

PRACTICUM AND EXPERIENCE REQUIREMENTS

Good morning Christy,

Yes, we have been monitoring closely the proposal with respect to revising the educational requirements for licensure as Marriage and Family Therapists in California. With respect to your particular questions regarding practicum units, I will respond by noting first that the MA Counseling Psychology Program housed in the Graduate School of Professional Psychology has always exceed the number of practicum units required by the BBS. We require that our students complete 21-24 quarter units of practicum experience. As a result, the majority of our students meet and easily exceed the number of face-to-face client hours (150) currently required by the BBS. Consequently, we have felt no need to require of students that they complete more than the current minimum of 150 as required by the BBS. There have been very rare cases in which a student who has a very intense work schedule, or who works for an employer who may be reluctant to provide flexibility with regard to work hours, would find it difficult to acquire too many additional hours beyond the 150. So I would urge careful consideration when increasing the number of face to face client hours required.

Please feel free to contact me should you require additional information. Have a good Thanksgiving.

Regards,

Gail Kinsley-Dame, Program Director
MA Counseling Psychology
Graduate School of Professional Psychology
John F. Kennedy University

From: Deborah Buttitta
Sent: Tuesday, November 06, 2007 4:23 PM
To: Benjamin Caldwell

Subject: RE: Letter to BBS: Require actual relational hours for MFT licensure

Hi Ben,

Thank you for forwarding this to the educators. We here at PGI are also reviewing the proposed curriculum and drafting some feedback for the BBS Education Committee.

In response to your letter, we are in agreement with your first recommendation for changing the licensure requirements to make family/couple therapy its own category and separating child therapy into a new category.

We have some concerns regarding your second consideration to make relational work a practicum requirement. We agree that ideally practicum would be a wonderful time to closely train students in couple and family therapy. Our immediate concern however, is the lack of couples and families that actually present for therapy in many of the clinical placements. Many sites may not be able to provide these clients, consequently the students may not be able to fill this requirement and this may actually keep students from graduating in a timely manner.

Degree completion is our greatest concern. We do want to reiterate our support for making couple and family work a distinct requirement for licensing MFTs in California.

Sincerely,
Deborah Buttitta, M.A., MFT
Department Chair, MFT Program
Phillips Graduate Institute

Dear Paul,

It was a pleasure to meet you and the staff of BBS last Friday at Phillips Graduate Institute. As per your request, I am emailing you what I had proposed to you, viz., whether the board would consider raising the "in degree" practicum (face to face direct client contact hours) from 150 to 300 hours. This would require student trainees to receive further clinical evaluation while in the academic institution granting the degree. I believe that 150 direct client contact hours may not be sufficient and should be raised.

Thank you for the opportunity to voice this.

Sincerely,

Kenichi Yoshida
Associate Director of Academic Affairs
Fuller Theological Seminary
School of Psychology
Department of Marriage and Family

Mr. Riches and Dr. Russ,

My name is Jay Willoughby, Associate Core Faculty in the Graduate Psychology Department at New College of California. I have a question regarding the most recent Concept Draft for MFT Curriculum. Unfortunately I was unable to attend the June 15 meeting, but was present at the meeting prior to that, held at Golden Gate University. One aspect of the most recent Concept Draft that I was not aware of seeing in the draft prior to that is letter (c), item (10). The new draft calls for nine semester units of practicum experience, and a minimum of 250 hours of face-to-face experience. Although I can see the reasoning behind increasing the minimum number of face-to-face hours of experience, as it will better prepare the trainee to conduct clinical work post-degree, what is the reasoning behind increasing the number of units the hours would need to be gained in? And why 9 semester units?

The reason I am curious is that our program is currently a two-year program. Given all of the proposed changes in the Concept Draft, we would still be able to offer a two-year program to interested students, with the exception of the nine semester unit practicum requirement. We currently have some students that complete 8 semester units of Fieldwork, and others that complete 6 semester units. To require 9 units would mean extending our program into a third year.

I appreciate your time and look forward to hearing from you.

Take care,
Jay Willoughby, M.A.

Christy,

Thanks for your e-mail. I had e-mailed my initial concerns about this proposed change to Ian Russ in August. New College of California requires 6 units of Fieldwork, and a minimum of 150 hours of face to face experience. This allows for us to offer a two-year Master's program. The proposed change to 9 semester units would extend our program beyond two-years, while the extended hours requirement to 225 may not necessarily do this. I did not hear back from Ian, but am hoping that the Education Subcommittee is taking our College's concerns into account.

Hope this information is what you were needing. Let me know if there is anything else I can do.

Jay Willoughby

Dear Ms Berger,

We have only recently become aware that there is a plan to increase pre-M.A. practicum to 225 face-to-face hours. We do provide six regular semester units for practicum and an additional first-year second semester practicum for a few hours, but the main experience in our clinic is the two semesters of the second year. Frankly, we are concerned that such an increase in hours would be difficult for us to Meet at Humboldt State University. Approval to offer graduate courses is at a breaking point due to budget constraints. We continually fight for appropriate courses. Be aware that we also have two courses in methodology and also require a thesis, since we adhere to the scientist-practitioner model. In our opinion our mission is to prepare a qualified candidate for internship, not to provide an internship. This number of pre-degree face-to-face hours may jeopardize our program. We are just beginning to be able to respond to such proposed changes. We must strongly disapprove it and cannot see the need at this time. The bulk of supervised hours should be in the internship and the academic preparation for that internship should remain rigorous. Could you please send me a total copy of all the proposed changes so we may be part of this discussion.

Sincerely,
James L. Dupree, Ph.D.
Associate Professor-Psychology
Humboldt State University

Dear Christy Berger,

Here at CIIS we require 12 full months of practicum experience, however, we only do 2 semester units per semester for total of 6 units. Raising the number of hours from 150 to 225 we heartily support. We would like to keep this unit requirement to 6 units, as we are being squeezed for units and these new requirements look to seriously jeopardize the integrity of our clinical training.

It would be great to get more feedback from schools about turning the MFT into the new social worker to provide cheap labor for community mental health. Although community mental health is well organized, its interests do not necessarily coincide with training in psychotherapy from a depth and systems perspective. In fact, these new proposed regulations may well spell the end of the MFT training in psychotherapy. If the new licensed mental health counselor becomes the new psychotherapy license at the MA level, we may switch to this new degree and license, since we do not want to simply train caseworkers for community mental health.

We at CIIS wish we could dialogue with the BBS more about these proposed changes before they are moved forward. If there is any way this can happen, please let me know.

Sincerely,
Brant Cortright, Ph.D.
Program Director, Integral Counseling Psychology
CIIS

Christy,
Our school requires 9 quarter units of practicum. We have registered our strong opinion that we are against raising the number of hours students must complete prior to graduation.

Thanks,

Teri Quatman
Chairperson
Dept of Counseling Psychology
Santa Clara University

Dear Christy,

We require 150 face-to-face hours over 2 semesters.

At least 2/3 of our students are mature men and women making career transitions. The average age of the GGU student is 30 and most are working full-time. Many are also supporting families while attending our program.

Since most trainee positions are unpaid, and many internship positions are paid - an increase to the requirements create a hardship that would prevent many mature individuals from pursuing an MFT license. Most of our students try to remain employed while attending classes in order to offset tuition costs and minimize debt.

Increasing the requirements would decrease the number of mature individuals able to acquire an MFT license - and increase personal debt and the stress associated with financial burdens.

I hope you'll take these factors into consideration as you review the BBS requirements.

Thanks,
Kit

Kit Yarrow, Ph.D.
Chair, Department of Psychology
Golden Gate University

Christy,

In the Department of Psychology at CSU Stanislaus, we require 6 practicum units with minimum of 150 hours.

I fear that increasing the number of practicum units would severely adversely affect our program by making it very unlikely for our students to finish their coursework in two years.

Kurt D. Baker, Ph.D.
Department of Psychology
California State University, Stanislaus

Hi,

I appreciate your work. We follow the former COAMFTE standards, which have become the de facto national standards and have for many years:

9 semester units of practicum
500 client contact hours (at least 250 of which must be with couples or families (not individual children) physically present in the room).

This applies to all Alliant locations (presently San Diego, Irvine, and Sacramento).

I think the most important things the BBS can do to raise the quality of MFTs in California are to

- 1) Require that student in practicum and preparing to be licensed actually see couples and families together so they learn to work with couples and families (i.e. do not allow individual children to count as relational hours).
- 2) Require 500 total hours of client contact during practicum.
- 3) Require that at least 250 of the 500 hours to be with couples and families physically present in the room.
- 4) Require supervisors of MFT student and interns demonstrate training in the field of Marriage and Family Therapy or in other words relational training. Currently social workers and psychologists etc. who have had NO training in MFT can and often do provide all of the supervision and training of MFTs.

I believe that #1 above is absolutely critical for protecting the public. I am amazed that people can become licensed as MFTs in California without ever having seen a couple or family together in therapy (since couple, families and children are all lumped together). This should not be. Please, please change this.

I also believe that raising the practicum hours from 150 to 225 is not nearly enough. When the national standard is 500 contact hours, we should at least be at 500 contact hours.

Please feel free to pass my comments on to any and all people that might find them useful.

Thanks for your good work,

Scott R. Woolley, Ph.D.
Professor and System-wide Director
Marital and Family Therapy Graduate Programs
California School of Professional Psychology
Alliant International University

We have only recently become aware that there is a plan to increase pre-M.A. practicum to 225 face-to-face hours. We do provide six regular semester units for practicum and an additional first-year second semester practicum for a few hours, but the main experience in our clinic is the two semesters of the second year. Frankly, we are concerned that such an increase in hours would be difficult for us to Meet at Humboldt State University. Approval to offer graduate courses is at a breaking point due to budget constraints. We continually fight for appropriate courses.

Be aware that we also have two courses in methodology and also require a thesis, since we adhere to the scientist-practitioner model. In our opinion our mission is to prepare a qualified candidate for internship, not to provide an internship. This number of pre-degree face-to-face hours may jeopardize our program.

We are just beginning to be able to respond to such proposed changes. We must strongly disapprove it and cannot see the need at this time. The bulk of supervised hours should be in the internship and the academic preparation for that internship should remain rigorous. Could you please send me a total copy of all the proposed changes so we may be part of this discussion.

Sincerely,
James L. Dupree, Ph.D.
Associate Professor-Psychology
Humboldt State University

INCREASE IN UNITS

Dear Dr. Russ and Mr. Riches,

After listening to some comments in a BBS meeting and seeing the proposed changes for MFT licensing, I want to state that I believe the recommendations will eventually kill the MFT license. Years ago, when we first installed our MFT program, it lasted for 11 months. What is being proposed would extend our existing program from 24 months to 30 months.

We have already had many students abandon our MFT program in favor of becoming Licensed Psychologists for obvious reasons, and if the BBS decides to cover other issues (like Case Management, Systems of care for severely mentally ill, public & private services, disaster/trauma response) I opine that many MFT programs will suffer the same decline for the simply reason that the student sees a better career choice in a PsyD degree.

So put me down as one who objects strongly to what is being proposed. I know it may make sense on some levels, but, considering the availability of alternative licenses, it creates a poor career path for students who look to optimize their time and tuition expense.

Steve Arthur, Ed.D.
Vice President of Administration
Ryokan College

Regarding the lengthening of degree programs to 60 to 90 Semester/ Quarter Units:
Consider that you would not only like to serve the under-served and diverse populations in California but would also desire to attract a diverse student population who can serve within their own communities.

The newly proposed unit requirements exceed 2 years of full-time enrollment and would add a considerable expense of time and money to an already lengthy licensing process. This will likely exclude and most severely impact just those students who would be most likely to add to the economic and cultural diversity of the profession.

Alternatively, you could leave the degree length the same and require some number of hours of experience to be gained in a community mental health setting; and, you could require some hours of post-graduate continuing ed in the areas you are trying to enhance. (While leaving in place the other pre-degree educational content changes you have made.)

Thus the new emphasis areas of training would extend throughout both the degree and post-degree periods and these students would be able to finish school in two years and begin their additional professional experience in an economical (Interns can make some money to make ends meet whereas trainees rarely can.) and timely manner (The overall MFT licensing process currently is typically four years minimum and most often takes 4-6 years.

Thank you for your consideration of this matter,

Dean Lobovits, MFT 20211
(Original author for John Vasconcellos in 1987, of the sections being revised)

Hi, Paul

This is to follow up our conversation last week.

1. I would like you to ask your initial question again, namely, if there is anything in the current MFT curriculum that can be taken out. We discussed the resistance in the field and among the educators. I think if you ask this question, there may be different answers.
2. another question would be "if any part of the current curriculum content can be pushed down to either undergraduate curriculum, or to be prerequisite?"

The rationale for both questions is the accessibility issue for potential students from the underserved population groups. If we increase the hour requirement, those who can't afford the training today still will not be able to afford it tomorrow even with the stipend.

Thanks!!
Linna Wang

CULTURAL COMPETENCE ISSUES

Excellent idea in adding culturally competent requirements to MFT curriculum. Also, more focus on resources and understanding of severe mental illness.

Melinda Echeverria, MA, MSW, LCSW
Program Director
College Community Services

Dear Mr. Riches,

As an Intern at an Agency where there is a huge need to understand and empathize with cultural differences, I am pleased to see that a large emphasis of change in the MFT requirements is to educate more about psychological implications of social-economic positions within cultures. The college I graduated from (Pacific Oaks College) was very social conscious and I have found that it has been a tremendous asset for my work. California is becoming more and more diverse and it is our responsibility as therapist to understand our client and not view them through our lens but rather the clients point of view. There is a concern that children raised with two languages may have learning disabilities but often have had my client tested by a psychologist the client has excelled in the language spoken at home. Having this awareness as a therapist would help in not labeling a child without more interventions. The same goes for children with many losses or trauma in the home that have Oppositional behavior and are medicated for ADHD and often it is behavior resulting in attachment, separation and trauma. Having students learn more of this information will help the therapist advocate for the client that is often labeled too quickly. Part D 2 of your proposal is extremely important, and one that I felt I have learned more in my internship and while studying to take my exams. I would have like more emphasis in Theory.

I specialized in Grief (I volunteered 2 weeks during Katrina) and I find many therapist are "afraid" to address loss and grief. More and more I see many losses our clients experience and we need to know how to help them. We are society of fast gratification but not one prepared for loss, yet we see it on TV, community on a daily basis.

I am sure when I was a student, I would not have liked being added more Units but I see the importance and I also was shocked to see some of the people that were graduating with a Masters that I would not want as my therapist. We have people's mental health in our hands and they deserve to get the best care. Of course better salary compensation for our line of work would be wonderful but you have no control over that.

I am pleased to see this proposal. Thank You.

Sincerely,
Joanne Koegl, M.A. MFT Intern
Hathaway-Sycamores

MANDATORY PERSONAL PSYCHOTHERAPY

Dear Dr. Riches,

I just received e-mail information from the BBS re changes to be made to the MFT curriculum. In my opinion, one of the glaring problems is the lack of MANDATORY personal therapy as a requirement for the MFT training programs.

Many students voluntarily seek their own personal therapy and take advantage of the triple hours towards their license. However, often it is the very students who need it the most who avoid it at all costs. It is frightening that they then are able to do harm to the public without any scrutiny.

In addition, students tell me they would like to have more experiential work along with their MFT theory classes. This probably would require 2 or 3 more classes added to the curriculum.

I appreciate your request for input. Thank you.

Dr. Judith Sherwin

I believe ALL Licensed psychotherapist should be required to receive a minimum 100 hours of individual therapy.

Susan Grossi, M.Ed., MA, LMFT

Dear Paul

Thank you for the opportunity to offer my suggestion regarding the training of MFTs. Something I always felt strongly about was that MFT students have at least one year of being in therapy. I know some schools request this and I know the board offers hours in the licensing process for this. Nevertheless I feel this should be an integral part of learning (experientially) what it feels like to seat on the other side of that chair.

There it is. Thank you for listening.

Sincerely,

Maria Torres

Hi Christy:

Thanks for sending this to me. I've looked over it and the only feedback I'd like to add is that I'd love to see a requirement at the state level about having personal therapy hours before getting licensed. Having accumulated many hours of personal therapy with various therapists and then starting on my own journey to become licensed, I find this is increasingly important. Without the experiential process of doing inner work, I personally don't feel a therapist has much value to a client, no matter how much formal education they have.

Thank you for taking my comments into consideration

Kind regards,

Lori Richan

SUBSTANCE ABUSE

I am very pleased to see your board is considering adding additional educational requirements for substance use disorders to your MFT requirements. Could you tell me how many class units will be required in this subject area?

Thank you,

Best Regards,
Cathie Smith
Mom, President and Founder
The Justin Foundation

OTHER ISSUES

BBS: I read the Proposed changes to the MFT required academic education for licensure in Cal. Why does the BBS continue to waste their time on MFT's. The educational requirements the MFT's is suggesting, are very similar to the MSW degree. Why does the BBS continue to mess around with the MFT? A MFT is just a wanna-be MSW/LCSW. Why should Californians waste money on a fake when they can have the real thing in a LCSW.

Gene Courter MA/MSW/LCSW/DCSW/ACSW

Mr. Riches,

I often wish I had more training in CBT with emphasis on behavioral. When working for agencies or the county it is imperative information. Thank you.

Lori L. Riddle-Walker, MA, MFT
Licensed Marriage and Family Therapist

Hi Ian and Paul,

Given Paul's talk at AAMFT about this being an opportunity to make changes in the educational requirements, the MFT faculty and I decided to offer a few thoughts and suggestions. Attached is a letter outlining these suggestions.

Overall, we are in agreement with the changes made thus far and truly appreciate the opportunity to be involved in this process. If you have any questions please feel free to email me or Kathy Wexler. Jose Luis, Kathy and I will be at the December 7th meeting.

Again, thank you for the opportunity to be involved.

Sincerely,

Deborah Buttitta, M.A., MFT
Department Chair
Master of Arts Degree in Psychology.

DATE: Wednesday, December 05, 2007

TO: Ian Russ, Chair

Paul Riches, Executive Officer
Board of Behavioral Sciences

FROM: Deborah Buttitta, Department Chair
Kathy Wexler, Curriculum Coordinator
Marriage and Family Therapy Program
Phillips Graduate Institute
MFT Core Faculty

RE: Suggestions for draft MFT curriculum

We appreciate all the hard work that has so far occurred to revise the educational requirements, and we are generally in agreement with what is being proposed. You asked for feedback, and we do have some suggestions, regarding both substance and language/organization.

1) Move Section d (11), Psychopharmacology, into section d (1).

The section would then read:

(1) Diagnosis, assessment, prognosis and treatment of mental disorders, including severe mental disorders, evidence-based practices, psychological testing, and psychopharmacology.

As you know, psychopharmacology is currently a separate section only because of the legislative history. We have an opportunity now to locate this coursework more logically, with other topics concerning the treatment of mental disorders.

2) In Section (c) 2, the wording might be improved, for clarity and to further highlight the key aspects of recovery and resilience that everyone seems to agree should be in the curriculum. We suggesting revising (c) 2 as follows:

Throughout its curriculum, integrate the principles of recovery-oriented care in mental health practice environments that are strength-based, and emphasize improving, restoring and maintaining healthy relationships.

3) Clarify and condense requirements to consider issues of human diversity, which appear several times in these draft regulations. (Specifically in (c) 6, (d) 3, C-F, (d) B 5 and 6.) Gender (and some other important contextual influences) are not mentioned in these lists, and sexual orientation is also occasionally omitted. To avoid repetition, the regulations might define all the significant dimensions of diversity the first time they are mentioned, and then use the phrase "issues of human diversity" thereafter. For example, (c) 6 could be modified as follows:

(c) 6 Integrate throughout the curriculum an understanding of various issues of human diversity: race, ethnicity or culture, religion or spiritual values, sexual orientation, socioeconomic status, age and gender.

4) In the section regarding Human Sexuality (d) 7), the terminology is possibly misleading, allowing the reader to confuse the concepts of sexual identity and sexual orientation. Current wording says: ...*Human sexuality, including the study of physiological, psychological and social-cultural variables associated with sexual identity, sexual behavior and sexual disorders.* Although this language is not being considered for revision, it has been problematic since it was originally drafted, and this revision represents a good opportunity for correction. We suggest rewording as follows:

(d) 7 Human sexuality, including the study of physiological, psychological and social-cultural variables associated with sexual behavior, sexual orientation, gender identity, and the assessment and treatment of psychosexual dysfunction.

5) The topics of child abuse, domestic violence and aging are already implicitly required by the existing educational requirements, and should be explicitly included in the revisions. We recommend that these important topics no longer be listed separately as “additional training required for license.”

Some students delay these important trainings until just before they apply for the license. We want these topics covered within the degree programs, although we do not think specific hours of training need to be mandated.

Again, we are grateful for the opportunity to have input into this complex process. We will be represented at the December 7 meeting, where we look forward to more discussion.

I was just perusing the minutes and can see the competing agendas exist in this arena.

I wanted to share with you two major concerns echoed through-out the State by our Community Based Organizational (CBO) Providers and Public, Governmental Providers (such as County Mental Health Plans):

1. The graduates of both MFT and LCSW oriented programs are not adequately schooled in documentation and progress note writing.
2. They lack skills in documenting mental status evaluations, effective interventions and outcomes, et cetera...

I concur that not all graduates will choose to work in these organizational environments, however, a large percentage *do work in these organizational settings...* Their un-preparedness has resulted in huge disallowances for claim reconciliation in the public sector; it is a shame since they probably did the work, but failed to document what interventions they provided clearly and succinctly...

Lisa Scott-Lee
Department of Health and Human Services
Division of Mental Health
Sacramento County

November 27, 2007

Dear Colleagues,

The BBS has proposed that models of recovery-oriented care be taught at every level of MFT professional education. In response to this proposed change to MFT training, we searched the literature for a clear and clinical definition of recovery-oriented care. We were unable to locate one. Such models are cited variously in reference to rehabilitation programs for individuals with severe mental illness, 12-step programs for substance abusers, strength-based case management, and peer-education programs. Practitioners of recovery models admit that “recovery” is a buzzword and nobody seems to know exactly what it means.

Despite this manifest lack of clinical specificity, the BBS appears to be favoring this type of care by making it the only one specifically included in the wording of its proposed regulations. We see this as problematic for two reasons. First and foremost, the current direction of the BBS is tantamount to a restructuring of our curriculum based on an ambiguously defined and relatively poorly researched model of treatment. Although some may state that this lack of clarity allows individual programs freedom to implement recovery-based care in whatever way they choose, we question the educational utility of mandating training in a model that has no clear guidelines. Moreover, we are concerned how the BBS

intends to assess students' knowledge of this vaguely defined type of care. For example, writers of licensure test questions will undoubtedly be biased toward a particular interpretation (or interpretations) of recovery-based care.

This leads us to our second objection, namely, that writing recovery-oriented care into the BBS requirements creates a space for vested interests to change our profession in potentially destructive ways. For instance, Meta Services, the prominent vendor for Value Options, Inc. in Arizona, which changed its name in 2006 to Recovery Innovations, Inc., has specified one particularly troubling version of the recovery model (see www.metaservices.com, www.recoveryinnovations.org; also <http://www.namisc.org/Recovery/2005/ImplementingRecoveryBasedCare.htm>). Their model has already been adopted by two states, and they are working to expand their business in California. This model shifts focus away from "treatment" to "education". "It's all about role transformation," said META President and CEO Eugene Johnson, CISW. "In this system the consumers become students, and this helps people jump into recovery because being a student is a valued social role, and being a mental patient is not." *What is the place of MFTs as roles shift from client and therapist to student and educator?*

Additionally, the Meta plan suggests the liberal use of peer educators as opposed to psychotherapists. To help peer staff, Meta has designated team leaders to serve as mentors. These positions include recovery coaches, team leaders, and administrative staff. It is important to note that Meta does not hire licensed mental health professionals to fill even the supervisory roles. "These peers have to hit the same production that other staff do," said Johnson. "It is fee for service, and they have to handle their own paperwork." *Considering that peer education and support are primarily delivered through peer staff, what is the place of MFTs in recovery oriented mental health delivery systems like Meta?*

We realize that not all recovery-oriented models use the same principles as the Meta plan. The Substance Abuse and Mental Health Services Administration unveiled in February 2006 a more general consensus statement outlining principles necessary to achieve mental health recovery. The ten fundamental concepts of recovery they outlined include: Self-Direction, Person-Centered, Empowerment, Holistic, Non-linear, Strength-based, Peer Support, Respect, Responsibility, and Hope. Although in the abstract these recovery-based principles sound positive, when considered more carefully, we note some significant concerns associated with them. First, recovery-oriented care is an adult-focused approach. Recovery models generally do not specify how these concepts apply to children, and the place of child and adolescent treatment within the recovery framework is unclear. For example, what do the terms self-direction, empowerment, peer support, and responsibility mean when applied to young children? *How does the treatment of children and adolescents fit into this consumer driven framework?*

Secondly, although "Recovery" seems to imply a broad field within which a number of approaches may flourish, none of the identified extant recovery models is family systems or couples oriented. Indeed, the recovery literature largely advocates groups for the person who is recovering and *separate* treatments for their partners and family members. Keeping firmly in mind that the license for which we are training our students is in Marriage and Family Therapy, this is somewhat anathema to the forces that created the entire MFT field.

Of equal significance, because recovery is defined as the return to a state of previous health, it seems to assume that the person in question had actually attained a prior state of healthy functioning. While this may be the case with alcoholism and substance abuse (the state of sobriety prior to using substances) or adjustment disorders, it is theoretically incongruous and clinically unattainable to apply this model to individuals with attachment disorders or personality disorders—individuals whose lives from birth or a very young age have been disorganized and incoherent. Recovery-based mental health models do not incorporate recent research with respect to attachment and neural development. *How do we make sense of attachment-related disturbances and psychopathology through the recovery-oriented framework?*

We do not deny that there is some value to recovery-oriented care and do not wish to unduly denigrate it. Clearly it has demonstrated efficacy in the application to a circumscribed domain of Axis I psychopathology, most especially the substance abuse disorders. Despite the availability of other empirically supported, efficacious, and commonly used intervention approaches, *recovery-oriented care is the only type of care named specifically in the proposed training guidelines*. Given the difficulties mentioned above, we believe that it is a mistake to favor this approach or any other *single* approach above other better-defined and historically proven approaches.

Sincerely,

The Faculty of the Department of Counseling Psychology
Santa Clara University

Paul Riches, Executive Officer and Ian Russ, Board Chair:

Presently, I am employed by the Los Angeles Community College District in the capacity of Adjunct Assistant Professor in Psychology. I have also worked for the El Camino College District in this capacity and for the Santa Monica College District & Compton College District in the capacity of Personal/Career/Academic Counselor. I am also a Magna Cum Laude graduate of the University of Puerto Rico and Harvard University.

Yet, after fifteen years of experience as a Counseling and Psychology Professor, teaching courses such as General Psychology, Abnormal Psychology, Child & Adolescent Psychology, Life Span Development, Human Development, Human Sexuality, Marriage/Family & Intimacy courses and serving as a Counselor to hundreds of diverse students, I have not been able to practice legally as a therapist. Partially this has been due to the fact that my B.A. in Psychology from the University of Puerto Rico @Rio Piedras, and the Harvard Graduate School of Education Ed.M. degree, in the concentration areas of Counseling & Consulting Psychology, Human Development & Psychology, and Administration, Planning & Social Policy, are not accepted for intern registration or licensure in California. Fifteen years after serving as a Personal Counselor and earning two California Community College Credentials in the areas of COUNSELING & PSYCHOLOGY, a person with these type of credentials should be able to practice legally as a therapist in our state.

Therefore, revisions to the educational requirements for MFT intern registration and licensure should include:

A. The California Community College credential in either Counseling and/or Psychology shall be acceptable certifications both for the intern registration as well as for licensure as an MFT in the state of California.

B. The hours spent under the supervision of an MFT licensed therapist or Counseling or Psychology Departmental Chair as to psycho-social and psycho-personal services provided to students at any California Community College District, shall be accepted for the purpose of MFT intern registration & licensure in the state of California.

Thank You.

Fraternally,

Mylo Egipciano
Adjunct Assistant Professor in Psychology
Los Angeles Southwest College/LACCD

There obviously has been a tremendous amount of work done on this project, and I commend you. However, before the language is approved for bill form, please have a strict grammarian go over the document. One instance I will mention is the use of less instead of fewer... no fewer than ___ hours would be correct grammar. Thank you for all your hard work!

Dena WL Brown, MFT 36969

Hopefully these proposed changes will concur with a **broadening acceptance of the license at least equal to that of the LCSW at least for state jobs**. These appear to be timely and appropriate changes. The only thing that disheartened me, is once again, there is not enough breadth and depth that is required in the curriculum for human sexuality. And we are MFT's for goodness sake... There should be at least a quarters worth of information on this, instead of a weekend seminar. How is therapy supposed to take place between partners when the therapist is not equipped to deal with this issue?

Julie Schmidt

Mr. Richards: I do hope the new requirements include more education on drugs and alcohol. Clinicians often fail to explore that area of a client's life because they do not know how to ask the questions needed to get the information.

I have worked in drug and alcohol for the county of Ventura, and am now with the Medi-Cal Access line for Ventura County, and am amazed when talking to our providers in the private network, how few of them think of screening for drugs and alcohol.

Thank you for hearing my concerns.

Geraldine Davis

Hello Paul,

I am an MFT working in a county mental health setting. My current position involves implementing MHSA principles.

I read the posting on the BBS website of proposed changes for MFT education. Wonderful work. The changes are really in step with what is needed now. I would like to offer two ideas to you.

First, education in parenting styles as well as learning positive parenting approaches is very important to have when working with families especially as we increase our focus on family self-efficacy and resiliency through the MHSA transformation process. Perhaps this was included and I just missed the category.

Second, I really believe that one's relationship with oneself is as important as one's relationship with family members. It seems to me this should be included in the definition of an MFT and education of an MFT. We seem to emphasize relationship with others yet relationships with others cannot be healthy if we do not have a healthy relationship with ourselves. MFTs spend considerable time on intrapersonal relationship issues and they are very valuable in the improvement of interpersonal relationships. This could be included in the overt description and education.

Thank you for entertaining my thoughts.

Warm Regards,
Gayle Lukeman, MFT

Hello,

As an ASW working on my LCSW license, I believe it would be more beneficial to align the MFT education requirements with those of a Masters of Social Work. The California Social Work Education Council has a great outline and expectations of what is required in the Masters of Social Work Programs. There is a definite difference in the way MFT's and MSW's/ASW's look at the factors that affect our clients, specifically looking at the person in their environment and how all the environmental, social, psychological and biological factors play a part in the development for our clients, and the clients themselves.

Thank you for allowing input into the MFT program.

Evelyn Eterno, MSW, ASW
NASW Kern Unit Co-Chair

FROM: Carmen Knudson-Martin
Program Coordinator
PhD, Marital and Family Therapy

RE: Recommendations for draft MFT curriculum

I want to thank you and your committee for the hard work of revising the MFT curriculum requirement to better meet the mental health work force requirements. I am writing in my capacity as a faculty member and family therapy program director. Though I am not writing in an "official" capacity, I also serve as the current president of the California Division of AAMFT.

I have spoken with other faculty here and in the State who are familiar with training issues when MFT is viewed as a core provider of mental health services. The attached page offers editorial/ content suggestions in three areas 1) clarification of the definition of what constitutes recovery approaches, 2) inclusion of gender and other contextual factors such as sexual orientation, and 3) insuring that students get experience working with families and couples.

I. Clarify definition of recovery approaches.

Add a phrase or sentence in c. 2 that helps to define recovery approaches, i.e., **strength-based approaches that emphasize improving, restoring, and maintaining healthy relationships.**

II. Gender (and some other important contextual influences) appear to be left out of the required study. Gender has profound implications for the onset and meaning of mental health symptoms. I suggest amending the draft as follows:

c 6 Integrate the understanding of various cultures and the social and psychological implications of socio-economic position **and gender** throughout the curriculum.

d 2. D a variety of **contextual and systemic understandings** of human development influences (e.g., **gender, socioeconomic status/culture/ethnicity, sexual orientation, spirituality, religion, larger systems**)

d. 2. E. The understanding of human behavior with the social context of socio-economic status and **other contextual issues affecting social position (e.g. gender, race/ethnicity, etc.).**

Alternatively, create a **new section d. 2. G** that explicitly addresses gender and sexual orientation as important contexts for development and behavior.

III. Experience with families. The research on family-based interventions shows that they are particularly important in cases of severe mental illness. The skills required to work effectively with families are different that with individuals. Therapists must be able to actively position themselves within the family group to create safety for all participants.

As I read the requirements of supervised practice in d. 11, it appears that the intention is that all MFT's actually get experience working with families. Since current guidelines allow trainees/interns to see an individual child and call it family therapy, I have found that many persons with masters degrees in MFT, even those to apply to do a PhD in family therapy, have accumulated no actual face-to-face experience with families or couples.

I suggest **specifying that at least half (or 100 or 75) of the face to face hours be with couples or families** (i.e., more than one family member/significant other in the room).

If the above is not accepted, 2.11. E could add **face to face experience in** treatment ofin all of the following

My concern here is that it be clear that face-to-face family work is mandated.

BBS: I read the Proposed changes to the MFT required academic education for licensure in Cal. Why does the BBS continue to waste their time on MFT's. The educational requirements the MFT's is suggesting, are very similar to the MSW degree. Why does the BBS continue to mess around with the MFT? A MFT is just a wanna-be MSW/LCSW. Why should Californians waste money on a fake when they can have the real thing in a LCSW.

Gene Courter MA/MSW/LCSW/DCSW/ACSW

PRIOR CORRESPONDENCE

To: The BBS Educational Committee
From: The Faculty of Santa Clara University's Program in Counseling Psychology
Re: Proposed changes in licensing requirements
Date: December 5, 2007

The current debate about the fitness of current MFT license holders to function in the public mental health sector (as highlighted by the Mental Health Services Act) is a fruitful discussion--one in which we as faculty of Santa Clara University wish to participate actively. The proposed changes in MFT requirements by the BBS Educational Committee will have significant repercussions, some intended; some unintended, that will directly and adversely impact our training program and students. As a major preparatory institution for MFT license holders in the State of California, we would like to bring our perspective to bear on this proposition.

Traditionally, of course, California has had two master's level clinical licenses: the LMFT and the LCSW, with distinct, but overlapping domains of competence, skills and target clientele. LMFT's have generally prepared themselves for the delivery of psychological counseling in private practice, non-profit agency work, and clinically-informed positions in the private sector. LCSW's have generally prepared themselves for the delivery of Public Mental Health services, including case management and agency related work. The legal descriptions of these two professions reflect the above distinction:

The practice of marriage and family therapy shall mean that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and premarriage counseling.

The application of marriage and family therapy principles and methods includes, but is not limited to, the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships, and the use, application, and integration of the coursework and training required by Sections 4980.37, 4980.40, and 4980.41.1.

Section: 4996.9. CLINICAL SOCIAL WORK AND PSYCHOTHERAPY DEFINED:

The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a non-medical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services; or doing research related to social work.

With the advent of the Mental Health Services Act, there has been particular attention paid to the anticipated Mental Health needs of the State of California. The current initiative by the BBS Educational Board has been an attempt to respond to the increased need for public mental health service provision by those trained as MFTs.

Our position parallels the position forwarded by the Northern California MFT Educators Consortium: that is, to develop a Certificate in Public Practice for those current and prospective LMFTs who wish to prepare themselves for bona fide public sector service. We want to strongly assert that although both are needed in California, the set of skills involved in public sector service versus private and non-profit individual, couples and family relational counseling are markedly distinct. We propose that those pursuing or holding an MFT have the option to augment their already quite extensive training with courses specifically focused on public sector service. However, to require all MFT candidates to do this training will add a tremendous extra load to a license that is already bursting at the seams with professional training requirements (all of them necessary for competent practice). If a licensed or pre-licensed MFT clinician desires to work in the public sector, then the burden of responsibility to augment his or her skill set should be born by that individual; not as it is being currently considered, by the many MFT clinicians who will never work in the public sector.

With respect to **unintended consequences** of the current proposal being considered by the BBS Educational Committee, we have the following perspectives to share with the Board:

1. The increase in university-based practicum hours from 150 to 500 hours is daunting, and may well be the straw that breaks the back of MFT training programs versus doctoral training programs. If the proposed increase in training hours (more than triple the current requirement) falls within the practicum year (the service required before graduation from the degree granting institution) this will require of the candidates an even longer commitment in the field before they receive any remuneration. In most cases such a drastic increase in requirements will lead to greater expense and an expanded length of time in completing the MA degree. The latency from starting graduate studies to licensure is already approximately 5 years -- most of the time without significant remuneration. Extending the practicum requirement will create a major setback for candidates considering an MFT as opposed to a doctoral degree. One option, of folding a fraction of those hours into the pre-practicum degree program may be possible, and if modest it could be desirable.

2. State funding comes and goes. Currently 8,000 jobs and approximately 42 million dollars are slated to be cut from the Santa Clara County mental health budget. This scenario does not bode

well for those graduates in the Bay Area. It is clear that the State of California has developed a non-paid trainee labor force to take care of its Mental Health needs. We feel that mandating yet more free training hours from already stretched pre-licensed interns is an unconscionable solution to the State's growing mental health problems.

3. We propose that the BBS consider creating a curriculum program that replicates our "emphasis" programs. Ian Russ said he feared students who did not opt for this emphasis will still drift into the public sector later and arrive unprepared and untrained. Such a series of courses that represent an emphasis or certificate (Minor) in public sector work would obviate such a problem. It is far more appropriate to have those MFTs who are not originally trained in public sector specialties, do the extra training as a requirement of employment. There is no "back door" if County Mental Health, for example, sets prescribed requirements for those who wish that arena of employment.

4. The proposed specific focus on the recovery model has the impact of one model of treatment above others; in effect, creating a monolithic theoretical bias in the clinical field. We propose that all programs provide exposure to this model, but not at the expense of other models which research has shown to have similar or better outcomes.

5. We also propose a certification of specific courses in social work be required for anyone seeking a position with the county, similar to the PPS credential in education. This would allow the social work positions to open to those who are interested in pursuing this avenue as opposed to forcing everyone into training and coursework. We would like to see some open discussion from the BBS and CAMFT about this idea.

By way of summary, we have endeavored to propose some potential compromises to the curriculum reform under consideration, especially in the development of an optional emphasis or specialty training track for those individuals who chose public sector service, while at the same time voicing a few of our significant reservations. These compromises, as we hope you will agree, meet the State's need for qualified and competent mental health professionals in the various public mental health agencies. We would suggest that our proposal accomplishes the goal of the changes without placing undue burden upon what we believe to be the majority of our graduates who do not and will not work in the public sector.

More fundamentally, we are gravely concerned over any proposed curricular changes that essentially blur the distinction between MFT and LCSW practitioners. Clearly, the original intent of the law that established these degrees was to provide a plurality of clinical training models in response to the heterogeneity of mental health needs from the citizens of our State. We strongly believe that while the proposed changes appear to be in the service of more individuals in the public sector it will in fact have the opposite effect and result in fewer qualified and competent MFTs in both public and private sectors service.

Sincerely,

Teri Quatman, Ph.D.
Chair, Dept. of Counseling Psychology
Santa Clara University

DATE: September 25, 2007
TO: Ian Russ, Paul Riches and the Education Committee of the BBS
FROM: Deborah Buttitta, M.A., MFT, Department Chair and the MFT Faculty
Phillips Graduate Institute
RE: Concept Draft for MFT Curriculum, September, 2007

We have just read the lengthy memo of June 21, 2007 from Santa Clara University. We feel that Jerrold Shapiro, Ph.D. and his faculty articulated brilliantly concerns that we fully share. Although the letter contained a small change that has been revised since June (the proposal is now for 225, not 500 hours in practicum), we believe that Santa Clara's analysis of the unintended consequences of the new curriculum are correct. We particularly support the statement "it is clear that the State of California has developed a non-paid trainee labor force to take care of its mental health needs," and that "mandating yet more free training hours from already-stretched pre-licensed interns is an unconscionable solution..." We are also in agreement with their proposal to make public mental health an emphasis (minor) within a 60 unit masters degree.

The MFT Faculty at Phillips Graduate Institute has been following with interest the proposed curriculum changes, and today we reviewed the latest version included in the meeting materials for September 28. We appreciate your invitation to schools to be involved, and would like to offer some comments in this memo, since none of us is able to attend the September 28 meeting.

Regarding the change from 48 to 60 units: We share the concerns expressed by others at previous board meetings regarding the additional financial burden on students. Adding twelve units increases tuition by 30% and time spent in school by at least a semester and perhaps an entire academic year. We worry that competent applicants will be discouraged from entering the field, and those of lower socioeconomic status will be most impacted. We realize that the decision to move to 60 units is really not up for reconsideration, but want to go on record with our concern.

Regarding the move to 9 units and 225 hours required in Practicum: We strongly suggest that the **minimum number of hours required remain at 150**. Of course direct experience with clients is critical to develop competence, and we do not advocate reducing the direct handling requirement for licensure. But we believe there is no advantage to pushing more of those hours into the practicum. In fact, we have always believed pedagogically that **just a few well-supervised cases allows for much better training during graduate school**, and that intensive work with clients should be delayed until internship. Pressure to earn hours has always been a distraction from **the real work of a student in practicum, which is learning, not delivering service**.

We are also concerned that the agencies in which trainees are placed may not have enough clients, and may not be able to provide enough supervision. Current students often report difficulty in getting 75 client hours each semester, and/or getting enough supervision when client loads increase beyond the 5:1 ratio. Before the Board mandates 225 client hours for every student, be sure these consumers exist in the state, and that agencies are prepared to offer enough supervision. Another option might be to require 225 hours, but allow client advocacy, documentation and other training activity to be counted along with direct provision of marriage and family therapy.

We have always had a few students who earn much more than the 150 hour minimum, usually because they already have full time jobs in the field for which they can get hours. However, the majority, who are juggling school, full time employment AND clinical placement, have great difficulty meeting the current 150 hour requirement. With more hours now required in addition to more academic work, students may lack time and energy for coursework. Why not keep the 150 hour minimum, giving students the option of delaying intensive clinical work until after graduation?

Suggestions regarding some small changes in language and organization:

In the Degree Program, section (c) (2), change the wording slightly to avoid enshrining a particular model in legislation:

(2) Integrate throughout its curriculum and practicum training those methods of service delivery that are evidence-based and emphasize resiliency, such as the recovery model.

It is a historical accident of legislation that Psychopharmacology appears separately as 10) in the Degree Program. Remove it, and add it to section (d) (1), where it logically belongs. The section would then read: *(1) Diagnosis, assessment, prognosis and treatment of mental disorders, including severe mental disorders, evidence-based practices, psychological testing and psychopharmacology.*

Again, we appreciate greatly the chance to be involved in planning these curriculum changes, and would be happy to discuss these points or others in more detail.

Sincerely,

Deborah Buttitta, M.A., MFT
Department Chair
Master of Arts in Psychology
Marriage and Family Therapy

September 26, 2007

To: Board of Behavioral Sciences
Att'n: Ian Russ, Chair
Paul Riches, Executive Director
Via Fax and Email, please forward

From: Kathy Wexler
Curriculum Coordinator and Core Faculty
Phillips Graduate Institute

RE: Additional Comments on Proposed Curriculum Changes

In addition to the comments forwarded yesterday by Deborah Buttitta, the MFT faculty would like to add the following remarks, after having a chance to study Jerrold Shapiro's June 20 memo to the Education Committee.

We feel the most crucial point Shapiro raises is the blurring of the distinction between the professions of Marriage and Family Therapy and Clinical Social Work. They ARE distinct, and revising curriculum to make MFTs more like social workers risks the loss of our unique professional identity. Marriage and Family Therapy is a nationally-recognized profession as well, and moving our curriculum in the directions outlined by the Education Committee makes it more difficult to stay in alignment with national educational standards. This will make license portability outside of California even more difficult than it is now.

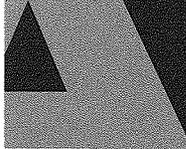
In his June 20 memo, Dr. Shapiro reports that Ian Russ fears that making public mental health a specialization, rather than weaving it through the entire curriculum, would result in insufficiently trained graduates "drifting into the public sector." Isn't it the job of employers to evaluate the qualifications of a candidate? It is not the Board's job to legislate into the curriculum requirements for working with specific populations or in specific settings. The existing educational requirements have produced many MFT interns and licensees who are already qualified to work in the public sector, and in fact have been successfully doing so for many years. Of course, as with any area of specialization, more education and training is desirable, and additional coursework and training will improve a student's chances of employment in that area of specialization. If the educational requirements allowed for public mental health as a specialization within 60 units, employers could decide whether they wanted to hire those who have basic competence but not specialized training. Students could also choose traineeship settings in which they learn the pragmatics of public mental health if that is an area in which they plan to seek employment.

I apologize for submitting these thoughts separately from Deborah Buttitta's message. The faculty just received Dr. Shapiro's memo yesterday, and Deborah's response had already been drafted.

Thanks,

Kathy Wexler

Blank Page



ALLIANT

INTERNATIONAL UNIVERSITY



