and the psychological, psychotherapeutic and health implications that arise within couples and families including, but not limited to childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting and geropsychology (optional)</i>	T: 8, 65 K: 15, 16, 17, 27, 123, 124, 125	2.1.1, 2.1.5, 2.3.1, 2.3.2, 2.3.7	G-11, G-14	T: 02.09, 02.10, 02.11 K: 11, 12, 13, 17
4980.40 (a)(4)	<i>A variety of approaches to the treatment of children.</i>	T: 18, 21, 54, 65, 70, 80, 90 K: 30, 33, 53, 62, 63, 75, 120, 123, 124, 125, 154, 165, 166	1.3.4, 1.3.9, 1.5.1, 2.1.1, 2.3.2, 2.3.5, 4.3.2, 5.3.4	B-1, B-4, B-8, B-12, C-15, C-16, D-8, D-12, D-13, D-15, E-11, E-19, F-5, G-14	T: 01.05, 01.06, 01.07, 02.01, 02.07, 02.10, 02.11, 02.12, 02.13, 03.04, 03.08, 03.10, 03.13, 03.16, 05.03 K: 03, 06, 07, 09, 10, 11, 12, 16, 17, 18, 19, 20, 21, 22, 23, 24, 28, 32, 33, 35, 38, 40, 42, 43, 55
4980.41 (d)	<i>Alcoholism and other chemical substance dependency</i>	T: 6, 7 K: 12, 13, 14, 39, 51, 119	1.2.2, 1.2.3, 1.3.8, 1.4.1, 2.1.2, 2.1.3, 2.1.5, 2.2.2, 2.3.1, 2.3.5, 3.1.4, 3.3.6, 3.3.8, 3.4.3, 3.4.5	A-2, B-6, C-8, C-22, D-8, D-17, E-5, E-8, E-14, E-17, E-18, F-3, G-3	T: 02.06, 02.07, 02.08, 02.11, 02.12, 02.18, 02.19, 02.20, 02.21, 03.11, 03.15, 03.18, 03.19, 03.20, 05.03, 05.04, 05.07, 05.08, 05.09, 05.11 K: 09, 12, 16, 19, 21, 22, 24, 30, 42, 44, 49, 55, 56
4980.41 (e)	<i>Spousal or partner abuse assessment, detection and intervention</i>	T: 2, 15, 16, 22, 23, 26, 37, 41, 42, 43, 45, 51 K: 4, 5, 24, 25, 28, 34, 35, 37, 41, 44, 60, 64, 65, 73, 74, 75, 78, 79, 80, 83, 92, 99, 155, 156	1.1.1, 1.1.4, 1.2.1, 1.2.2, 1.2.3, 1.3.1, 1.3.2, 1.3.4, 1.3.9, 2.1.5, 2.2.1, 2.2.2, 2.2.3, 2.2.4, 2.3.5, 2.3.8, 2.4.4, 3.3.6, 3.4.3, 4.3.5, 4.3.7, 4.4.6, 4.5.2, 5.3.4	B-8, B-12, B-13, C-8, D-8, E-1, E-9, E-10, E-11, E-12, E-21, E-22, G-4, G-6, G-11	T: 01.06, 01.07, 02.01, 02.02, 02.03, 02.04, 02.06, 02.07, 02.08, 02.09, 02.10, 02.11, 02.12, 02.13, 02.17, 02.18, 02.19, 02.20, 02.21, 03.04, 03.05, 03.08, 03.11, 03.12, 03.13, 03.14, 03.15, 03.16, 04.02, 04.03, 05.03, 05.04, 05.05, 05.06, 05.07, 05.08, 05.09, 05.10, 05.11 K: 01, 03, 04, 06, 07, 08, 09, 10, 11, 15, 16, 17, 18, 19, 21, 22, 23, 27, 28, 29, 30, 31, 37, 38, 56

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 K = Knowledge      AAMFT = American Association of Marriage and Family Therapists

**TABLE 3 – ADDITIONAL COURSEWORK REQUIRED PRIOR TO LICENSURE**

	Topic Required by Law	BBS Occupational Analysis Task and Knowledge Statements	AAMFT Core Competencies	MFT DACUM Tasks	AMFTRB Task and Knowledge Statements
4980.39	<i>Aging and long term care</i>	T:* 8, 65, 80 K:** 15, 16, 17, 27, 120, 123, 124, 125, 154	2.1.1, 2.1.5, 2.3.1, 2.3.2, 2.3.7	B-8, B-11, B-12, B-14, C-26, D-10, D-11, D-12, D-17, D-18, E-6, E-11, E-12, E-14, F-5	T: 01.05, 02.01, 02.06, 02.08, 02.09, 02.10, 02.11, 02.12, 02.13, 02.18, 02.19, 02.20, 02.21, 03.04, 03.08, 03.10, 05.05 K: 07, 11, 12, 13, 17, 19, 20, 21, 29, 30, 38, 45, 46, 49
4980.41 (a)	<i>California law and professional ethics</i>	T: 67, 68, 69, 70, 71, 72, 73, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 93, 94, 95 K: 132, 133, 134, 135, 136, 137, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 168, 170, 171, 172, 173	1.3.5, 1.5.3, 2.5.1, 5.1.1, 5.1.2, 5.1.3, 5.1.4, 5.2.1, 5.2.2, 5.2.3, 5.2.4, 5.3.1, 5.3.2, 5.3.3, 5.3.4, 5.3.5, 5.3.6, 5.3.7, 5.3.8, 5.3.9, 5.3.10, 5.4.1, 5.4.2, 5.5.1, 5.5.2, 5.5.3, 5.5.4	A-4, A-5, A-6, A-9, B-15, D-8, D-12, D-20, D-21, D-22, E-4, E-16	T: 05.01, 05.02, 05.03, 05.04, 05.05, 05.06, 05.07, 05.08, 05.09, 05.10, 05.11, 05.12, 05.13 K: 49, 50, 51, 52, 56
4980.41 (b)	<i>Child abuse assessment and reporting</i>	T: 21, 24, 26, 36, 42, 55, 69, 70 K: 1, 2, 3, 4, 33, 41, 60, 61, 62, 63, 75, 96, 134, 135, 136, 154, 157	1.2.2, 1.2.3, 1.5.1, 1.5.2, 2.2.2, 2.3.2, 2.3.3, 2.3.5, 2.3.8, 5.1.1, 5.1.2, 5.1.3, 5.2.1, 5.3.2, 5.3.3, 5.3.4, 5.3.5, 5.3.6	A-9, B-1, B-8, B-12, D-8, D-12, D-15, D-21, D-22, E-19, F-6, F-9, G-14	T: 01.05, 01.06, 01.07, 02.01, 02.07, 02.10, 02.11, 02.12, 02.13, 03.04, 03.08, 03.10, 03.13, 03.16, 05.03 K: 03, 06, 07, 09, 10, 11, 12, 16, 17, 18, 19, 20, 21, 22, 23, 24, 28, 32, 33, 35, 38, 40, 42, 43, 55
4980.41 (c)	<i>Human sexuality</i>	T: 79, 89 K: 126, 148, 164	1.1.1, 2.1.1, 2.2.5, 2.3.7	None	T: 01.04 K: 03, 04, 08, 13, 14, 34, 36, 39, 40, 41, 43
4980.41 (f)	<i>Psychological testing</i>	T: 11, 13, 35, 93 K: 21, 22, 23, 58, 59, 143, 169	2.1.4, 2.1.7, 2.3.4, 2.3.6, 2.4.1, 5.3.7	B-9, B-17, E-2	T: 02.14, 03.10, 05.03, 05.05 K: 25, 26, 27
4980.41 (g)	<i>Psychopharmacology</i>	T: 28 K: 44	2.1.1, 2.2.2, 2.2.5, 3.1.3, 5.3.7	D-11, D-18, E-6, E-7, F-1, G-5	T: 02.18, 02.19, 05.03, 05.05, 05.09 K: 22, 29, 30, 54

**Missing:**

**AAMFT Core Competencies**

6.1.1, 6.1.2, 6.1.3, 6.2.1, 6.3.1, 6.3.2, 6.3.3, 6.3.4, 6.4.1, 6.5.1

**DACUM**

A-8, D-5, E-13, F-4, F-8, G-1, G-8, G-9, G-13, G-15, G-16, G-17, H-1, H-2, H-3, H-4, H-5, H-6, H-7, H-8, H-9, H-10, H-11, H-12, H-13, H-14, H-15, H-16, H-17, H-18, H-19, H-20, H-21, I-4, I-5, I-9, I-10, I-11, I-12, I-13

**AMFTRB**

K: 02

**LEGEND:**

BPC = Business and Professions Code

T = Task

K = Knowledge

BBS = Board of Behavioral Sciences

AAMFT = American Association of Marriage and Family Therapists

DACUM = Developing A Curriculum

AMFTRB = Association of Marriage and Family Therapy Regulatory Boards

# ATTACHMENT

Agenda Item II A

Pertinent B&P Code

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## **PERTINENT B&P CODE**

### **§4980.37. DEGREE PROGRAM; COURSE OF STUDY AND PROFESSIONAL TRAINING**

(a) In order to provide an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of marriage and family therapists, a degree program which meets the educational qualifications for licensure shall include all of the following:

(1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, prognosis, and treatment of mental disorders.

(2) Prepare students to be familiar with the broad range of matters that may arise within marriage and family relationships.

(3) Train students specifically in the application of marriage and family relationship counseling principles and methods.

(4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(5) Teach students a variety of effective psychotherapeutic techniques and modalities that may be utilized to improve, restore, or maintain healthy individual, couple, and family relationships.

(6) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(7) Prepare students to be familiar with cross-cultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California's population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans.

(b) Educational institutions are encouraged to design the practicum required by subdivision (b) of Section 4980.40 to include marriage and family therapy experience in low-income and multicultural mental health settings.

### **§4980.39. ADDITIONAL COURSEWORK**

(a) Any applicant for licensure as a marriage and family therapist who began graduate study on or after January 1, 2004, shall complete, as a condition of licensure, a minimum of 10 contact hours of coursework in aging and long-term care, which could include, but is not limited to, the biological, social, and psychological aspects of aging.

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

#### **§4980.40. QUALIFICATIONS**

To qualify for a license, an applicant shall have all the following qualifications:

(a) Applicants shall possess a doctor's or master's degree in marriage, family, and child counseling, marital and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university accredited by the Western Association of Schools and Colleges, or approved by the Bureau for Private Postsecondary and Vocational Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval. In order to qualify for licensure pursuant to this subdivision, a doctor's or master's degree program shall be a single, integrated program primarily designed to train marriage and family therapists and shall contain no less than 48 semester or 72 quarter units of instruction. The instruction shall include no less than 12 semester units or 18 quarter units of coursework in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment.

The coursework shall include all of the following areas:

(1) The salient theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy, and marital and family systems approaches to treatment.

(2) Theories of marriage and family therapy and how they can be utilized in order to intervene therapeutically with couples, families, adults, children, and groups.

(3) Developmental issues and life events from infancy to old age and their effect upon individuals, couples, and family relationships. This may include coursework that focuses on specific family life events and the psychological, psychotherapeutic, and health implications that arise within couples and families, including, but not limited to, childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting, and geropsychology.

(4) A variety of approaches to the treatment of children. The board shall, by regulation, set forth the subjects of instruction required in this subdivision.

(b) (1) In addition to the 12 semester or 18 quarter units of coursework specified above, the doctor's or master's degree program shall contain not less than six semester or nine quarter units of supervised practicum in applied psychotherapeutic techniques, assessment, diagnosis, prognosis, and treatment of premarital, couple, family, and child relationships, including dysfunctions, healthy functioning, health promotion, and illness prevention, in a supervised clinical placement that provides supervised fieldwork experience within the scope of practice of a marriage and family therapist.

(2) For applicants who enrolled in a degree program on or after January 1, 1995, the practicum shall include a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(3) The practicum hours shall be considered as part of the 48 semester or 72 quarter unit requirement.

(c) As an alternative to meeting the qualifications specified in subdivision (a), the board shall accept as equivalent degrees, those master's or doctor's degrees granted by educational institutions whose degree program is approved by the Commission on Accreditation for Marriage and Family Therapy Education.

(d) All applicants shall, in addition, complete the coursework or training specified in Section 4980.41.

(j) An applicant for licensure trained in an educational institution outside the United States shall demonstrate to the satisfaction of the board that he or she possesses a qualifying degree that is equivalent to a degree earned from a school, college, or university accredited by the Western Association of Schools and Colleges, or approved by the Bureau of Private Postsecondary and Vocational Education. These applicants shall provide the board with a comprehensive evaluation of the degree performed by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES), and shall provide any other documentation the board deems necessary.

#### **§4980.41. ELIGIBILITY TO SIT FOR LICENSING EXAMINATIONS; COURSEWORK OR TRAINING**

All applicants for licensure shall complete the following coursework or training in order to be eligible to sit for the licensing examinations as specified in subdivision (g) of Section 4980.40:

(a) A two semester or three quarter unit course in California law and professional ethics for marriage and family therapists, which shall include, but not be limited to, the following areas of study:

(1) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the profession's scope of practice.

(2) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including family law.

(3) The current legal patterns and trends in the mental health profession.

(4) The psychotherapist/patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.

(5) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics.

This course may be considered as part of the 48 semester or 72 quarter unit requirements contained in Section 4980.40.

(b) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations promulgated thereunder.

(c) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Section 4980.40.

(d) For persons who began graduate study on or after January 1, 1986, a master's or doctor's degree qualifying for licensure shall include specific instruction in alcoholism and other chemical substance dependency as specified by regulation. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Section 4980.40.

(e) For persons who began graduate study during the period commencing on January 1, 1995, and ending on December 31, 2003, a master's or doctor's degree qualifying for licensure shall include coursework in spousal or partner abuse assessment, detection, and intervention. For persons who began graduate study on or after January 1, 2004, a master's or doctor's degree qualifying for licensure shall include a minimum of 15 contact hours of coursework in spousal or partner abuse assessment, detection, and intervention strategies, including knowledge of community resources, cultural factors, and same gender abuse dynamics. Coursework required under this subdivision may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course. The requirement for coursework shall be satisfied by, and the board shall accept in satisfaction of the requirement, a certification from the chief academic officer of the educational institution from which the applicant graduated that the required coursework is included within the institution's required curriculum for graduation.

(f) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychological testing. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Section 4980.40.

(g) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychopharmacology. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Section 4980.40.

## **M e m o r a n d u m**

**To:** MFT Education Committee

**Date:** October 18, 2006

**From:** Christy Berger  
Legislation Analyst

**Telephone:** (916) 574-7847

**Subject: Public Mental Health Competencies in California: A Comparison**

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### Background

In 2005, the California Mental Health Planning Council (CMHPC) Human Resources Project performed an analysis of MFT public/community practice called the “DACUM” (Developing a Curriculum) Competency Profile for MFTs. In 2006, the California Social Work Education Center (CalSWEC) performed a similar analysis for the social work profession, though this analysis focused on **student** competencies for public mental health services.

The DACUM is already being used to help determine curriculum changes that might be needed for MFTs, who are working more and more often in public practice settings. However, a comparison between the DACUM and the CalSWEC competencies should be useful as another point of reference in understanding the skills required for public mental health practice.

### Comparison

The DACUM's tasks are fairly short where CalSWEC's student competencies are very detailed. Some of the ideas expressed explicitly in the CalSWEC are often more subtly implied in the DACUM. For this reason, a side-by-side comparison was not possible. Instead, we made a best attempt at describing important differences between the two documents, provided below. An attempt was made to hone down the CalSWEC competencies to its fundamental ideas for purposes of the analysis. The comparison focuses strictly on items related to public/community practice. The CalSWEC competencies are used as a framework for comparison since the document is more comprehensive.

### **I. Culturally and Linguistically Competent Generalist/Mental Health Practice**

The DACUM contains several tasks and one “knowledge” related to cultural and linguistic competence. In comparison, this section of the CalSWEC is extremely detailed and includes the following items which are not in the DACUM:

- An understanding of the impact and importance of assimilation and acculturation processes.
- An understanding of how the consumer's language can affect the expression and understanding of symptoms.
- An understanding of how the student's own worldview, biases, prejudices, and beliefs affect relationships with consumers.
- An understanding of the disparities for diverse groups in terms of access, availability and quality of mental health services.

- Knowledge regarding the impact of culture on diagnosis, treatment and help-seeking behavior.

## **II. Foundation Practice/Advanced Mental Health Practice**

### *A. Practice with Individuals*

The DACUM contains a fairly thorough listing of tasks related to treatment, some of which are directed at the individual. However, many of those tasks overlap with practice focused on families and groups. The CalSWEC document is much more detailed regarding treatment of individuals, and includes the following not addressed in the DACUM:

- An understanding of factors contributing to serious emotional disturbances.
- An understanding of the factors contributing to the disabling effects of severe mental illness.
- The ability to apply research methodology to evaluate and apply evidence-based and promising practices.
- Knowledge of the supervisor's tasks in relation to various functions in public mental health agencies.

### *B. Practice with Families / C. Practice with Groups*

The DACUM document and the CalSWEC do not differ in any major ways in these categories.

### *D. Practice with Community*

The CalSWEC document includes the following, which is not in the DACUM:

- The ability to apply the concepts of crisis intervention and intensive case management to community disasters.

## **III. Human Behavior and the Social/Mental Health Environment**

This area focuses on human behavior, developmental processes and their impact on consumers with mental illness. It does not have a direct parallel in the DACUM, though when compared to other areas of the DACUM no major differences were found.

## **IV. Workplace Management/Mental Health Policy, Planning and Administration**

This area of the CalSWEC is mainly focused on organizational and administrative functions, many of which are not directly related to clinical practice, and are therefore beyond the scope of the Board. The DACUM has a similar content area. After disregarding non-clinical tasks, the following CalSWEC item remains, which is not reflected in the DACUM:

- An understanding of legal and ethical issues affecting the treatment and rehabilitation of persons with severe mental illness.

### Attachments

CalSWEC Curriculum Competencies for Public Mental Health in California

- Foundation Year

- Advanced Year

MFT DACUM

# ATTACHMENT

Agenda Item II B

CaISWEC Curriculum Competencies for Public  
Mental Health in California: Foundation Year

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**CalSWEC II Mental Health Initiative**  
**Mental Health Competencies**  
**Foundation Year**  
**August 2006**

**A Competency-Based Curriculum in Community Mental Health  
For Graduate Social Work Students**

**Introduction**

The Mental Health Competencies were developed by a collaborative partnership consisting of California practitioners, educators, community leaders, and other stakeholders from the fields of mental health and social work. The competencies support and promote recovery and wellness through independence, hope, personal development and resiliency for children, adults and older adults with serious emotional disturbances and severe mental illness. The competencies support the development and utilization of evidence-based and promising practices throughout the mental health system and promote culturally and linguistically competent services that are sensitive and responsive to the needs of local communities and focus on issues of ethnicity, age, gender, sexual orientation and religious/spiritual beliefs. Consistent with the shared vision of the mental health partnership, services are to be provided in the least restrictive and most appropriate setting with attention to consumer and family involvement at all levels of the mental health system.

The Mental Health competencies are divided into Foundation and Advanced/Specialization categories, which correspond roughly to the first and second years of the MSW program. The Competencies are based on a series of principle statements adapted from the Mental Health Services Act (December 2004) and the California Mental Health Master Plan: A Vision for California (March 2003).

<b>Foundation Competencies (1<sup>st</sup> Year)</b>	<b>Advanced Competencies (2<sup>nd</sup> Year)</b>
I. Culturally and Linguistically Competent Generalist Practice	I. Culturally and Linguistically Competent Mental Health Practice
II. Foundation Practice	II. Advanced Mental Health Practice
III. Human Behavior and the Social Environment	III. Human Behavior and the Mental Health Environment
IV. Workplace Management	IV. Mental Health Policy, Planning And Administration

## California Community Mental Health Curriculum Principles

*The CalSWEC Mental Health Competencies are designed to prepare an MSW level workforce to effectively provide mental health services to children, adults and older adults, and to contribute to a Mental Health system which:*

- 1. Promotes recovery/wellness through independence, hope, personal development and resiliency for adults and older adults with severe mental illness and for children with serious emotional disorders and their families.*
- 2. Provides culturally and linguistically competent services that are sensitive and responsive to the needs of the local community, and addresses issues of ethnicity, age, gender, sexual orientation and religious/spiritual beliefs.*
- 3. Strives to involve clients and families appropriately in all aspects of the public mental health system, including but not limited to: planning, policy development, service delivery and evaluation.*
- 4. Strives to create a partnership of cooperation and a shared vision of mental health services with other agency partners in the social service arena.*
- 5. Is an advocate for clients' rights.*
- 6. Promotes the development and use of self-help, peer support and peer education for all persons with mental illness and their families.*
- 7. Assists clients in their recovery to return to the most constructive and satisfying lifestyle of their own definition and choice.*
- 8. Provides persons with severe mental illness and/or serious emotional disturbances effective treatment and high priority for receiving services in the most timely manner.*
- 9. Provides services in the least restrictive and most appropriate setting.*
- 10. Supports a Children's System of Care consisting of family-driven, culturally competent, individualized, coordinated and integrated care with accountability to positive outcomes, which meet the unique needs of children and their families.*
- 11. Supports an Adult System of Care consisting of client driven, culturally competent, coordinated, integrated and effective services meeting the unique needs of adults with severe mental illness, their families and their extended social support system.*
- 12. Supports an Older Adult System of Care consisting of comprehensive and integrated service meeting the unique needs of older adults with severe mental illness, their families, their caregivers and their extended community support system.*
- 13. Addresses the special mental health needs of all persons with severe mental illness and/or serious emotional disorders who also present with co-occurring substance abuse, psychiatric disabilities and/or other multiple vulnerabilities.*

## **I. Culturally and Linguistically Competent Generalist Practice**

*A working knowledge of and sensitivity to the dynamics of ethnic and cultural differences is at the core of mental health services. As a result of their personal experiences with mental illness, mental health systems and their own cultural identity, mental health consumers and social workers alike develop attitudes regarding mental health, along with their individual values, beliefs and lifestyles. Given that cultural awareness and sensitivity are key aspects of providing effective mental health services, this section includes the foundation knowledge, values and skills essential to working with multicultural populations. Linguistically competent practice not only underscores the importance of language itself, but also includes an understanding of the complexities of effective communication in rendering culturally competent services.*

1. Student demonstrates understanding of the influence of racial, ethnic, age, class, cultural identity, gender identity, and sexual orientation identity on interpersonal relationships in community mental health practice.
2. Student demonstrates knowledge of immigration, migration, resettlement and relocation patterns of the major ethnic groups in the United States in the context of both historical and current manifestations of oppression, racism, prejudice, discrimination, bias and privilege.
3. Student demonstrates knowledge of differences between the experiences of immigrants and refugees and the different impact those experiences have on individuals and families.
4. Student demonstrates awareness of the effects of acute and accumulative trauma on the health status, health beliefs, help-seeking behavior, health practices, customs, and traditions of diverse consumers and communities.
5. Student demonstrates knowledge of the unique legal, historical and current relationships between the American Indian/Alaska Native nations and the United States government and the effect these relationships have on the health status and practices, health beliefs, and help-seeking behaviors, as well as on the customs and traditions within and among their diverse tribal communities.
6. Student demonstrates understanding of the influence and value of traditional ethnic and culturally based practices, which affect the mental health of the individual or family and uses this knowledge in working with consumers, families and the community.
7. Student demonstrates knowledge of legal, social, political, economic and psychological issues facing immigrants and their families in new environments. Student uses this knowledge to better understand consumer's choices/decisions related to multiple health care systems (mental health care, health care, etc.).
8. Student demonstrates understanding of the impact and importance of assimilation and acculturation processes in working effectively with culturally diverse individuals, families, and communities
9. Student is able to apply appropriate theories of practice to various ethnic and cultural groups, as well as other diverse groups.

10. Student demonstrates a commitment to cultural competence by undertaking an ongoing self evaluation process with regard to his/her own multicultural awareness and perceptions of difference.
11. Student demonstrates understanding of the importance and necessity of using the consumer and community's native language in all forms of communication (staff, signage, forms, etc.) and its importance to mental health treatment.
12. Student demonstrates understanding of the full range of implications for assessment and diagnosis, including the danger of misdiagnosis when English is not the consumer's primary language and professional translation services are not utilized.
13. Student demonstrates understanding of how variance in a consumer's language can impact the expression and understanding of symptoms and attributions of illness.
14. Student demonstrates understanding and awareness of how his/her own cultural values, beliefs, norms, and world view influence perception and interpretation of events and can influence the relationship with consumers.
15. Student respects religious and or spiritual beliefs and values about physical and mental functioning that differ from his/her personal beliefs and values.
16. Student demonstrates understanding of how biases, prejudices and beliefs are formed about poverty, gender identities, sexual orientation, homelessness, substance abuse and mental illness and how these biases affect relationships with consumers.
17. Student demonstrates understanding of disparities for racial and ethnic minorities, and other culturally diverse groups in terms of access, appropriateness, availability and quality of mental health services.
18. Student demonstrates understanding of the value, necessity, and promotion of consumer and community engagement, participation and involvement in mental health program design and treatment

## **II. Foundation Practice**

*This section identifies the foundation skills that are essential for basic practice in the public mental health domain. Competencies include interviewing, assessment, treatment planning and intervention using an ethno, bio-psycho-social strength-based approach. This approach includes skills in working with children, and adolescents with serious emotional and behavioral disorders, as well as adults and older adults with severe mental illness. Underlying principles of these competencies include knowledge of cultural diversity, linguistic sensitivity and client strength as well as knowledge of concepts of recovery, empowerment, and a consumer-centered, family driven, community mental health perspective. These competencies are demonstrated in accordance with legal and ethical standards, principles of cultural diversity, and commitment to social and economic justice, with sensitivity to the needs of vulnerable populations.*

### **Practice with Individuals**

1. Student demonstrates understanding of human development and the life cycle. Student understands the major themes and tasks of each developmental stage.
2. Student demonstrates recognition of personal values and biases and can distinguish life-style choices from clinical issues.
3. Student demonstrates effective interviewing and engagement skills with individuals and families.
4. Student demonstrates understanding of the role and limitations of using interpreters and translators in providing services.
5. Student demonstrates the ability to complete a comprehensive assessment of an individual and his/her family. Student follows legal and ethical guidelines and obtains appropriate collaborative information for assessment.
6. Student demonstrates an understanding of contributing factors to serious emotional and behavioral disorders.
7. Student demonstrates an understanding of the factors that contribute to the disabling effects of severe mental illness.
8. Student is able to identify the signs of abuse/neglect with minors, older adults and dependent adults. Student demonstrates knowledge of reporting laws and collaborates with supervisors in reporting.
9. Student demonstrates knowledge of reporting laws regarding suicidal and homicidal intent. Student collaborates with his/her supervisor regarding appropriate action including involuntary commitment.
10. Student demonstrates knowledge of ethical issues pertaining to treatment including boundaries, dual relationships and confidentiality.
11. Student understands and utilizes proper documentation/charting as required by the agency.
12. Student demonstrates knowledge of natural, community and institutional supports for persons in crisis.
13. Student demonstrates beginning knowledge of crisis intervention models of suicide and family violence prevention.
14. Student demonstrates knowledge of the diagnostic criteria for substance abuse and dependence.
15. Student demonstrates beginning ability to develop a diagnostic formulation based on thorough assessment.

16. Student is able to develop a coordinated intervention plan, including treatment and/or case management services and a discharge plan.
17. Student demonstrates beginning skills using time-limited interventions.
18. Student demonstrates understanding of therapeutic ‘use of self’ as an intervention tool for delivery of effective services.
19. Student demonstrates knowledge of the principles of integrated dual diagnosis treatment.
20. Student demonstrates knowledge of the principles underlying recovery supportive practice.

### **Practice with Families**

1. Student demonstrates understanding of interdisciplinary theories and clinical models that guide social work intervention with diverse family systems.
2. Student demonstrates awareness of the changes that affect family functioning occurring across the life span of family members.
3. Student is able to assess from an ecological perspective the diversity of family characteristics (i.e. membership in an ethnic and racial group, gender, sexual orientation, etc.) as these guide the design and implementation of interventions.
4. Student demonstrates ability to implement a psycho-educational intervention model which provides information, support and structure for families of a consumer with a major mental illness.
5. Student demonstrates ability to engage and work with a family in an effective family-driven manner.

### **Practice with Groups**

1. Student demonstrates understanding of the appropriateness of group intervention following a comprehensive assessment.
2. Student is able to distinguish the different types of groups (i.e. psycho-educational, psychodynamic, self-help) and formats for group structure (i.e. open ended vs. closed, directive vs. non-directive).
3. Student demonstrates understanding of the cultural dynamics of the consumer and how this affects the consumer’s involvement in a group.
4. Student demonstrates knowledge of the normative stages of group development.
5. Student demonstrates knowledge of available resources in the community that utilize group interventions.
6. Student is able to use strategies that improve adherence to group participation.

7. Student demonstrates ability to work with persons with co-occurring mental illness and substance abuse in group intervention.

### **Practice with Community**

1. Student demonstrates understanding of the resource advocate role in relation to the policies and programs that impact public mental health agencies and their consumers.
2. Student understands and supports the consumer movement, including issues of patient's rights, peer support, self-help and advocacy.
3. Student is able to respect, value, and effectively work with diverse communities.
4. Student demonstrates knowledge of current target population eligibility criteria for publicly funded mental health services.
5. Student demonstrates understanding of the development and resource potential of the self-help movement such as reciprocal help and family advocacy for children, youth, adults and older adults.

### **III.Human Behavior and the Social Environment**

*The competencies in this section include knowledge and understanding of how developmental, psychological, social and cultural theories influence the life span of human development, and the evolution of community and societal change, and how these processes affect practice with children and adolescents with serious emotional disorders, and adults and older adults with severe mental illness*

1. Student is able to identify the major theories, categories and models used to explain serious emotional disturbances in children and serious mental illness in adults and older adults.
2. Student demonstrates understanding of mental illness along the life cycle, and the effect of cultural, bio-psycho-social and environmental conditions.
3. Student demonstrates understanding of the family life cycle, the intergenerational conceptual framework and human development across cultures and social classes.
4. Student demonstrates appreciation for the special strengths, issues and variations found in various family models (i.e. two-parent family, single parent family, blended family, extended family, etc.)
5. Student demonstrates understanding of the developmental, intergenerational and life cycle approach to community mental health practice transculturally.
6. Student understands the impact of mental illness and substance abuse on the consumer and family members at all stages of the life cycle.

7. Student demonstrates awareness of the difference between protective factors and risk factors in individuals and families, and how these factors influence the development of coping skills.
8. Student demonstrates understanding of the dynamics of trauma in its various forms and the impact on individuals, families and communities.
9. Student demonstrates understanding of the unique mental health needs of people in transition between life stages.

#### **IV. Workplace Management**

*This section contains competencies concerning important aspects of agency practice. They address internal relations, organizational requirements, and interdisciplinary and community collaboration for empowerment and social justice. In the foundation year, the students acquire strategies for self-care and safety on the job. Students demonstrate understanding of practice and policy advocacy. Students also understand the importance of consumer, family, organization and community feedback for evaluation of practice processes and outcomes.*

1. Student demonstrates awareness of the need to negotiate and advocate for the development of community based and culturally sensitive resources to assist mental health populations in meeting their goals.
2. Student demonstrates ability to work effectively with agency personnel and consumers in an environment characterized by human diversity.
3. Student demonstrates understanding of consumer and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.
4. Student is able to identify the interaction between a community and an organization's strengths and limitations, and is able to assess their effects on services for community mental health populations.
5. Student is able to identify the strengths and limitations of an organization's cultural competence and commitment to human diversity and how these are demonstrated.
6. Student is able to seek consumer, family, organization and community feedback (including mental health consumer advocacy groups) for evaluation of practice, process and outcomes.
7. Student demonstrates ability to utilize interdisciplinary collaborative skills and techniques in organizational and community settings to enhance service quality.
8. Student demonstrates understanding of how organizations operate and how their organizational culture impacts service delivery and social work roles, including internal and external forces that both promote and inhibit organizational change.

9. Student is able to plan, prioritize and effectively monitor completion of assigned activities and tasks within required time frames and standards.
10. Student demonstrates awareness of organizational risk management issues, and is able to appropriately respond to potentially harmful situations, including workplace violence.
11. Student demonstrates awareness of potential work-related stress factors and is able to develop self-care and organizational strategies to minimize their impact.
12. Student demonstrates knowledge of fiduciary responsibilities tied to funding streams, regulatory compliance and practice requirements.
13. Student demonstrates understanding of the relationship between accountability for performance outcome, the quality of service and the financial sustainability of the organization.

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# ATTACHMENT

Agenda Item II B

CalSWEC Curriculum Competencies for Public  
Mental Health in California: Advanced Year

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**CalSWEC II Mental Health Initiative**  
**Mental Health Competencies**  
**Advanced/Specialization Year**  
**August 2006**

**A Competency-Based Curriculum in Community Mental Health  
For Graduate Social Work Students**

**Introduction**

The Mental Health Competencies were developed by a collaborative partnership consisting of California practitioners, educators, community leaders, and other stakeholders from the fields of mental health and social work. The competencies support and promote recovery and wellness through independence, hope, personal development and resiliency for children, adults and older adults with serious emotional disturbances and severe mental illness. The competencies support the development and utilization of evidence-based and promising practices throughout the mental health system and promote culturally and linguistically competent services that are sensitive and responsive to the needs of local communities and focus on issues of ethnicity, age, gender, sexual orientation and religious/spiritual beliefs. Consistent with the shared vision of the mental health partnership, services are to be provided in the least restrictive and most appropriate setting with attention to consumer and family involvement at all levels of the mental health system.

The Mental Health competencies are divided into Foundation and Advanced/Specialization categories, which correspond roughly to the first and second years of the MSW program. The Competencies are based on a series of principle statements adapted from the Mental Health Services Act (December 2004) and the California Mental Health Master Plan: A Vision for California (March 2003).

<b>Foundation Competencies (1<sup>st</sup> Year)</b>	<b>Advanced Competencies (2<sup>nd</sup> Year)</b>
I. Culturally and Linguistically Competent Generalist Practice	I. Culturally and Linguistically Competent Mental Health Practice
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## California Community Mental Health Curriculum Principles

*The CalSWEC Mental Health Competencies are designed to prepare an MSW level workforce to effectively provide mental health services to children, adults and older adults, and to contribute to a Mental Health system which:*

- 1. Promotes recovery/wellness through independence, hope, personal development and resiliency for adults and older adults with severe mental illness and for children with serious emotional disorders and their families.*
- 2. Provides culturally and linguistically competent services that are sensitive and responsive to the needs of the local community, and addresses issues of ethnicity, age, gender, sexual orientation and religious/spiritual beliefs.*
- 3. Strives to involve clients and families appropriately in all aspects of the public mental health system, including but not limited to: planning, policy development, service delivery and evaluation.*
- 4. Strives to create a partnership of cooperation and a shared vision of mental health services with other agency partners in the social service arena.*
- 5. Is an advocate for clients' rights.*
- 6. Promotes the development and use of self-help, peer support and peer education for all persons with mental illness and their families.*
- 7. Assists clients in their recovery to return to the most constructive and satisfying lifestyle of their own definition and choice.*
- 8. Provides persons with severe mental illness and/or serious emotional disturbances effective treatment and high priority for receiving services in the most timely manner.*
- 9. Provides services in the least restrictive and most appropriate setting.*
- 10. Supports a Children's System of Care consisting of family-driven, culturally competent, individualized, coordinated and integrated care with accountability to positive outcomes, which meet the unique needs of children and their families.*
- 11. Supports an Adult System of Care consisting of client driven, culturally competent, coordinated, integrated and effective service meeting the unique needs of adults and older adults with severe mental illness, their families and their extended social support system.*
- 12. Supports an Older Adult System of Care consisting of comprehensive and integrated services meeting the unique needs of older adults with severe mental illness, their families, their caregivers, and their extended community support system.*
- 13. Addresses the special mental health needs of all persons with severe mental illness and/or serious emotional disorders who also present with co-occurring substance abuse, psychiatric disabilities and/or other multiple vulnerabilities.*

## **I. Culturally and Linguistically Competent Mental Health Practice**

*This section builds upon the multicultural knowledge, values and skills delivered in the foundation year. Culturally competent practice acknowledges the integral role that culture plays in all individuals' lives, and its influence on not only the ability to adapt to life events, stresses, successes and failures, but also the willingness and ability to undergo treatment for mental health disorders. Advanced students demonstrate the ability to recognize, understand and appreciate their personal culture as well as the culture of others. In conducting mental health assessments, intervention and termination activities, advanced students demonstrate understanding of the impact and interaction of social and political categories of race, ethnicity, age, gender, class, ability, mental illness, sexual/affectional orientation, religion, education, profession, residence, marital status, etc. at the personal, interpersonal, institutional and community levels. Advanced students demonstrate attention to culturally guided community based interventions as well as a commitment to social justice.*

1. Student demonstrates knowledge and appreciation of personal culture and the cultural differences of others, and is able to identify the strengths of diverse populations. Student is able to identify how his/her personal culture may have positive or negative effects on service provision.
2. Student demonstrates knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, acculturation and the individual's way of being.
3. Student is able to develop treatment goals and interventions that are congruent with cultural perspectives across diverse groups.
4. Student demonstrates ability to critically evaluate the use of personal cultural values and norms in transcultural social work mental health practice. Student demonstrates skill in understanding and using personal identity and sense of self in same culture as well as cross-cultural interpersonal encounters.
5. Student demonstrates flexibility in using an array of culturally sensitive and relevant clinical skills in the teaching, advocacy, treatment, healing and case-management roles.
6. Student demonstrates understanding of the common elements of practice (e.g. making eye contact, initiating a handshake, etc.) and how these behaviors may clash with the cultural values of various ethnic and cultural groups.
7. Student demonstrates knowledge about: a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
8. Student demonstrates knowledge and ability to work with interpreters in on-going treatment and long term treatment relationships.

9. Student is able to apply awareness of the effects of acute and accumulative trauma on the health status, health beliefs, help-seeking behaviors, health practices, customs and traditions of diverse consumers and communities.
10. Student demonstrates ability to work sensitively through differences in community mental health practice relationships with consumers, their families, colleagues, other professionals and the community.
11. Student demonstrates ability to critically evaluate the appropriate use of applied intervention models with diverse ethnic and cultural populations and other special needs groups.
12. Student demonstrates knowledge of immigration, migration, resettlement and relocation patterns of the major ethnic groups in the United States, in the context of both historical and current manifestations of oppression, racism, prejudice, discrimination, bias and privilege.
13. Student works to remove institutional barriers that prevent ethnic and cultural groups from using mental health services, and can identify appropriate macro-level interventions.
14. Student demonstrates awareness of the potential bias in clinical assessment instruments and critically interprets findings within the appropriate cultural, linguistic and life experience context of the consumer.
15. Student systematically collects and organizes observations, knowledge and experience to advocate for improved policies and delivery of services in the community.

## **II. Advanced Mental Health Practice**

*Practice competencies in the advanced/specialization year address the complexity and scope of mental health treatment, including specialized services with distinct sub-groups of individuals and families dealing with serious emotional disorders and severe mental illness. Competencies in this section include skills necessary to implement a variety of integrated models of intervention including advocacy, case management, psychosocial rehabilitation, team consultation, evidence-based practice, support of concepts of recovery, time limited treatment and nontraditional healing practices. These competencies are demonstrated in accordance with legal and ethical standards, principles of cultural diversity, commitment to social and economic justice and with sensitivity to the needs of vulnerable populations.*

### **Practice with Individuals**

1. Student demonstrates the ability to apply more advanced and complex analyses of human development and the life cycle in understanding the reciprocal interactions of bio-psycho-social factors.

2. Student is able to distinguish the relationship between theories and treatment in formulating a comprehensive, service goal oriented assessment.
3. Student demonstrates awareness of the mental status examination as part of an assessment to support diagnosis of children, adolescents, adults and older adults.
4. Student is able to diagnose the major mental health disorders using the DSM-IV-TR or other currently accepted diagnostic tools. In working with diverse racial, cultural, and lifestyle groups, student is able to identify the challenges and limitations of diagnosis.
5. Student demonstrates awareness of the prevalence of co-occurring mental health and substance abuse issues, understands the impact of substance abuse on major mental health disorders, and is able to include this knowledge in assessment and treatment planning with consumers.
6. Student demonstrates awareness of the effects of acute, chronic and complex trauma upon the health status and help seeking abilities of individuals.
7. Student demonstrates awareness of issues related to the use of medication and medication information, non-pharmacological interventions, and psychiatric consultation in ethnic-specific populations within the scope of social work practice.
8. Student is able to apply research methodology as it relates to synthesizing, applying and evaluating evidence-based and promising practices. Student is able to assist consumers and their families in applying evidence-based practices that support positive outcomes.
9. Student demonstrates knowledge and appropriate utilization of models of treatment intervention with individuals.
10. Student demonstrates understanding of the limitations of evidence-based practices as they relate to the general population and to specific racial and ethnic groups.
11. Student demonstrates knowledge of the supervisor's tasks in relation to clinical, administrative, educational and supportive functions in public mental health agencies.
12. Student demonstrates awareness of supervisory skills in conflict resolution for the purpose of enhancing multidisciplinary collaborative relationships maximizing service delivery.

### **Practice with Families**

1. Student applies integration of family systems theories to the treatment needs of diverse consumers and their families.
2. Student is able to apply the principles and techniques of crisis and time limited treatment to high-risk families.
3. Student demonstrates awareness of core psycho-social rehabilitation competencies that underlie recovery-oriented practice.

4. Student demonstrates understanding of the recovery process, and is able to use self-help, peer support resources and other programs supporting recovery that are available in the community for consumers and families.
5. Student is able to assess family strengths and limitations in order to more effectively involve collaborative resources (i.e. schools, housing, rehabilitative services).
6. Student demonstrates ability to intervene in a family system where a member has a co-occurring substance abuse and major mental illness, to promote stability and relapse prevention.
7. Student is able to identify and respond to the mental health needs of children in out-of-home placements and their families.
8. Student appropriately utilizes various models of treatment intervention with families.

### **Practice with Groups**

1. Student is able to communicate effectively in an ethnically sensitive practice environment.
2. Student demonstrates understanding of a consumer's barriers to effective problem solving and emphasizes consumer empowerment via group process.
3. Student demonstrates awareness of how the 'use of self' affects group process.
4. Student is able to develop and maintain group structure.
5. Student demonstrates understanding of ethical standards that apply to group work.
6. Student demonstrates knowledge of evidence-based practice of positive outcomes as related to the consumer's compliance and accountability in group process.

### **Practice with Community**

1. Student is able to utilize principles of integrated services, continuity of care, case coordination, collaboration and effective discharge from services in work with consumers and families.
2. Student is able to demonstrate integrated case management including supported education, housing and employment programs, and alternatives to hospitals and other institutional 24-hour care settings. Student maximizes utilization of natural community support.
3. Student is able to utilize differing outreach and advocacy strategies for the benefit of consumers and their families.
4. Student demonstrates knowledge of specific strategies that empower consumers and their families and support self-determination.

5. Student demonstrates knowledge of the various funding streams associated with public health and human services at the local, state and national levels. Student understands how these funding streams relate to public mental health services.
6. Student is able to utilize outcome measures in developing and evaluating programs.
7. Student is able to apply the concepts of crisis intervention and intensive case management to community disasters.

### **III. Human Behavior and the Mental Health Environment**

*Competencies in this section allow students to build on basic knowledge and understanding of human behavior and development across the life span, and apply these theories to specialized circumstances and sub-groups within the mental health consumer community. Included are knowledge of the effects of homelessness, poverty, and co-occurring disorders such as substance abuse on individuals with severe mental illness, as well as an ability to utilize community and family resource support systems as interventions.*

1. Student demonstrates understanding of the unique mental health needs of special populations, including homeless and incarcerated individuals, children, women, older adults, gay and lesbian persons, and individuals with HIV+/AIDS, physical challenges, or co-occurring disorders.
2. Student is able to identify and utilize individual, family and community strengths in the assessment, service planning and service delivery phases. Student recognizes the importance of addressing multiple domains of functioning in each of these phases.
3. Student demonstrates understanding of contributing and interacting aspects of biology, personal attributes, coping style, trauma and developmental events. Student understands how these may affect children with serious emotional disturbances and adults with severe mental illness.
4. Student demonstrates understanding of the role of both natural community supports and resources, and other effective community programs (i.e. community-based support systems).
5. Student demonstrates understanding of the consumer in his/her family context and is able to help identify the role of family in the recovery process. The student understands the support needs of both the consumer and family members.
6. Student is able to use clinical outcome measures in developing and evaluating programs in a cross cultural milieu.
7. Student demonstrates awareness of public misperceptions regarding individuals with mental illness, and understands how these misperceptions may affect help-seeking behaviors and generate stigma and discrimination. Student has knowledge of published research investigating these commonly held misperceptions.

#### **IV. Mental Health Policy and Planning**

*Competencies in this area build on foundation knowledge of agency environments and practice and focus more broadly on policy development, program planning, evaluation and service delivery. Skills in administration and leadership are also addressed, as well as other strategies to enhance organizational effectiveness. Critical to the development of the student in these competency areas is an understanding of the role of the practitioner, the agency and the community (with emphasis on consumers and families), in shaping policy, influencing legislation and participating in the development and implementation of mental health service programs.*

##### **Policy**

1. Student demonstrates understanding of how political ideologies and social values influence the development of legislation, policies, program services and funding at all system levels.
2. Student demonstrates knowledge of current mental health policy and legislation and the implications of these for diverse and disenfranchised populations and communities.
3. Student demonstrates knowledge of the stakeholder community.

##### **Program Planning and Evaluation**

4. Student demonstrates understanding of the role of consumers and families in how community mental health programs are designed and implemented.
5. Student demonstrates understanding of how community mental health programs are designed and evaluated and the relationship between the two.
6. Student demonstrates understanding of the methods of scientific research and applies this knowledge to critically assess mental health services data to promote delivery of evidence-based practice.

##### **Service Delivery**

7. Student demonstrates knowledge of the range and effectiveness of community supports needed to sustain a “life in the community.”
8. Student demonstrates knowledge of state and federal laws that regulate community mental health services and protect the individuals and communities they serve.
9. Student demonstrates understanding of legal and ethical issues affecting the treatment and habilitation of persons with severe mental illness.

##### **Administration/Leadership**

10. Student demonstrates understanding of the various organizational structures of behavioral health systems at the local, state, national and international levels, and how these impede or enhance quality care.

11. Student demonstrates knowledge of organizational change theories and how they influence mental health systems.
12. Student demonstrates knowledge of the functions of administrative practice regarding planning, organizing, staffing, coordinating, reporting, budgeting, and evaluation.
13. Student demonstrates understanding of the administrative and systemic issues of providing direct services to individuals with serious emotional disturbances and severe mental illness in a consumer/family-driven, creative, flexible and culturally competent manner.
14. Student demonstrates understanding of the roles and responsibilities of a leader/manager to plan and develop systems that maximize the abilities and talents of diverse staff and consumer populations.

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# ATTACHMENT

Agenda Item II B

MFT DACUM

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# DACUM Competency Profile for Marriage and Family Therapist

A Marriage and Family Therapist is a clinician who utilizes systemic and/or relational interventions to provide multiple systems.

Duties		Tasks				
<b>A</b>	<b>Complete Service Intake</b>	A-1 Verify eligibility criteria	A-2 Record brief description of substance abuse / mental health problem	A-3 Obtain provisional diagnosis	A-4 Determine financial status and ability to pay	A-5 Discuss and complete consent to treat forms
		B-1 Determine appropriate participants	B-2 Review client related documentation	B-3 Establish presenting problem	B-4 Obtain family and cultural history	B-5 Obtain education and employment history
<b>B</b>	<b>Conduct Bio-Psychosocial Assessment</b>	B-13 Determine current support services and resources	B-14 Establish level of care	B-15 Provide brief description of available services	B-16 Develop treatment plan recommendations	B-17 Determine the need for psychological testing
		C-1 Review assessment	C-2 Engage client in culturally and linguistically relevant treatment	C-3 Develop treatment plan with client driven goals	C-4 Establish measurable and observable outcomes with client	C-5 Determine evidence based treatment modality
		C-13 Provide supportive counseling	C-14 Implement motivational interviewing	C-15 Provide interventions with children that are cognitive and behavioral	C-16 Provide non-verbal therapies	C-17 Provide intensive therapeutic services
<b>C</b>	<b>Provide Mental Health Treatment</b>	C-25 Receive clinical supervision from clinical team	C-26 Arrange for on-going care	C-27 Administer client satisfaction surveys	C-28 Terminate treatment and discharge	
		D-1 Develop a service plan for case management	D-2 Provide cultural facilitation (i.e. interpreting) for client and/or family members	D-3 Assist clients and family members to understand and navigate the mental health system	D-4 Assist in enrollment for financial entitlements	D-5 Provide benefits counseling
		D-13 Attend Individualized Education Plan and other school meetings	D-14 Refer clients and family members to self help and peer support services	D-15 Observe home living environment	D-16 Provide extended on-site services for employed consumers	D-17 Coordinate treatment and discharge planning in higher level treatment facilities
<b>D</b>	<b>Provide Case Management</b>	D-25 Assist in obtaining and maintaining educational and vocational goals	D-26 Complete annual financial updates (UMDAPs)	D-27 Coordinate and participate in client celebratory events		

<b>E</b> <b>Provide Crisis Intervention Services</b>	E-1 Receive a crisis referral	E-2 Perform mental status evaluation	E-3 Perform lethality assessment	E-4 Complete duty to warn if indicated (Tarasoff)	E-5 Evaluate substance abuse status
	E-13 Report to supervisor	E-14 Determine appropriate level of care	E-15 Negotiate a no harm contract	E-16 Complete 5150 as required	E-17 Locate available hospital bed or crisis program
<b>F</b> <b>Coordinate Client Care</b>	F-1 Collaborate with psychiatrist to ensure continuity of care	F-2 Collaborate with case managers to ensure continuity of care	F-3 Collaborate with specialty mental health services to ensure continuity of care	F-4 Participate in case conferences or daily treatment team meetings	F-5 Identify and involve family members
<b>G</b> <b>Provide Education</b>	G-1 Provide education to clients about client rights	G-2 Educate client to advocate for self	G-3 Provide education to clients and family on mental illness and recovery	G-4 Refer to peer-facilitated support and education groups	G-5 Provide education to clients about medications
	G-13 Provide education to consumer providers about work in the mental health field	G-14 Provide education on parenting skills	G-15 Provide education to erase the stigma about mental illness	G-16 Provide education on foster parenting skills	G-17 Educate community about co-occurring and other mental illnesses and recovery
<b>H</b> <b>Perform Administrative Functions</b>	H-1 Adhere to agency policies and procedures	H-2 Participate in quality assurance	H-3 Attend staff meetings	H-4 Perform weekly supervision	H-5 Track productivity levels of staff
	H-13 Maintain all required documentation	H-14 Participate in staff performance evaluations	H-15 Monitor MediCal eligibility through MIS (Management Information Systems)	H-16 Participate in program development and design	H-17 Complete billing procedures and logs
<b>I</b> <b>Promote Professional Development</b>	I-1 Promote culturally competent, ethnically diverse professional services	I-2 Utilize clinical supervision	I-3 Practice self care to prevent compassion fatigue	I-4 Maintain CEU requirements	I-5 Participate in and promote mandatory trainings
	I-13 Participate in career development opportunities				

## **(Public or Community-Based Mental Health Services)**

mental health services including assessment, treatment, and referral for individuals, families, and children within

A-6 Discuss and complete consent to release forms	A-7 Complete application form	A-8 Discuss and obtain signatures on HIPAA disclosure forms	A-9 Discuss limits of confidentiality	A-10 Refer to appropriate service		
B-6 Obtain medical, mental health, and substance abuse history	B-7 Obtain legal and criminal justice history	B-8 Evaluate for abuse	B-9 Conduct mental status exam	B-10 Establish the diagnosis	B-11 Assess independent living skills	B-12 Assess client and family strengths
C-6 Commence mental health treatment	C-7 Initiate discharge planning	C-8 Refer to appropriate resources	C-9 Provide individual therapy	C10 Provide family therapy	C-11 Provide behavioral therapy	C-12 Provide cognitive therapy
C-18 Provide milieu therapy	C-19 Facilitate skills based groups	C-20 Facilitate support groups	C-21 Facilitate therapy groups	C-22 Review progress with client toward stated goals	C-23 Chart progress toward objectives	C-24 Update treatment plan
D-6 Obtain required signatures from clients or family members on needed reports	D-7 Provide linkages to community services	D-8 Generate reports for schools and courts	D-9 Represent mental health in Lanteman, Petrus, Short conservatorship process [5250's]	D-10 Assist in obtaining and/or maintaining housing	D-11 Assist in accessing medical prescriptions	D-12 File Adult Protective Services and Child Protective Services reports
D-18 Refer and monitor clients w/ medical needs to appropriate treatment and resources	D-19 Assist in obtaining and maintaining financial resources	D-20 Arrange follow-up of 5150's	D-21 Respond to subpoenas	D-22 Provide legal testimonies in court	D-23 Provide support services for medical treatment	D-24 Provide client transportation

E-6 Obtain medical clearance	E-7 Request psychiatric consult for medication evaluation	E-8 Consult with treatment team	E-9 Provide crisis counseling	E-10 Determine relational resources	E-11 Assess family strengths, coping skills and resources	E-12 Determine need for family involvement while obtaining release
E-18 Arrange for admission	E-19 Provide directive to family to utilize resources	E-20 Provide necessary follow-up	E-21 Facilitate crisis debriefing	E-22 Provide on-call support as required		
F-6 Advocate for clients with other systems	F-7 Collaborate with schools to ensure continuity of care	F-8 Coordinate with point of authorization	F-9 Collaborate with other agencies involved in care			
G-6 Provide anger management education	G-7 Provide client education on life skills	G-8 Educate law enforcement workers about mental illness and recovery	G-9 Educate students & interns about adult and child systems of care and coordinated services	G-10 Educate clients and families about wellness / prevention and recovery	G-11 Provide domestic violence education	G-12 Provide education to clients, families, and staff about employment and vocational srvc
H-6 Gather performance outcome data	H-7 Review client service data reports	H-8 Monitor agency contracts	H-9 Handle consumer/family complaints and grievances	H-10 Supervise consumer staff volunteers	H-11 Triage new referrals / determine dispositions	H-12 Write clinical reports
H-18 Write grants and contracts	H-19 Participate in hiring panels	H-20 Outreach to find new clients	H-21 Develop referral and community resource manuals			
I-6 Maintain memberships in professional organizations	I-7 Enhance skills by learning new therapeutic techniques	I-8 Adopt strategies to maintain wellness	I-9 Mentor potential mental health workers	I-10 Promote development/use of systemic, relational interventions in public mental health systems	I-11 Develop community mental health training programs	I-12 Attend professional events.

# **DACUM Competency Profile for**

## **Marriage and Family Therapist (Public or Community-Based Mental Health Services)**

December 20 - 21, 2005

**Produced by:**

California Community College

Economic and Workforce Development Program

Health Initiative

Butte College – RHORC

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## General Knowledge and Skills

Americans with Disabilities Act (ADA)  
Archetypes in dreams  
Child development and assessment  
Community resources including peer support  
Computer skills—electronic records/data reporting/access  
Criminal justice system (including juvenile justice and prison system)  
Cultural competence  
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision published by the American Psychiatric Association (DSM IV TR)  
Differential diagnosis  
Domestic violence treatment programs  
Domestic violence shelters  
Dual Diagnosis/co-morbidity  
Evidence-based best practices  
Fair housing laws  
Family court system  
Family systems and their utilization  
Financial assist programs for MFT students  
General information on larger systems (SSI, Foster Care, DSS, Regional Center, Schools, Residential Care, etc)  
Generational issues—needs of children/elderly  
Genogram preparation  
Geriatric information & referrals  
Group process  
HIPAA regulations  
Homeless shelters  
Housing regulations and resources  
ICD-9-CM Codes  
Individual Educational Plan  
Lanternmann, Petrus, and Short (LPS) laws/codes  
Life span development  
Limits of confidentiality  
MediCal/MediCare regs and doc requirements  
Mental illnesses/how difficult clients can be  
Mental Health Service Act (Prop 63)  
Parenting Wisely Program  
Psychopharmacology  
Psychosis  
Psychosocial rehabilitation  
Recovery philosophy  
Recovery-oriented practice  
Reporting requirements  
Resiliency qualities in youth  
Schizophrenia  
Strengths-based engagement process  
Subsidized housing  
Substance abuse treatment programs  
System of care  
Systemic and relational theories of practice

Supported education  
Techniques for working with various population groups—children, older adults, etc  
Transition age youth  
Treatment modalities  
Aggression replacement therapy  
Anger management groups  
Art therapy  
Behavior modification  
Behavioral family therapy  
Cognitive behavioral therapy  
Crisis intervention  
Day treatment milieu therapy  
Dialectical behavioral therapy  
Domestic violence groups (victims/perpetrators)  
Dual diagnosis groups  
Incredible years  
Integrated behavioral therapy  
Family therapy  
Functional family therapy  
Grief counseling  
Matrix  
Motivational interviewing  
Multifamily therapy  
Multifunctional foster care  
Multisystemic family therapy  
Narrative therapy  
Parent child groups  
Parent child interactive therapy  
Peer support  
Play therapy  
Roadmap to recovery  
Sex offender groups  
Skills based groups (examples)  
Assertiveness  
Budgeting  
Communication  
Conflict Resolution  
Employment Interviewing  
Solution focused therapy  
Strategic family therapy  
Support groups (vocational, family, HIV, medication, etc)  
Supportive counseling  
Therapy groups (depression, anxiety, etc)  
Therapeutic behavioral services  
Wrap around services  
Triple P Parenting Program  
Vocational rehabilitation  
Welfare and institutions codes  
Working with clients in the field

## Tools, Equipment, Supplies and Materials

Art supplies	DC-03	Subscriptions / professional organizations
Beck; Duke Depression Inventory	Evidence Based Practices tool kits (E.B.P. Tool Kits)	Subscriptions / journals
Books on Psychopharm	Laptops	Substance Abuse and Mental Health Services Administration tool kits (SAMHSA Tool Kits)
Book: Adolescent Tx and their Families	Merck Manual	Testing instruments
Books: child therapy + play	One way mirror	Therapeutic and safe toys such as doll house, anatomically correct dolls, puppets, therapeutic games, wooden blocks, etc.
Car/van	PDR: physicians' desk reference	Therapeutic tools for children
Cell phone/pager	Resource manuals (paper/electronic)	Video camera
Client education materials	Rocking chair	
Computer/software templates/forms	Sand tray + figures	
Craft supplies	Scale (weight)	
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision published by the American Psychiatric Association (DSM IV TR)	Secure email / electronic records	

## Worker Characteristics/Behaviors

Ability to convey & sustain a non-anxious presence	Flexibility	Resiliency
Ability to maintain appropriate boundaries	Good common sense/judgment	Respect others
Ability to tolerate governmental process	Good listening skills	Self awareness
Able to handle stress	Good range of life experiences	Self-disciplined
Absence of paternalism	Good sense of humor	Strong professional identity
Accepting of consumer staff/volunteers	Good writing skills	Team player
Analytical	Mature	Understanding essential role of multidisciplinary team
Bilingual skills preferred/not mandatory	Openness	Understands boundaries and respects them
Compassionate/empathetic	Organized	Willing to consult w/ others
Conscientious	Patience	Willing to speak up about agency problems
Creative	Perceptive	Willing to identify/adjust personal biases that impact ability to work with various populations
Culturally aware	Positive/hopeful	Willing to work "out of the office"
Detail oriented	Possess strong follow thru	
Energetic	Problem-solving	
	Public speaking skills a plus for community work (not mandatory)	

### **Future Trends and Concerns**

- Client-directed treatment plans
- Elderly population growing, increased pressure on various systems
- Evidence-based practice
- Expanding consumers and family member employment in the mental health workforce
- Increasing use of technology for communication and documentation
- Integrated systems of service provision
- Internet therapy and consultations
- Promoting the diversity and cultural competence of the workforce
- Recovery and resiliency as a guiding principle for the development and implementation of training and retraining programs
- “Whatever it takes” provision of the Mental Health Service Act
- Development of full partnership programs
- Parity for MH Insurance
- Simultaneous treatment for co-occurring disorders
- Increase in incidence of youth self mutilating (cutting)
- Development of Birth to Five programs for screening and assessment
- Increase in the number of children prescribed medication
- Integration of Primary Care, Mental Health and Substance Abuse
- Train staff to work with consumer staff at the agency
- Acknowledge increase in influence of the self help groups in the treatment plan
- Use of videoconferencing to increase treatment accessibility, especially interpreter’s services
- Move away from services provided at the agency to services in community locations or in the client’s home

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## Memorandum

**To:** Board Members  
**Date:** October 4, 2006

**From:** Christy Berger  
Legislation Analyst  
**Telephone:** (916) 574-7847

**Subject: Mental Health Services Act and the Workforce Education and Training Draft Strategic Plan**

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### Background

In November of 2004, California voters approved Proposition 63, now known as the Mental Health Services Act (MHSA). The overall purpose of the MHSA is to build a better public mental health system, and is funded through a 1% tax on personal incomes of over \$1 million. The Act provides a remarkable opportunity for the Department of Mental Health (DMH) to provide increased funding, personnel and other resources to support county mental health programs for youth, adults, older adults and families. The Act addresses prevention, early intervention and service needs as well as necessary infrastructure, technology and training elements.

The DMH has developed, with stakeholder input, a set of core values which apply to all MHSA activities:

- Promote wellness, recovery and resilience.
- Increase consumer and family member involvement in policy and service development, and employment in service delivery.
- Develop a diverse, culturally sensitive and competent workforce in order to increase the availability and quality of mental health services and supports for individuals from every cultural group.
- Deliver individualized, consumer and family-driven services that are outcome oriented and based upon successful or promising practices.
- Outreach to underserved and unserved populations.

The MHSA consists of six major components, the implementation of which are being staggered. Each component addresses critical needs and priorities to improve access to effective, comprehensive, culturally and linguistically competent county mental health services and supports. These components are:

- Community Program Planning Process – A local process to identify community issues, define populations to be served, and effective strategies to provide services.
- Community Services and Supports (CSS) – The programs and services being identified by each county to serve unserved and underserved populations.
- Education and Training – Targets workforce development programs to remedy the shortage of qualified individuals to provide services.
- Capital and Information Technology – Addresses the infrastructure needed to support the CSS programs.
- Prevention and Early Intervention – Programs designed to prevent mental illnesses from becoming severe and disabling.
- Innovation – Focuses on development and implementation of promising and proven practices.

## Workforce Education and Training Five-Year Strategic Plan

### *Background*

One component of the MHSA is the establishment of an education and training program with dedicated funding to remedy the shortage of qualified individuals and to implement a five-year education and training development plan. The mission is to develop and maintain a sufficient workforce, including consumers and family members, who are capable of providing consumer- and family-driven, culturally competent services that promote wellness, recovery, and resiliency, and lead to evidence-based, values-driven outcomes.

Statewide estimates indicate that over 4,300 new positions are being created with just the initial MHSA funding. Counties have reported the following challenges related to workforce:

- Language proficiency, cultural competency and diversity of the workforce, especially individuals with Hispanic/Latino or Native American heritage, and staff who are bicultural or bilingual.
- Geographical challenges or recruiting staff in remote areas as well as communities unable to compete economically for a limited pool of qualified workers.
- Recruiting and retaining licensed staff. The public mental health system has experienced a chronic shortage of individuals capable of prescribing medications, diagnosing serious mental illness and signing treatment plans. New MHSA-funded programs are exacerbating this problem.

### *Goals, Objectives and Actions*

The following Objectives are a specific set of outcomes stipulated by the MHSA to be included in the Five-Year Plan, and are proposed in order to accomplish each broad Goal. Additionally, we have included specific actions that will be taken in the 06/07 fiscal year that are relevant to the MFT Curriculum Committee's purpose.

#### **Goal #1 – Develop sufficient qualified individuals for the public mental health workforce.**

Objective A: Expand the capacity of postsecondary education programs meet the needs of identified mental health occupational shortages.

Action #4. Provide funding that enables release time for community public mental health service providers and education faculty to work together in their respective settings to impact curricula and stigma, and promote wellness, recovery and resiliency. Fund consumers and family members to participate in faculty and staff exchanges at the workplace and in educational settings.

Objective B: Expand loan forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system. Extend these programs to interns and current employees of the mental health system who want to obtain Associate of Arts, Bachelor, Masters, and Doctoral degrees.

Objective C: Create stipend programs for persons enrolled in academic institutions who want to be employed in the public mental health system.

Objective D: Promote the employment of consumers and family members at all levels in the mental health system.

#### **Goal #2 – Increase the quality and success of educating and training the public mental health workforce in the expressed values of the Act.**

**Objective E:** Develop curricula to train and retrain staff to provide services in accordance with the expressed values of the Act.

**Objective F:** Promote the inclusion of cultural competency in all training and education programs.

**Action #12.** Cultural competency is a crosscutting objective that is proactively addressed in all goals and objectives. All MHSA funded education and training will be required to address how their program/training will include the principles and practices of cultural competency.

**Goal #3 – Increase the partnership and collaboration of all entities involved in public mental health workforce education and training.**

**Objective G:** Establish regional partnerships within the public mental health and educational systems in order to expand outreach to multicultural communities and increase the diversity of the public mental health workforce, reduce the stigma associated with mental illness, and promote the use of web-based technologies and distance learning techniques.

**Objective H:** Increase the prevalence of mental health career development opportunities in high schools, adult education and regional occupational programs, such as health science and human service academies, in order to recruit students for public mental health careers.

**Objective I:** Promote the meaningful inclusion of mental health consumers and family members, and incorporate their viewpoints and experiences in all training and education programs.

**Action #16.** Inclusion of consumers and family members is a crosscutting objective that is proactively addressed in all objectives. All MHSA funded education and training will be required to address how their program/training will include the viewpoints and experiences of consumers and family members.

**MHSA Funding**

As of May 2006, funding for the main MHSA components is as follows:

Local Assistance	Actual FY 04-05	Estimated FY 05-06	Projected FY 06-07
Education and Training	-	-	\$251,600,000
Capital Facilities & Technology	-	-	\$251,600,000
Local Planning	\$12,624,260	-	-
Prevention*	-	-	\$274,600,000
Community Services & Support*	-	\$356,870,000	\$398,300,000
<b>TOTAL</b>			<b>\$1,176,100,000</b>

Percentage Funding Distribution by Component	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Education and Training	45%	10%	10%	10%
Capital Facilities & Technology	45%	10%	10%	10%
Local Planning	5%	0%	0%	0%
Prevention*	5%	5%	5%	5%
Community Services & Support*	0%	20%	20%	20%
<b>TOTAL</b>	<b>0%</b>	<b>55%</b>	<b>55%</b>	<b>55%</b>

\*5% of Prevention and CSS funding will be available for Innovative Programs

**Attachments**

LAO Summary of Proposition 63  
Workforce Education and Training Five-Year Strategic Plan (Draft)

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# ATTACHMENT

Agenda Item III

Legislative Analyst's Office Summary of  
Proposition 63

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## legislative analyst's office

Written July, 2004

### Proposition 63

## Mental Health Services Expansion and Funding. Tax on Incomes Over \$1 Million. Initiative Statute.

### Background

**County Mental Health Services.** Counties are the primary providers of mental health care in California communities for persons who lack private coverage for such care. Both children and adults are eligible to receive such assistance. Counties provide a range of psychiatric, counseling, hospitalization, and other treatment services to patients. In addition, some counties arrange other types of assistance such as housing, substance abuse treatment, and employment services to help their clients. A number of counties have established so-called "systems of care" to coordinate the provision of both medical and nonmedical services for persons with mental health problems.

County mental health services are paid for with a mix of state, local, and federal funds. As part of a prior transfer of mental health program responsibilities from the state to counties, some state revenues are automatically set aside for the support of county mental health programs and thus are not provided through the annual state budget act. Other state support for county mental health programs is provided through the annual state budget act and thus is subject to change by actions of the Legislature and Governor.

**State Personal Income Tax System.** California's personal income tax was established in 1935 and is the state's single largest revenue source. It is expected to generate an estimated \$39 billion in revenues for the support of state government in 2004-05. The tax is levied on both residents and nonresidents, with the latter paying taxes on income derived only from California sources. Tax rates range from 1 percent to 9.3 percent, depending on a taxpayer's income level.

### Proposal

This proposition establishes a state personal income tax surcharge of 1 percent on taxpayers with annual taxable incomes of more than \$1 million. Funds resulting from the surcharge would be used to expand county mental health programs.

**New Revenues Generated Under the Measure.** This measure establishes a surcharge of 1 percent on the portion of a taxpayer's taxable income that exceeded \$1 million. The surcharge would be levied on all such tax filers beginning January 1, 2005. We estimate that 25,000 to 30,000 taxpayers would be subject to paying the surcharge.

Under this measure, beginning in 2004-05, the State Controller would transfer specified amounts of state funding on a monthly basis into a new state fund named the Mental Health Services Fund. The amounts transferred would be based on an estimate of the revenues to be received from the surcharge. The

amounts deposited into the fund would be adjusted later to reflect the revenues actually received from the tax surcharge.

**How This Funding Would Be Spent.** Beginning in 2004–05, revenues deposited in the Mental Health Services Fund would be used to create new county mental health programs and to expand some existing programs. These funds would not be provided through the annual state budget act and thus amounts would not be subject to change by actions of the Legislature and Governor. Specifically, the funds could be used for the following activities:

- **Children’s System of Care.** Expansion of existing county system of care services for children who lack other public or private health coverage to pay for mental health treatment.
- **Adult System of Care.** Expansion of existing county system of care services for adults with serious mental disorders or who are at serious risk of such disorders if they do not receive treatment.
- **Prevention and Early Intervention.** New county prevention and early intervention programs to get persons showing early signs of a mental illness into treatment quickly before their illness becomes more severe.
- **“Wraparound” Services for Families.** A new program to provide state assistance to counties to establish wraparound services, which provide various types of medical and social services for families (for example, family counseling) where the children are at risk of being placed in foster care.
- **“Innovation” Programs.** New county programs to experiment with ways to improve access to mental health services, including for underserved groups, to improve program quality, or to promote interagency collaboration in the delivery of services to clients.
- **Mental Health Workforce: Education and Training.** Stipends, loan forgiveness, scholarship programs, and other new efforts to (1) address existing shortages of mental health staffing in county programs and (2) help provide the additional staffing that would be needed to carry out the program expansions proposed in this measure.
- **Capital Facilities and Technology.** A new program to allocate funding to counties for technology improvements and capital facilities needed to provide mental health services.

This measure specifies the portion of funds that would be devoted to particular activities. In 2004–05, most of the funding would be provided for expanding the mental health care workforce and for capital facility and technology improvements. In subsequent years, most funding would be used for new prevention and early intervention programs and various expansions of the existing types of services provided by counties directly to mental health clients.

**Oversight and Administration.** Under the terms of the proposition, each county would draft and submit for state review and approval a three-year plan for the delivery of mental health services within its jurisdiction. Counties would also be required to prepare annual updates and expenditure plans for the provision of mental health services.

The Department of Mental Health, in coordination with certain other state agencies, would have the lead state role in implementing most of the programs specified in the measure and allocating the funds through contracts with counties. In addition, a new Mental Health Services Oversight and Accountability Commission would be established to review county plans for mental health services and to approve expenditures for certain programs. The existing Mental Health Planning Council would continue to review the performance of the adult and children’s system of care programs. The Franchise Tax Board would be the lead state agency responsible for administration of the tax provisions of this proposition.

The measure permits up to 5 percent of the funding transferred into the Mental Health Services Fund to be used to offset state costs for implementation of the measure. Up to an additional 5 percent could be used annually for county planning and other administrative activities to implement this measure.

**Other Fiscal Provisions.** The proposition specifies that the revenues generated from the tax surcharge must be used to expand mental health services and could not be used for other purposes. In addition, the state and counties would be prohibited from redirecting funds now used for mental health services to other purposes. The state would specifically be barred from reducing General Fund support, entitlements to services, and formula distributions of funds now dedicated for mental health services below the levels provided in 2003–04.

The state would also be prohibited from changing mental health programs to increase the share of their cost borne by a county or to increase the financial risk to a county for the provision of such services unless the state provided adequate funding to fully compensate for the additional costs or financial risk.

## Fiscal Effects

**Revenue and Expenditure Increases.** The tax surcharge would generate new state revenues of approximately \$275 million in 2004–05, \$750 million in 2005–06, \$800 million in 2006–07, and probably increasing amounts annually thereafter. (The impact in 2004–05 is a partial-year effect generated by increased taxpayer withholding, with the first full-year impact occurring in 2005–06.) The state and counties would incur additional expenditures for mental health programs basically mirroring the additional revenues generated by the surcharge.

**Reduction in Support Prohibited.** As noted earlier, this measure contains provisions that prohibit the state from reducing financial support for mental health programs below the 2003–04 level and that restrict certain other changes in mental health programs. Such restrictions could prevent the Legislature and Governor from taking certain actions in the future to reduce state expenditures for mental health services. As a result, state spending in the future could be higher than it otherwise would have been.

**State and County Administrative Costs.** This measure would result in significant increased state and local administrative expenditures related to the proposed expansion of county mental health services. These costs could amount to several millions of dollars annually for the state, with comparable additional costs incurred by county mental health systems on a statewide basis. These administrative costs would be largely if not completely offset by the additional revenues generated under this measure.

The state administrative costs associated with the tax provisions of this measure would be minor.

**Additional Federal Funds.** The expansion of county mental health services provided under this proposition—particularly the provisions expanding services for adults who are mentally ill—could result in the receipt of additional federal funds for community mental health services under the Medi-Cal Program. The amount of additional federal funds is unknown and would depend upon how the state and counties implement this proposal, but could potentially exceed \$100 million annually on a statewide basis.

**Partially Offsetting Savings.** State and national studies have indicated that mental health programs similar to some of those expanded by this measure generate significant savings to state and local governments that partly offset their additional cost. Studies of such programs in California to date suggest that much of the savings would probably accrue to local government. The expansion of county mental health services as proposed in this measure would probably result in savings on state prison and county jail operations, medical care, homeless shelters, and social services programs. The extent of these potential savings to the state and local agencies is unknown, but could amount to as much as the low hundreds of millions of dollars annually on a statewide basis.

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# ATTACHMENT

Agenda Item III

Workforce Education and Training Five-Year  
Strategic Plan (Draft)

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**CALIFORNIA DEPARTMENT OF  
MENTAL HEALTH**

**MENTAL HEALTH SERVICES ACT  
WORKFORCE EDUCATION AND TRAINING  
FIVE-YEAR STRATEGIC PLAN**

**DRAFT 9-25-2006**

**FOR DISCUSSION ONLY**

*The Mental Health Services Act (Act) stipulates that California will develop a five-year education and training development plan (Five-Year Plan). This second draft incorporates stakeholder input of the first draft, reports on accomplishments to date, and proposes actions for implementation in the near-term. Inserts such as this are interspersed throughout the document to provide a commentary on the parts of the Five-Year Plan. This Five-Year Plan will remain in draft form until an inclusive stakeholder process is completed for all parts of the Plan.*

**Fiscal Year 2005-06 through Fiscal Year 2009-10**

**Mental Health Services Act  
Workforce Education and Training  
Five-Year Strategic Plan**

**September, 2006**

**Arnold Schwarzenegger  
Governor**

**Kimberly Belshe  
Secretary, Health and Welfare Agency**

**Stephen W. Mayberg, Ph.D.  
Director, California Department of Mental Health**

**California Department of Mental Health  
1600 9<sup>th</sup> Street  
Sacramento, California 95814**

## ***EXECUTIVE SUMMARY***

***The Executive Summary will be written by the Director of the Department of Mental Health (The Department), and will summarize the Five-Year Plan, how it was developed, and how it will be implemented. The Department is responsible for the development of the Five-Year Plan, with review and approval by the California Mental Health Planning Council (Council), and oversight by the Mental Health Services Oversight and Accountability Commission (Commission). The Department will follow an inclusive stakeholder process, by which all interested individuals will be invited to participate in the development of this plan, and to comment upon all regulations, policies, practices and use of funds earmarked for education and training activities within the purview of the Act.***

STEPHEN W. MAYBERG, Ph.D., Director

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    Accomplishments \_\_\_\_\_

***The above section will list the education and training activities that have been planned and accomplished to date. These primarily consist of stakeholder participation in the development of the Five-Year Plan and early implementation of activities consistent with the intent of the Act. The following section will list Actions for fiscal year 2006/07 that will lead to the development of a workforce capable of providing public mental health services as envisioned by the Act. These Actions and Accomplishments will be reviewed and adjusted annually, with a yearly report of each year's Accomplishments and Actions for the duration of the Five-Year Plan.***

    Actions for FY 2006-07 \_\_\_\_\_

Resources \_\_\_\_\_

***This section will depict resources allocated to the Education and Training Fund, as well as funds budgeted by each county for education and training activities. Annual updates will reflect expenditures as well as budget adjustments for succeeding years.***

## Appendices

### Appendix A: Statewide Agreements \_\_\_\_\_

***This section will summarize contracts, interagency agreements, and memoranda of understandings that are executed and administered by the Department that contribute to the accomplishment of objectives listed in the Five-Year Plan.***

### Appendix B: County Plans \_\_\_\_\_

***This section will summarize county needs assessments and program and expenditure plans pertaining to education and training activities.***

### Appendix C: Stakeholder Process \_\_\_\_\_

***This section will document input by all interested individuals through meetings, forums and Departmental website calls for comment.***

## ***INTRODUCTION***

In November of 2004 the people of California enacted the Mental Health Services Act (Act) in order to build a better public mental health system. A component of the Act is to establish an education and training program with dedicated funding to remedy the shortage of qualified individuals, and to implement a five-year education and training development plan.

The California Department of Mental Health (Department), in partnership with its stakeholders, has created a five-year strategic planning process as a means to implement this component of the Act. The key elements of this Five-Year Plan are 1) the mission, core values and vision that are consistent with the intent of all components of the Act, 2) a comprehensive statewide workforce education and training needs assessment, 3) goals and objectives stipulated by the Act, 4) a continuous five-year planning cycle of actions, with a yearly report of accomplishments, and 5) a yearly report of resource assumptions, to include the Education and Training Fund. Finally, statewide and county agreements, programs and plans are described in the appendices, with a documentation of the process of stakeholder inclusion that was undertaken in the development of the Five-Year Plan.

This Five-Year Plan covers the period of June, 2005 through June, 2010. The mission, core values, vision statement, goals and objectives will remain throughout the plan. The needs assessment, accomplishments, planned actions and resources will be updated annually.

## ***MISSION***

The California public mental health community, in partnership with its diverse stakeholders, will develop and maintain a sufficient workforce, to include consumers and family members, capable of providing consumer- and family-driven, culturally competent services that promote wellness, recovery, and resiliency, and lead to measurable, values-driven outcomes.

## ***CORE VALUES***

The following core values encompass all activities pursuant to the Act, to include workforce education and training:

- Promote wellness, recovery and resilience.
- Increase consumer and family member involvement in policy, program development, and employment in service delivery and behavioral health administration.
- Develop a diverse, culturally sensitive and competent workforce in order to increase the availability and quality of mental health services and supports for individuals from every cultural group.
- Deliver individualized, consumer and family-driven services that are outcome oriented and based upon successful or promising practices.
- Create access to services for underserved and unserved populations.

## ***VISION STATEMENT***

This leadership guidance was derived from a keynote speech provided by the Director of the Department of Mental Health, Dr. Stephen Mayberg, at a February, 2006 statewide education and training policy forum in Newport Beach.

- Leadership. The Act has provided both a mandate and an opportunity for transforming the public mental health system. Transformative change starts with the people who have the capacity and passion to excel and mentor the practices, approaches and treatments that are sensitive and responsive to consumers' needs and cultures, and produce more favorable outcomes. The Five-Year Plan needs to recognize and support those successful individuals, programs and practices.
- Responsiveness. All service disciplines must be sufficiently staffed to meet California's mental health services and support needs at all

levels of education and experience; from peer and family supports to licensed professionals.

- Inclusion. The Five-Year Plan needs to reflect an ongoing process that positively engages all individuals who can impact the mental health system workforce. This includes a) outreaching to present and future mental health service providers, b) engaging all stakeholders in planning and decision-making, c) partnering with all education and training institutions, internship programs and potential entities capable of addressing workforce needs, and d) engaging the public.
- Fidelity. Both curricula and methods of teaching at all levels of education and training need to be consistent with an agreed upon set of curricula and methods of teaching that appropriately integrate theory and practice, and are based upon the Five-Year Plan's Core Values. A consistent mental health career pathway should facilitate navigation from entry level through licensed professional occupations, while allowing entry into the workforce at any level.
- Relevance. Finally, the Five-Year Plan should be a permanent means to incrementally improve the workforce, with accountability at all levels. This involves planning, resourcing, implementing and evaluating on an ongoing basis to realistically reflect both emerging program developments and fiscal constraints. It should also balance the appropriate level of education and training provided at the community, regional and statewide levels.

## ***STATEWIDE NEEDS ASSESSMENT***

Background. California faces a significant shortage of individuals capable of delivering the public mental health services envisioned by the Act. Previous studies have pointed to high vacancy rates in certain occupational classifications, lack of diversity in the workforce, poor distribution of existing resources, and under-representation of consumers and family members in the provision of services and supports. The workforce also needs the skills to deliver services and supports that emphasize wellness, recovery and resilience, and that result in positive outcomes.

The historical lack of sufficient public mental health funding has challenged county and contract agency administrators to creatively adjust their capacity to deliver services to reflect available resources. In addition, the traditional emphasis on treating symptoms rather than promoting strengths has resulted in a workforce composition that is responsive to a more “medical model” approach. Current mental health licensing and credentialing requirements reinforce this tendency. For the Act to fulfill its mandate to transform mental health service delivery the composition and capabilities of the workforce that provides the services must also transform. For example, the projection of numbers of individuals in occupational categories in the next five years will likely include a transformation within the categories themselves.

The needs assessment included in this Five-Year Plan will address current workforce requirements as well as workforce projections consistent with the transformative vision of the Act. The following issues, among others, will influence the development of the needs assessment and guide the Department in constructing a model that assists in funding education and training programs:

- The public mental health system must be relevant and responsive to underserved and unserved populations, and be deployed to meet needs not presently reflected in current perceived vacancy rates.
- Ethnic diversity, linguistic capacity, and cultural competence of the workforce will need to keep pace with the changes in ethnic and monolingual populations.
- Changes in how services are delivered as a result of the Act are likely to affect licensure and credentialing requirements.
- Emerging best practices, which are consistent with the values of the Act, may change regulations and policies governing the composition of the workforce, as well as related recruitment, training and education.
- Identifying occupational functions rather than focusing on specific classifications of mental health service providers will influence the current service provider-to-population ratios.
- The enrollment capacities of educational programs will need to be considered in planning the strategic use of education and training funds.

The dynamic nature of these variables dictates an ongoing participatory research approach to the development of the needs assessment, ensuring that the values of stakeholders are included and operationalized in the methodology used to project future workforce needs.

Workforce needs generated by the Act. Pursuant to local stakeholder planning processes, county mental health programs have begun implementing community services and supports (CSS) plans. The Act requires that each county mental health program submit a needs assessment identifying the anticipated increases in each professional and other occupational category needed to provide the projected increase in services to consumers and their families.

Submitted county CSS Plans were summarized and analyzed for new MHSA workforce positions, stated needs and challenges, and cultural diversity and language proficiency issues.

Statewide estimates indicate that over 4,300 new positions are being created with initial MHSA funding, with the following service provider occupational classifications reported:

- 5% - Psychiatrists and other physicians
- 9% - Nursing personnel
- 15% - Social workers
- 5% - Psychologists
- 17% - Therapists or counselors
- 21% - Case managers
- 17% - Mental health workers
- 9% - Other occupations

Over 20 percent of all of the new MHSA positions have been specifically designated to be filled by consumers and/or family members. While employing significant numbers of the more traditional occupations, the above numbers delineate a movement toward a different workforce composition than currently exists. To fill newly created positions there is both a need to respond to challenges in recruiting and retaining traditional occupations, as well as an evolving need to recruit, train and support

individuals in transformative roles, with newly defined job descriptions and required qualifications.

Counties reported the following recurring challenges:

- Language proficiency, cultural competency, and diversity of the workforce. Individuals with Hispanic/Latino heritage are uniformly underrepresented in the workforce. Counties reported a need to attract and retain staff who are bicultural and bilingual, especially in Spanish. Specific communities reported discrete immigrant populations that pose cultural competency and language proficiency challenges. Native American tribes and rancherias continue to be underserved.
- Organizational capacity to support new services. Due to a history of chronic under funding of public mental health, counties and contract agencies lack the infrastructure to administratively support the significant addition of new workers and programs.
- Geographical challenges of recruiting staff and reaching consumers. County mental health programs have responded to stakeholder input to field programs dedicated to underserved and unserved populations. These new programs now face the challenge of finding workers willing and able to work in remote areas. Many of these communities are not able to compete economically for a limited pool of qualified workers.
- Hiring consumers and family members. The Act has created a significant number of service provider positions for consumers and family members. In addition, consumers and family members might fill a number of non-designated positions at all levels of the mental health system. Counties have indicated a number of challenges in incorporating these new employees into their existing workforce. Expected challenges include role transition from consumer to provider, reasonable accommodations, ongoing employment supports to new employees to navigate changes in public benefits, role transitions for existing employees accommodating to a recovery-based system, and incorporation of positions into civil service classifications to facilitate career progression.
- Recruiting and retaining licensed staff. The public mental health system has experienced a chronic shortage of individuals capable of prescribing and administering psychotropic medications, diagnosing

serious mental illness, and signing treatment plans. The addition of new MHSA funded programs has exacerbated the problem.

The identification of counties' challenges in developing a capable workforce for new MHSA services has provided useful information with which to initially plan and implement actions to address these challenges, and ultimately to increase and strengthen the entirety of California's community public mental health workforce.

***The Department is working with consultants and stakeholders to develop a strategy for conducting a comprehensive assessment of the entirety of California's needs related to its community public mental health workforce. The intent is to analyze and measure workforce need, capacity to meet the need, and provide valid data and analysis to facilitate workforce education and training planning and allocation of resources. Also, an ongoing evaluative process will be developed to measure progress toward meeting workforce needs over time.***

## ***GOALS AND OBJECTIVES***

The purpose of the following Goals and Objectives is to provide a structure for the creation of a realistic set of actions for California's public mental health community to accomplish in order to positively influence the workforce, and thereby improve the quality of services and supports received by individuals and their families.

The Goals listed are limited in number, and provide broadly defined strategic directions. The Objectives are a specific set of outcomes that have been stipulated by the Act to be included in the Five-Year Plan, and are proposed to accomplish each broad Goal.

### **Goal #1 – Develop sufficient qualified individuals for the public mental health workforce.**

Objective A: Expand the capacity of postsecondary education programs to meet the needs of identified mental health occupational shortages.

Objective B: Expand loan forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system. Extend these programs to interns and current employees of the mental health system who want to obtain Associate of Arts, Bachelor, Masters and Doctoral degrees.

Objective C: Create stipend programs for persons enrolled in academic institutions who want to be employed in the public mental health system.

Objective D: Promote the employment of consumers and family members at all levels in the mental health system.

**Goal #2 – Increase the quality and success of educating and training the public mental health workforce in the expressed values of the Act.**

Objective E: Develop curricula to train and retrain staff to provide services in accordance with the expressed values of the Act.

Objective F: Promote the inclusion of cultural competency in all training and education programs.

**Goal #3 – Increase the partnership and collaboration of all entities involved in public mental health workforce education and training.**

Objective G: Establish regional partnerships within the public mental health and educational systems in order to expand outreach to multicultural communities and increase the diversity of the public mental health workforce, reduce the stigma associated with mental illness, and promote the use of web-based technologies and distance learning techniques.

Objective H: Increase the prevalence of mental health career development opportunities in high schools, adult education and regional occupational programs, such as health science and human service academies, in order to recruit students for public mental health careers.

Objective I: Promote the meaningful inclusion of mental health consumers and family members, and incorporate their viewpoints and experiences in all training and education programs.

# ***ACCOMPLISHMENTS AND ACTIONS***

## **1. Accomplishments**

A. Enacted Public Planning Process. Upon passage of the Mental Health Services Act the Department of Mental Health engaged in a public planning process to facilitate maximum participation by the broadest group of participants, or stakeholders, in transforming community public mental health service delivery in California. The Department, in partnership with its stakeholders, developed a process and set of guiding principles by which policy and decision-making could be accomplished in as inclusive and transparent manner as possible. Key to these guiding principles was 1) implementing practices that would ensure active participation by consumers and family members in order to incorporate their viewpoints and experiences, and 2) promoting the inclusion of cultural competency throughout all activities connected to the Act.

Within this context the MHSA workforce education and training component embarked upon a public planning process, beginning with a series of three statewide forums (June of 2005 in Sacramento, February 2006 in Newport Beach, and April 2006 in Sacramento and Anaheim) for the public to provide input on what was needed and how to address California's workforce education and training challenges.

A statewide advisory body was formed that included leaders and subject matter experts from 1) statewide constituency organizations, such as the National Alliance for the Mentally Ill – California (NAMI), California Network of Mental Health Clients (CNMHC), California Mental Health Directors Association (CMHDA), United Advocates for Children of California (UACC), California Association of Psychosocial Rehabilitation Agencies (CASRA), California Mental Health Planning Council (CMHPC) and the Oversight and Accountability Commission (OAC), 2) educational institutions, and 3) professional organizations.

This advisory body assisted in the formation of special topic workgroups, each focusing on one of the objectives outlined in the Five-Year Plan, and responsible for crafting a series of recommended actions for public consideration. Each workgroup was comprised of a cross-section of individuals representing county mental health, contract agencies, educational

institutions, professional organizations, and consumers and family members. Participants articulated the issues and concerns of racial/ethnic groups, administration and service provider staff, and special populations/age groups being served.

B. Developed MHSWA Workforce Education and Training Infrastructure.

The Department formed an MHSWA Workforce Education and Training Unit that is responsible for facilitating and supporting the public planning process and writing and administering the Five-Year Plan. This unit works with the Human Resources Committee of the California Mental Health Planning Council and the Education and Training Committee of the Oversight and Accountability Commission to execute the statutory requirements of the Act for approval and oversight of the Five-Year Plan.

C. Implemented Early Education and Training Resources. MHSWA funding was added to existing California resources recognized for their ability to immediately address training and workforce needs on a statewide basis.

- Organizational Change Support. The California Institute for Mental Health (CIMH) expanded its existing statewide training and technical assistance mission of supporting county mental health programs. This expansion included ongoing technical assistance for organizational movement toward values-driven, evidence-based service delivery as envisioned by the Act, and to facilitate regional learning collaborative networks to plan and implement new practices.
- Financial Incentive Program. The California Social Work Educational Consortium (CalSWEC) expanded its existing stipend program to provide financial incentives for students in masters-level social work programs to commit to work in community public mental health. One hundred seventy-three graduates are now available for employment this year. This program provides a replicable model for development of additional financial incentive programs.
- Statewide Constituency Partnership. The statewide constituency organizations of the California Network of Mental Health Clients (CNMHC), United Advocates for Children (UACC), and the National Alliance for the Mentally Ill – California (NAMI) are expanding their efforts to reach consumers and family members with self-help technical assistance and train-the-trainer curricula,

such as Educate, Equip and Support – Building Hope, Peer-to-Peer, Family-to-Family, and Wellness Recovery Action Planning. These curricula will promote the meaningful inclusion and employment of consumers and family members at all levels of the public mental health system.

***Stakeholders are invited to provide input on the following proposed education and training Actions to be taken in the current fiscal year that address the above listed objectives. These are short-term strategies to address immediate needs, and provide incremental steps toward fully honoring the stipulations of the Act. For example, the funding of replicable models enables new programs and structures to be started that can immediately address need, develop lessons learned, and provide assistance for the subsequent growth of programs and trainings to the level of established need.***

## **2. Actions for FY 2006/2007**

Objective A: Expand the capacity of postsecondary education programs to meet the needs of identified mental health occupational shortages.

- Action #1. Fund replicable model residency and internship programs that have the capacity to address critical shortages of individuals capable of prescribing and administering psychotropic medications and signing treatment plans.
- Action #2. Expand certification programs that produce individuals proficient in delivering community public mental health services that are in accordance with the intent of the Act.
- Action #3. Promote the development of continuing education unit (CEU) trainings to address services delivered in accordance with the intent of the Act.
- Action #4. Provide funding that enables release time for community public mental health service providers and education faculty to work together in their respective settings to influence curricula that promotes wellness, recovery and resiliency and stigma reduction.

Fund consumers and family members to participate in faculty and staff exchanges at the workplace and in educational settings.

Objective B: Expand loan forgiveness and scholarship programs offered in return for a commitment to employment in California's community public mental health system. Extend these programs to interns and current employees of the mental health system who want to obtain Associate of Arts, Bachelor, Masters and Doctoral degrees.

- Action #5. DMH to partner with the Health Professions Education Foundation (HPEF) to develop an MHSA scholarship and loan forgiveness program modeled after existing statewide programs.
- Action #6. DMH to partner with the Office of Statewide Health Planning and Development (OSHPD) to maximize federal funding to California for existing scholarship and loan forgiveness programs in designated mental health profession shortage areas.

Objective C: Create stipend programs for persons enrolled in academic institutions who want to be employed in the public mental health system.

- Action #7. In addition to CalSWEC expand the capability of additional occupational professions to develop stipend programs.

Objective D: Promote the employment of consumers and family members at all levels in the mental health system.

- Action #8. Fund replicable model community public mental health entry level preparation programs for consumers and family members.
- Action #9. Expand existing statewide contracts to CNMHC, NAMI, UACC and trainers/consultants to California's Mental Health Cooperative Programs to focus development in the areas of a) career advancement, or pipeline strategies for positions designated for consumer and family members, b) alternate civil service minimum qualifications to honor consumer, family member lived experience, c) agency assessment of readiness to support consumer and family members in the workplace, d) essential elements of ongoing employment support, and e) preparation to run programs operated by consumer and family members.

- Action #10. Expand the functions of the consumers and family members who participate in the DMH expert pool, and establish similar expert pools at regional levels.

Objective E: Develop curricula to train and retrain staff to provide services in accordance with the expressed values of the Act.

- Action #11. Establish an ongoing MHSA education and training coordinating council comprised of leadership from county mental health programs and their contract agencies, professional organizations, education and training institutions, and consumers and family members. This council would provide guidelines and principles for training and technical assistance tracks and topics appropriate under the Act, and review and comment on core competencies and curricula.

Objective F: Promote the inclusion of cultural competency in all training and education programs.

- Action #12. Cultural competency is a cross-cutting objective that is proactively addressed in all goals and objectives. All MHSA funded education and training will be required to address how their program/training will include the principles and practices of cultural competency, and will positively impact the diversity and language proficiency of the public mental health workforce.

Objective G: Establish regional partnerships within the mental health and educational systems in order to expand outreach to multicultural communities and increase the diversity of the mental health workforce, reduce the stigma associated with mental illness, and promote the use of web-based technologies and distance learning techniques.

- Action #13. Fund initial regional partnership structures throughout California as replicable models, and support the establishment of additional regional partnerships, as locally determined.
- Action #14. Convert MHSA relevant trainings into a blended learning format to enable web-based access throughout California.

Objective H: Increase the prevalence of mental health career development opportunities in high schools, adult education and regional occupational programs, such as health science and human service academies, in order to recruit students for mental health careers.

- Action #15. Fund the planning process to establish replicable model mental health career pathway programs.

Objective I: Promote the meaningful inclusion of mental health consumers and family members, and incorporate their viewpoints and experiences in all training and education programs.

- Action #16. Inclusion of consumers and family members is a cross-cutting objective that is proactively addressed in all objectives. All MHSA funded education and training will be required to address how their program/training will include the viewpoints and experiences of consumers and family members.

## ***RESOURCES***

## ***APPENDICES***

- 1. Appendix A: Statewide Agreements**
- 2. Appendix B: County Plans**
- 3. Appendix C: Stakeholder Process**

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