MEETING NOTICE

October 10, 2009

Hilton Los Angeles Airport
5711 West Century Blvd
Los Angeles, CA 90045
(310) 410-4000

8:30 a.m.

FULL BOARD OPEN SESSION - Call to Order & Establishment of a Quorum

I. Introductions

II. Approval of the May 21-22, 2009 Board Meeting Minutes

III. Approval of the April 10, 2009 Policy and Advocacy Minutes

IV. Chairperson’s Report
   A. Upcoming Board and Committee Meetings

V. Executive Officer’s Report
   A. Budget Report
   B. Operations Report
   C. Retroactive Fingerprinting Update
   D. Legislation Update
   E. Regulation Update
   F. Personnel Update
   G. Review of Board Publications
   H. Review of Bibliography for Senate Bill 33 Curriculum Changes

VI. Review and Discussion of the Board’s Enforcement Program

VII. Review and Discussion of the Substance Abuse Coordination Committee’s Uniform Standards

VIII. Review and Discussion of Licensing Requirements Related to Aging

Page 1 of 2
IX. Discussion and Possible Action Regarding Board Registrants Paying for Supervision by a Licensee

X. Discussion and Possible Legislative or Rulemaking Action Regarding Experience Requirements for Licensed Clinical Social Workers

XI. Discussion and Possible Action to Amend California Code of Regulations Title 16, Sections 1807, 1807.2, 1810, 1819.1, 1887 to 1887.14 Regarding Continuing Education Requirements: Licensed Educational Psychologists, Exceptions, and Providers

XII. Public Comment for Items Not on the Agenda

XIII. 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

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 Blvd., 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, contact the Board at (916) 574-7830.
May 21, 2009

Members Present
Ian Russ, Chair, MFT Member
Joan Walmsley, Vice Chair, LCSW Member
Gordonna (Donna) DiGiorgio, Public Member
Harry Douglas, Public Member
Elise Froistad, MFT Member
Judy Johnson, LEP Member
Victor Perez, Public Member

Staff Present
Paul Riches, Executive Officer
Kim Madsen, Assistant Executive Officer
Sean O’Connor, Outreach Coordinator
Christina Kitamura, Administrative Analyst
Marsha Gove, Administrative Assistant
Kristy Schieldge, Legal Counsel

Members Absent
D’Karla Leach, Public Member
Karen Roye, Public Member
Rita Cameron Wedding, Public Member

Guest List
On file

Dr. Ian Russ, Board Chair, called the meeting to order at 12:30 p.m. Marsha Gove called roll, and a quorum was established.

I. Introductions

Dr. Russ welcomed new board member, Dr. Harry Douglas.

Dr. Douglas provided a brief background. His background is primarily health services administration. Dr. Douglas retired from Charles R. Drew University of Medicine and Science where he served as President, Executive Vice President, and Vice President for Academic Affairs and Dean of the College of Allied Health. Prior to that, Dr. Douglas coordinated the opening of several hospitals. Dr. Douglas is a graduate from University of Denver and an undergraduate of University of California, Los Angeles. He also received a master’s degree and a doctorate degree from University of Southern California. Dr. Douglas has been involved in international health programs, and recently worked with a group in Cuba. Dr. Douglas serves on several committees and communities.

Audience members, board staff, and board members introduced themselves.
II. Approval of February 26-27, 2009 Board Meeting Minutes

Donna DiGiorgio moved to approve the board meeting minutes of February 26-27, 2009. Judy Johnson seconded. The board voted unanimously (7-0) to pass the motion.

III. Chairperson’s Report

A. Upcoming Board and Committee Meetings

Paul Riches indicated that a memo in the meeting materials lists the future board and committee meeting dates.

B. Discussion and Possible Action Regarding Mandatory Fingerprint Submission, Title 16, Sections 1815 and 1886.40 of the California Code of Regulations

Mr. Riches reported that the regulation regarding mandatory fingerprint submission was approved by the Office of Administrative Law on May 20th and will be effective within 30 days from that date. Staff was hired to fill the new positions to implement the program. Notices will be sent to the first batch of licensees in July.

IV. Petition for Reinstatement of License, Gerold Simon MFC 12383


Opening statements and testimony were presented. Ms. Gordon and board members presented questions to the petitioner. The hearing concluded with closing statements from Mr. Sundar and Ms. Gordon.

The meeting adjourned for a break at 3:10 p.m., and reconvened at approximately at 3:20 p.m.

V. Petition for Early Termination of Probation, Cherrlynn Hubbard LCS 25055


Opening statements and testimony were presented. Ms. Gordon and board members presented questions to the petitioner. The hearing concluded with closing statements from Ms. Gordon.

VI. Pursuant to Government Code section 11126(c)(3) the board will convene in closed session to deliberate on disciplinary matters, including the petition for reinstatement (Gerold Simon MFC 12383), and the petition for early termination of probation (Cherrlynn Hubbard LCS 25055)

The board went into closed session to deliberate on the petition for restatement and the petition for early termination of probation.

Following deliberations, the meeting was adjourned.
May 21, 2009

**Members Present**
- Ian Russ, Chair, MFT Member
- Joan Walmsley, Vice Chair, LCSW Member
- Gordonna (Donna) DiGiorgio, Public Member
- Harry Douglas, Public Member
- Judy Johnson, LEP Member
- D'Karla Leach, Public Member
- Victor Perez, Public Member

**Members Absent**
- Elise Froistad, MFT Member
- Renee Lonner, LCSW Member
- Karen Roye, Public Member
- Rita Cameron Wedding, Public Member

**Staff Present**
- Paul Riches, Executive Officer
- Kim Madsen, Assistant Executive Officer
- Tracy Rhine, Legislation Analyst
- Sean O’Connor, Outreach Coordinator
- Christina Kitamura, Administrative Analyst
- Marsha Gove, Administrative Assistant
- Kristy Schieldge, Legal Counsel

**Guest List**
- On file

Dr. Ian Russ, Board Chair, called the meeting to order at 8:30 a.m. Dr. Russ introduced Earl Plowman, Deputy Attorney General. Mr. Plowman has worked closely with the Board of Behavioral Sciences for over 25 years. The board presented a Resolution to Mr. Plowman for his service to the board and to the people of California.

Marsha Gove called roll, and a quorum was established.

Judy Johnson presented a Resolution to Dr. Russ for his dedication and service to the Board of Behavioral Sciences as the Board Chairperson. Ms. Johnson highlighted Dr. Russ' work on the MFT Education Committee meeting and the proposed legislation to change the MFT curriculum requirements, the loan forgiveness program for mental health workers, and his leadership.

**VII. Executive Officer’s Report**

**A. Budget Report**

Paul Riches reported on the state budget crisis. Current numbers indicate the deficit is $21 billion on the general fund budget that is running on $85 billion this year. The Governor presented two May revised budgets. The plans contain a massive reduction in state spending. The second plan is a contingency plan if ballot measures were not approved by voters. This plan contains language for $6 billion in borrowing, $15 billion in reductions, and $6 billion in “borrowing and rolling it over.”

The legislature must work to immediately reduce the deficit, and it must work through the summer to find a way to change the system. As of July 1st, there is a budget in place; however, it is $21 billion in the hole. That budget was balanced partly on a significant number of tax increases that were included in the February budget agreements that were going to be extended by Proposition 1A, which failed. Those increases will expire and in the next budget year, that revenue will be lost. With the additional revenue those provided, it kept state revenue flat. The general fund revenue expectations from the February budget was about $86 billion dollars for 2008-2009. In 2009-2010, with tax increases, the general fund revenue which projected at $86 billion. Taking those tax increases away, it will be much worse in 2009-2010.
Among the recommendations that the Legislative Analyst Office made was to implement a third furlough day for state employees. State employees have been subjected to a 2-day furlough, which reduces pay by 10%, and the employees are granted 2 days of leave. Furloughs provided immediate savings as opposed to layoffs, which may take up to 6 months to implement. At the moment, general fund agencies are subjected to layoffs. As a special fund agency, the board does not receive tax dollars. The board is completely self-sufficient and continues to operate within its means.

Among the issues in the Governor’s May budget revision is the revival of the proposal to merge the Board of Behavioral Sciences with the Board of Psychology and the Psychiatric Technician Program into one program. This proposal does not save any general fund money. This proposal would require a statutory change. All three boards and executive officers would be eliminated. A new board, the Board of Mental Health, would have an entirely new board and executive officer; the staff would stay in place.

Another issue is that as of the end of June, the state will have no money. Currently, there is about $6 billion dollars in the state’s bank account, which is special fund money. State operations incur most of its expenses in the first 6 months of the year, and most of the revenues are accrued in the last 6 months of the year. Every year, the state has cash flow issues that are covered by borrowing. This year’s borrowing need is about $23 billion dollars. Considering the market and economy, there’s an issue regarding the state’s access to cash. The state will most likely be in a situation where it will selectively pay bills. By the Constitution, k-12 schools will be paid first and debt service is second. Vendors and services secured through contracts may not be paid immediately. The board makes a profit everyday; therefore, the board’s operations are covered.

Dr. Douglas asked how the current state cash situation will impact the board’s operations. Mr. Riches responded that the board will start to feel the pressure soon. The board is subject to two-day furloughs per month. Work performance has remained steady due to this year’s salary savings. With that savings, staff has been able to work overtime to complete work that could not be completed due to the furloughs. That budget flexibility will no longer exist as of July 1st. The special fund agencies are not subjected to the hiring freeze. However, a third furlough day is expected, and it is not expected that staff will sustain the levels of performance that it has to date. This will be seen especially in the enforcement program.

The most critical contract the board has is for administering the examinations. Last year, the board received an exemption for that contract.

Mr. Riches reported that the board will end the year with a balance of $230,000. Mr. Riches reviewed the fund condition and predictive model. Sean O’Connor developed the predictive model to determine, or predict, the growth scenario of the application workload and bottom line revenue.

B. Operations Report

Mr. Riches reported that most of the programs are doing well in spite of the furloughs. Staff has been making progress in the LCSW application backlog; processing time has been reduced from 48 days to 31 days. As for the enforcement program, the report does not reflect the hiring of new staff and getting them fully trained. The first reports are beginning to come in regarding field investigations.
Mr. Riches added that the budget allocation for the Attorney General’s Office is about $450,000 a year. This year, the board will finish the year at $560,000. The board will receive an additional $400,000 over the next couple of years to fund the fingerprint program.

C. Personnel Update

Mr. Riches reported that 4 positions were filled for the fingerprint program; two of those positions were filled internally. The board is in the process of filling the 2 vacant positions. Mr. Riches referred to the personnel update provided in the meeting materials regarding the new hires and vacancies listed.

An issue the board is dealing with is finding space to build additional cubicles for the new staff. A new building is being constructed at the headquarters site, which is expected to be completed by June 2010. The board will likely be moved to the new building.

The board adjourned for a break at 9:46 a.m. and reconvened at 10:08 a.m. Víctor Perez excused himself temporarily from the meeting.

VIII. Report of the Policy and Advocacy Committee

A. Recommendation # 1 – Support AB 244 (Beall)

Donna DiGiorgio reported on AB 244, the mental health parity bill, which would require health care service plan contracts which provide hospital, medical, or surgical coverage, and health insurance policies issued, amended or renewed on or after January 1, 2010 to provide coverage for the diagnosis and treatment of a mental illness of a person of any age under the same terms and conditions applied to other medical conditions.

Tracy Rhine added that this bill is almost identical to a bill the board supported last year. There was a federal bill that was past that required parity in treatment limitations between health and mental health plans. AB 244 states that a health care plan that only provides health care service must provide mental health services. The Policy and Advocacy Committee (committee) recommended a position of support.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to support AB 244.

Upon Mr. Perez’s return, the full board took the following action:

**Judy Johnson moved to support AB 244. Donna DiGiorgio seconded. The board voted unanimously (6-0) to pass the motion.**

B. Recommendation # 2 – Oppose AB 484 (Eng) unless amended

Donna DiGiorgio reported on AB 484 regarding license suspension due to unpaid tax liability. This bill would allow the Franchise Tax Board to send a notice of license suspension to the issuing state licensing entity and to the licensee if the licensee has unpaid state tax liabilities. The committee recommended a position of oppose unless amended.

Ms. Rhine reported that the recommended amendment is to allow the board to suspend the licenses of individuals with outstanding tax liabilities based on the model currently used for individuals in violation of a judgment or order for child support. The Department
of Consumer Affairs (DCA) and the board already have a process in place that allows the board to receive information regarding individuals out of compliance with child support orders, and, in turn, requires the board to take action against those licensees, including suspension or denial of licensure.

Ms. Rhine added that AB 484 failed in the policy committee where it was heard. AB 484 is no longer viable; however, this bill can be reintroduced under a different bill number. Ms. Rhine suggested that the board take a formal position in case the bill is reintroduced later.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to oppose AB 484 unless amended.

Upon Mr. Perez’s return, the full board took the following action:

Donna DiGiorgio moved to oppose AB 484 unless amended. D’Karla Leach seconded. The board voted unanimously (6-0) to pass the motion.

C. Recommendation # 3 – Oppose AB 612 (Beall)

Ms. Rhine reported that AB 612 regarding parental alienation in child custody. This bill has been substantively amended. The new version of the bill is not within the jurisdiction of the board. No discussion or action was needed.

D. Recommendation # 4 – Support AB 681 (Hernandez)

Ms. DiGiorgio reported on AB 681 regarding confidentiality of medical information, psychotherapy exemption. This bill would allow a psychotherapist to disclose information related to the patient’s outpatient treatment, if the psychotherapist believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims, and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, without a written request, as specified in current law. The committee recommended a position of support.

Mary Riemersma, California Association of Marriage and Family Therapists (CAMFT), added that this bill protects therapists when making reports.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to support AB 681.

Upon Mr. Perez’s return, the full board took the following action:

Donna DiGiorgio moved to support AB 681. Judy Johnson seconded. The board voted unanimously (6-0) to pass the motion.

E. Recommendation # 5 – Support AB 1113 (Hernandez)

Ms. DiGiorgio reported on AB 1113 regarding marriage and family therapist intern experience within the Department of Corrections and Rehabilitation (CDCR). This bill would allow licensure requirements for mental health practitioners employed with the state correctional system to be waived for a person to gain qualifying experience for licensure as a marriage and family therapist. The committee recommended a position of support.
Ms. Rhine added that the board supported this bill last year as AB 2652. The committee recommended to the board to support this legislation, however, the bill was no longer viable at the time the board considered a position on the bill, and therefore no formal position was adopted by the board.

Ms. Riemersma noted that AB 1113 passed the Assembly and will have difficulty in the Senate. The union that represents CDCR employees who are psychologists and clinical social workers have gone to the statewide union and convinced the board of the statewide union to take a position of opposition.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to support AB 1113.

Upon Mr. Perez’s return, the full board took the following action:

Victor Perez moved to support AB 1113. Donna DiGiorgio seconded. The board voted unanimously (6-0) to pass the motion.

F. Recommendation # 6 – Oppose AB 1310 (Hernandez) unless amended

Mr. O’Connor reported on AB 1310 regarding the data survey requirement for healing arts boards. The Office of Statewide Health Planning and Development (OSHPD) was given authority to develop the Health Care Workforce Clearinghouse, which is responsible for the collection analysis, and distribution of information on the educational and employment trends for health care occupations in the state. This bill would require specific healing arts boards in DCA to collect certain types of data and provide that to OSHPD. The committee recommended a position of oppose unless amended.

Mr. O’Connor explained that the bill mandates the collection of the data, and it tells the healing arts boards how it is to collect the data which is through license renewals. This is problematic for the board. The bill also lists the types of fields the healing arts boards must collect. This would require DCA to make modifications to its current database, which would be a lengthy process. Additional reasons for the committee’s position of oppose unless amended was provided in the bill analysis.

Kristy Schieldge added that this bill would also require social security numbers to be disclosed on renewal applications, and DCA is not permitted by law to do so. In addition, all of the highly personal information to be disclosed on the first application of licensure as well as the renewal form, this information is not necessary to determine whether someone qualifies for licensure. Yet if they do not disclose the information to the board, it will be a basis for not processing their license renewal.

Kim Madsen added that although the bill does not include the Board of Behavioral Sciences, the author’s staff indicated that it is the intention to include the board.

Mr. Riches stated that if OSHPD resolves the board’s operational and legal issues with the bill, the board could take a position of support.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to oppose AB 1310 unless amended.

Upon Mr. Perez’s return, the full board took the following action:
Donna DiGiorgio moved to oppose AB 1310 unless amended. Judy Johnson seconded. The board voted unanimously (6-0) to pass the motion.

G. Recommendation # 7 – Support SB 43 (Alquist)

Mr. O’Connor reported on SB 43 on improving healthcare workforce and education data. Existing law established the Office of Statewide Health Planning and Development (OSHPD) Health Care Workforce Clearinghouse. This is another data collection bill like AB 1310. SB 43 does not mandate that the healing arts boards collect the information; instead it authorizes the collection of information. SB 43 does not mandate that the information be collected at the time of licensure application or license renewal. SB 43 authorizes the collection of smaller amounts of data related to cultural and linguistic competencies. The committee recommends a position of support.

Ms. Schieldge added that SB 43 states that personally identifiable information collected pursuant to this section shall be confidential and not subject to public inspection.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to support SB 43.

Upon Mr. Perez’s return, the full board took the following action:

Judy Johnson moved to support SB 43. D’Karla Leach seconded. The board voted unanimously (6-0) to pass the motion.

H. Recommendation # 8 – Support SB 296 (Lowenthal)

Ms. DiGiorgio reported on SB 296 on mental health services. This bill would find and declare that the coordination of care between mental health care providers and general physical health care providers is necessary to optimize the overall health of the patient. This bill would also require health care service plans to issue a benefits card to each enrollee for assistance with mental health benefits coverage information. The committee recommended a position of support.

Ms. Rhine added that SB 296 would require every health care service plan that offers professional mental health services to establish an internet Web site, to include plan policies and procedures related to enrollee benefits, modified contracts, providers, continuity of care, independent review and grievances.

Ms. Riemersma explained that a problem with the continuity of care, there are occasions when the mental health provided attempts to contact the managed care company to find out the primary care provider, and that managed care company refused to give the information. It’s difficult to coordinate care. In regards to the cards, rarely is the direct contact information for mental health on the card.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to support SB 296.

Upon Mr. Perez’s return, the full board took the following action:

Donna DiGiorgio moved to support SB 296. D’Karla Leach seconded. The board voted unanimously (6-0) to pass the motion.
I. **Recommendation # 9 – Oppose SB 389 (Negrete McLeod) unless amended**

Mr. Riches reported on SB 389 regarding fingerprint submission. This bill is a follow on to a series of articles published last year by the L.A. Times. Those articles highlighted on the fact that healing arts boards have collected fingerprints from new applicants for purposes of collecting criminal history and subsequent arrests information. However, those boards did not go back to fingerprint the those who were licensed before that requirement was implemented. The Board of Behavioral Sciences (BBS) proposed a regulation that was approved that mandates submission of fingerprints from all of its licensees who did not previously submit fingerprints. SB 389 was introduced to create a mandate for all boards do so as well. SB 389 would trump the board’s regulation that was just approved and set the board back by 2 ½ years. Staff requested to the author to remove BBS from the bill. The committee recommends a position of oppose unless amended.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to oppose SB 389 unless amended.

Upon Mr. Perez’s return, the full board took the following action:

*Donna DiGiorgio moved to oppose SB 389 unless amended. D’Karla Leach seconded. The board voted unanimously (6-0) to pass the motion.*

J. **Recommendation # 10 – Consider SB 543 (Leno)**

Ms. DiGiorgio reported on SB 543 regarding minors consent to mental health treatment. The committee did not take a position on SB 543. This bill would allow a minor who is 12 years of age or older to consent to mental health services on an outpatient basis or to a residential shelter facility if the minor is mature enough to participate intelligently in the counseling services or if the minor either would present a danger of serious physical or mental harm self or others without receiving the services or if the minor is an alleged victim of incest of child abuse.

Judy Johnson noted that licensed educational psychologists and credentialed school psychologists are regulated under the Department of Education, and their credentials in that regard gives them the right to confidentially speak to minors who are 12 years of age and older on campus. However, a parent is contacted.

As a subcommittee of the board, all voted (1 yea, 2 nay, 2 abstain) to recommend to the full board to not take a position on SB 543.

Upon Mr. Perez’s return, further discussion took place.

Ms. Rhine explained that this bill would allow minors between the ages 12-18 to receive mental health services if they are: 1) in immediate harm or a danger to themselves, or 2) can intelligently participate in mental health services. Currently the minor must meet both criteria to receive services without parental consent. This bill states that the minor must only meet one of the criteria to receive services without parental consent. The bill would also allow services for minors at residential facilities without notification to the parent. Currently, the professional treating the minor would involve the parents unless the professional deemed it inappropriate. This bill would allow the professional treating the minor to involve the parents if they deemed it appropriate.

Mr. Perez stated that he opposes the bill.
Dr. Russ expressed his concerns about a 12 year-old minor seeking mental health treatment for issues lesser than a crisis or an emergency.

Mr. Perez expressed his concerns regarding absence of disclosure to the minor’s parents.

Ms. DiGiorgio stated her position is to oppose the bill.

Mr. Riches stated that this bill presents an issue where everyone loses. There are a population of children, especially lesbian, gay, bisexual, and transgender (LGBT) youth, where there are issues regarding parental consent. There are good reasons why this population of youth does not want to go to the family. Those reasons may not fit comfortably in the current construct. This is the intent of the bill. The challenge is that it is difficult to write a bill that states it only applies to the youth that are desperate.

Ms. Riemersma explained that current law states that any child 12 years of age or older who can communicate effectively enough to engage in therapy and has been a victim of incest or child abuse or is a danger to self or others can seek treatment. The therapist will attempt to communicate with the family as soon as possible if it is appropriate. CAMFT took a position of support. CAMFT had concerns taking a position on the bill because of the risk that the current provisions in law will be lessened. This is a controversial bill.

Ms. Johnson stated that she already sees these systems in place on school campuses, under existing law. The movement is towards the campus right now. This is where students feel that they can usually come out to someone on campus. Statistics show that students will trust and open up to a person on campus even if that person is not a mental health provider.

**Donna DiGiorgio moved to oppose SB 543. Victor Perez seconded. The board voted unanimously (4 yea, 2 abstain) to pass the motion.**

K. **Recommendation # 11 – Consider SB 638 (Negrete McLeod)**

Ms. Rhine reported on SB 638 regarding Board membership reconstitution. Currently in statute, boards under DCA have sunset dates, meaning there is are specific dates when each board becomes inoperative and becomes a bureau. Under the Sunset Review Process, all boards to prepare an analysis and submit a report to the Joint Committee on Boards, Commissions, and Consumer Protection (JCBCCP) no later than 22 months before the board is scheduled to become inoperative. The JCBCCP holds public hearings to receive testimony from the Director of DCA, the board involved, the public and the regulated industry. This review takes place every four years to evaluate and determine whether each board has demonstrated a public need for the continued existence of that board. This has not happened over a number of years because the JCBCCP has not been funded; therefore, the sunset dates have been extended.

This bill would create a new process for evaluating boards. Instead of the boards becoming inoperable and becoming bureaus, their entire board memberships are reconstituted. The boards would continue as boards with new entirely memberships. This process does not provide for a committee; instead a policy committee in the legislature would evaluate and determine if the memberships would be reconstituted.
The committee did not take a formal position but suggested that the board provide comment to the legislature regarding revamping an effective oversight process. Staff provided ideas listed in the bill analysis.

Mr. Riches added that there was a different bill carried last year to reform the Sunset Review Process. The biggest problem with the Sunset Review Process is that it created situations where the boards disappeared. Boards have been effective entities due to the ongoing contact with the public, the open discussions that come with operating the board under the restrictions of the Public Meetings Act. When a board turns into a bureau, that structure goes away. A reconstitution approach is a big step towards a positive direction. There are no clear articulated standards regarding good performance.

Dr. Douglas asked how the oversight manifests itself. Mr. Riches responded that in SB 638, it manifests itself in two different ways. Under the prior structure, there was a joint committee that performed the oversight. SB 638 allows for committees in each house that are performing oversight and reaching opposite conclusions. There are inter-house politics present that make it difficult to reconcile the differences. This bill lacks a unified oversight.

Dr. Douglas agreed that this type of oversight becomes a political war, and added that the legislature does not have the time to oversee the process.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to not take a position on SB 638 and to continue the dialogue with the legislature and provide suggestions.

Upon Mr. Perez's return, the full board took the following action:

**Donna DiGiorgio moved to take no formal position on SB 638 and to continue the dialogue with the legislature and provide suggestions. Judy Johnson seconded. The board voted unanimously (6-0) to pass the motion.**

L. **Recommendation # 12 – Consider SB 707 (DeSaulnier)**

Mr. Riches reported on SB 707 regarding alcohol and other drug counselor licensing. There are a significant set of amendments pending; staff and the board will need to review the new language before taking action. Mr. Riches suggested bringing SB 707 back to the table after the amendments are made.

As a subcommittee of the board, all voted (5-0) to recommend to the full board to not take a position on SB 707.

Upon Mr. Perez's return, the Mr. Riches stated that no action was necessary due to pending amendments by the author of the bill.

M. **Recommendation # 13 – Support SB 788 (Wyland)**

Mr. Riches reported on SB 788 regarding licensed professional clinical counselors. The board has supported previous introductions and versions of this legislation. This bill would create a new category of license issued by the Board of Behavioral Sciences for professional counselors. This license would be another master’s level psychotherapy counseling license. The bill introduced is very similar to last year’s bill; those issues have not changed.
Ms. Riemersma noted that CAMFT’s position is neutral on SB 788. The National Association of Social Workers (NASW) and the California Society for Clinical Social Work (CSCSW) also remain neutral on the bill as long as the grandparenting provisions for the MFT and LCSW professions remain. If those provisions are taken out of the bill, CAMFT, NASW, and CSCSW will turn their positions to oppose.

Olivia Loewy, American Association for Marriage and Family Therapy (AAMFT), noted that AAMFT opposes SB 788 due to the broad and overlapping scope of practice. The grandfathering clause indicates that there is not a distinction between the MFT and the licensed professional clinical counselor professions. In regards to workforce shortages, if this license were to become established, this could create more of a workforce shortage because those counselors now working in public mental health could leave and create private practices. Ms. Loewy explained that AAMFT is not opposed to having a license category for professional clinical counselors; AAMFT would like to see changes in the bill’s language.

Mr. Perez returned to the meeting and joined the board in the discussion and action.

Judy Johnson moved to support SB 788. Donna DiGiorgio seconded. The board voted (5 yea and 1 abstain) to pass the motion.

Dr. Russ returned to the previous items to take action as a full board.

N. Recommendation # 14 – Sponsor Legislation Regarding Supervised Experience Requirements for Marriage and Family Therapists

Mr. Riches reported on a recommendation from the committee for the board to sponsor legislation. There are four significant changes to the experience requirements:

1. Double counting the first 150 hours providing family therapy. Many interns are not getting opportunities to obtain therapy in this fashion, which is key to marriage and family therapy. The incentive provided is similar to that for obtaining personal psychotherapy under current law.
2. Combine existing limits on telephone crisis counseling and telemedicine into a single category with a maximum of 375 hours allowed. Current law treats experience providing “telephone crisis counseling” and “telemedicine” separately despite the activities appearing to overlap one another. Telephone crisis counseling is currently limited to 250 hours and telemedicine is currently limited to 125 hours.
3. Change the supervision ratio for post-graduate experience to parallel that required of associate clinical social workers. Existing law requires IMFs to receive one unit of supervision (one hour of individual or two hours of group supervision) for each 10 hours of psychotherapy/counseling work experience. A typical MFT candidate must receive over 400 hours of supervision to be eligible for licensing examinations. However, a typical LCSW candidate receives around 150 hours of supervision. This disparity makes little sense given the overlapping scopes of practice and the limited availability of supervision.
4. Allow hours of experience to be gained in any category as a trainee. Current law restricts the types of experience that can be gained as a trainee to certain categories. This would allow trainees to gain experience for clinical documentation and psychological testing.
Mr. Riches clarified on page 1 (a)(7) of the draft language, the language should read “Not more than a total of 1250 hours of experience combined for…”.

Judy Johnson moved to sponsor legislation regarding supervised experience requirements for marriage and family therapists. Donna DiGiorgio seconded. The board voted unanimously (6-0) to pass the motion.

O. Legislation Update

Mr. Riches reported that SB 33 passed out in the Senate and is awaiting similar action in the Assembly. Mr. Riches reported that the update contains the items that were previously approved by the board. Many of those items were carried over due to the Governor's vetoes last year.

P. Regulation Update

Ms. Rhine referred to the Regulation Update provided in the meeting materials for review.

IX. Discussion and Possible Action Regarding Other Pending Legislation Affecting the Board

Mr. Riches stated that there is no other pending legislation to report.

The board adjourned for a short break at noon and reconvened at 12:10 p.m.

X. Discussion of Senate Bill 1441 (Chapter 548, Statutes of 2008)

Mr. Riches reported that SB 1441 was passed last year in the wake of the shut-down of the Medical Board's Diversion Program. SB 1441 requires the development of standards to guide healing arts licensing boards in handling addicted licensees. SB 1441 creates the Substance Abuse Coordination Committee, which is composed of the Director of DCA), executive officers of all healing arts boards in the DCA, and the Medical Director the State Department of Alcohol and Drug Programs. This committee is required to develop uniform standards that each healing arts board will be required to use in dealing with substance-abusing licensees by January 1, 2010. The bill requires 16 separate standards to be developed. The committee has met twice and has developed 6 draft standards.

The legislation also requires the committee to consider the use of a “deferred prosecution” stipulation similar to the stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency unless or until the licensee commits a major violation, in which case it is revived and the license is surrendered.

This is an opportunity for the board to provide its thoughts regarding how to handle substance abuse among our licensees to bring those thoughts to the committee’s deliberations.

Dr. Russ indicated that he does not prefer a recovery program that will be monitored and overseen by the board.

Ms. DiGiorgio asked how this is currently handled in an urgent situation. Mr. Riches explained that there are several tools currently available to the board: 1) the ability to compel a psychiatric or physical examination of a licensee, 2) interim suspension order if there is evidence that someone is an immediate threat, and 3) Penal Code 23, which gives the board the ability to seek action in criminal court when a licensee is in a criminal process. This
usually results in suspension of the license pending resolution of the criminal process. The board usually becomes aware of the substance abuse problem through an arrest.

Ms. DiGiorgio asked if there is a way to do this that is not as harsh or happens sooner than an arrest. Mr. Riches explained that there is a provision in the professional conduct statutes that states that the use of alcohol or controlled substance in any manner harmful to self or others is unprofessional conduct. Mr. Riches stated that he does not recall that there has ever been a revocation of licensure, but some practitioners have decided to surrender their licenses. The enforcement program’s approach is to get the practitioner supervision, get them in a rehabilitation program, and get them into therapy.

Ms. Riemersma stated that this has been visited in the past; it’s been looked at the licensing boards’ perspective, the associations and professional organizations perspective, and it’s been before the board several times in the past. Prior boards came to the conclusion that there is not much that can be done on the board level other than through the disciplinary process. The profession organization considered coming up with a diversion program, and CAMFT came to the conclusion that it cannot do a diversion program because CAMFT handles it through their ethics process and the board handles it through its disciplinary process. It’s difficult to separate it and handle it through a diversion program.

Mr. Riches stated that staff will report back to the board in August with an update.

XI. Ethical Decision Making for Regulators - Presentation by DCA Senior Staff Counsel Kristy Schieldge

Kristy Schieldge gave a presentation regarding ethical decision making for regulators as part of the DCA’s efforts to promote good government practices. Ms. Schieldge discussed requirements for board members regarding ethics training Form 700 filing. Ms. Schieldge provided the Bagley-Keene Open Meeting Act to the board members and discussed the open meeting act’s purpose and its requirements. Ms. Schieldge also discussed ethical decision making in disciplinary actions.

XII. Public Comment for Items Not on the Agenda

No public comments were made for items not on the agenda.

XIII. Suggestions for Future Agenda Items

No suggestions were made for future agenda items.

The board adjourned at 1:09 p.m.
Policy and Advocacy Committee Meeting Minutes - DRAFT
April 10, 2009

Dept of General Services
The Ziggurat Building
77 Third Street, Suite #320
West Sacramento, CA 95605

Members Present
Gordonna DiGiorgio, Chair, Public Member
Renee Lonner, LCSW Member
Karen Roye, Public Member
Dr. Ian Russ, Chair, MFT Member

Guest List
On file

Staff Present
Paul Riches, Executive Officer
Kim Madsen, Assistant Executive Officer
Tracy Rhine, Legislation Analyst
Sean O’Connor, Outreach Coordinator
Kristy Schieldge, Legal Counsel
Christina Kitamura, Administrative Analyst
Michelle Eernisse, MFT Evaluator

Members Absent
None

Gordonna DiGiorgio called the meeting to order at 9:33 a.m. Christina Kitamura called roll, and a quorum was established.

I. Introductions
Audience, staff, and Committee members introduced themselves.

II. Review and Approval of the January 16, 2009 Policy and Advocacy Committee Meeting Minutes
Kim Madsen noted the following corrections: on page one, omit Sean O’Connor and Christina Kitamura under Staff Present, and add Kim Madsen under Staff Present.

Renee Lonner moved to approve the January 16, 2009 Policy and Advocacy Committee Meeting minutes as amended. Ian Russ seconded. The Committee voted unanimously (4-0) to pass the motion.

III. Discussion and Possible Action Regarding Pending Legislation Including:
A. Assembly Bill 244 (Beall)
Tracy Rhine presented a brief analysis of AB 244, the Mental Health Parity Bill. The Committee recommended a position of support on identical legislation last year, and the Board took a formal position of support.
This bill requires health care service plan contracts which provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and treatment of mental illnesses. The bill defines “mental illness” as a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV.

Last year, the Federal Mental Health Parity Bill was passed. Questions were raised about the need for the State Mental Health Parity Bill when the Federal Mental Health Parity Bill already exists. The difference is that the federal legislation requires health plans that already covered mental health illnesses to provide certain parity. The state legislation expands parity requirements to all health plans.

Karen Roye moved to recommend to the Board to support AB 244. Ian Russ seconded. The Committee voted unanimously (4-0) to pass the motion.

B. Assembly Bill 484 (Eng)
Ms. Rhine presented a brief analysis of AB 484 regarding suspension of occupational and professional licenses for unpaid tax liability. This legislation is identical to last year’s legislation. This bill would allow the Franchise Tax Board to suspend the licenses of those who have unpaid tax liabilities. The same issue from last year’s legislation is in this year’s version: the ability of another entity taking disciplinary action against BBS licensees. This could cause several issues, one being confusion for consumers and practitioners regarding license status. The second issue is the unintended consequences of BBS licensees not being able to practice in a profession that is greatly impacted.

Last year, the Board took a position of oppose unless amended to delete the current language and instead model the bill on the existing practice for child support obligations set forth in Family Code section 17520, which allows the Board to take action upon notification that a licensee is out of compliance with child support orders.

Renee Lonner moved to recommend to the Board to oppose AB 484 unless amended. Ian Russ seconded. The Committee voted unanimously (4-0) to pass the motion.

C. Assembly Bill 612 (Beall)
Ms. Rhine presented a brief analysis of AB 612 regarding Parental Alienation Syndrome. In 2007, there was a similar bill considered by the Committee and the Board. The Board did not take a position on this bill.

This bill would prohibit a court, in a proceeding to determine child custody, from considering a nonscientific theory, as defined, in the making of a child custody determination. The bill specifies Alienation Theory as a nonscientific theory.

Dr. Russ explained that Parental Alienation Syndrome was created by Richard Gardner, a psychiatrist and professor. His work on Parental Alienation Syndrome does not have any scientific validity.

Dr. Russ explained the issues with Alienation Theory and what makes this a dangerous piece of legislation. He stated that the people who are pushing this do not want the issue of parental alienation to come up at all, because their position is that it “undoes” allegations of child abuse. This would limit the ability of custody evaluators to bring up the issues of how one parent might be alienating the other parent. This is
an attempt to stop that from happening. The problem is that if somebody writes a report that mentions the process of alienation, the report is going to get thrown out of family courts. Dr. Russ expressed a recommendation to the Board to not support this bill.

Renee Lonner moved to recommend to the Board to oppose AB 612. Ian Russ seconded. The Committee voted unanimously (4-0) to pass the motion.

D. Assembly Bill 681 (Hernandez)
Ms. Rhine presented a brief analysis of AB 681 regarding an exemption from the California Confidentiality of Medical Information Act (CMIA). This bill would allow a psychotherapist to disclose information related to the patient’s outpatient treatment, if the psychotherapist in good faith believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims.

Current law prohibits a health care provider from releasing information that specifically relates to a patient’s participation in outpatient treatment with a psychotherapist unless the requester submits a written request, signed by the requester, that includes: 1) the specific information relating to patient’s participation in outpatient treatment and the intended use or uses of the information; 2) the length of time during which the information will be kept before being destroyed or disposed of; 3) a statement that the information will not be used for any other purpose other than its intended use; and 4) a statement that the person or entity requesting the information will destroy the information after the specified length of time.

This bill would provide consistency within the law, allowing for an exemption from the written request requirement in order to allow a psychotherapist to warn and protect a potential victim in a timely manner.

Ian Russ moved to recommend to the Board to support AB 681. Renee Lonner seconded. The Committee voted unanimously (4-0) to pass the motion.

E. Assembly Bill 1113 (Lowenthal)
Ms. Rhine presented a brief analysis of AB 1113 regarding Marriage and Family Therapist (MFT) Intern experience in the Department of Corrections and Rehabilitation. The current law governing correctional facilities allows a waiver of the licensure requirements for trainees in psychology and clinic social work; the waiver does not currently extend to MFT trainees. This bill allows licensure requirements for mental health practitioners employed with the state correctional system to be waived for a person to gain qualifying experience for licensure as a MFT.

Identical legislation was introduced last year, AB 2652 (Anderson). The Committee recommended to the Board to support this legislation; however, the bill was no longer viable at the time the Board considered a position on the bill, and therefore no formal position was adopted by the Board.

Karen Roye moved to recommend to the Board to support AB 1113. Ian Russ seconded. The Committee voted unanimously (4-0) to pass the motion.
F. **Assembly Bill 1310 (Hernandez)**  
Sean O’Connor presented a brief analysis of AB 1310 regarding data survey requirements for healing arts boards. This bill requires specific healing arts boards in the Department of Consumer Affairs (DCA) to add and label as “mandatory” certain fields on an application for initial licensure or renewal.

Recently, the Office of Statewide Health Planning and Development (OSHPD) was mandated to create the Health Care Workforce Clearinghouse, which is responsible for the collection, analysis, and distribution of information on the educational and employment trends for health care occupations in the state. Since there is not enough data available that the clearinghouse has access to, this bill will mandate specific healing arts board to collect this type of information.

This bill lists boards that would be subject to the provisions of the bill; however, the bill’s current language does not include the BBS. The author’s staff indicates this was an oversight, and the BBS will be included in an amended version of the bill. In the most recent revision of the bill, the BBS was still not included.

Mr. O’Connor outlined other issues with the bill. The bill mandates that DCA collect this information. Administratively, DCA does not have the fields available in its database programs to collect the information. The bill also mandates collection of information on a license application or renewal application.

Ms. Schieldge stated that DCA cannot collect much of the highly personal data outlined in the bill’s language. The other problem is that it’s not something that is required for licensure but DCA would be required to collect it. From a legal perspective, it could be a problem. This is overly broad for the Board’s purposes. When a statute is overly broad for its intended purposes for the Board’s administration and jurisdiction, the courts do not like that. This will certainly hold up licensure renewal issues, and it will be difficult for the Board to enforce.

*Renee Lonner moved to recommend to the Board to oppose AB 1310 unless amended. Karen Roye seconded. The Committee voted unanimously (4-0) to pass the motion.*

The Committee adjourned for a short break at 10:46 and reconvened at 11:01 a.m.

G. **Senate Bill 43 (Alquist)**  
Mr. O’Connor presented a brief analysis of SB 43 regarding the improvement of healthcare workforce and education data. This bill would authorize OSHPD to obtain labor market, workforce, and earnings data from the Employment Development Department (EDD), for use by the OSHPD Health Care Workforce Clearinghouse. This bill would also authorize healing arts boards, including the BBS, to collect information regarding the cultural and linguistic competency of its licensees and registrants. Personally identifiable information collected shall be confidential and not subject to public inspection.

*Ian Russ moved to recommend to the Board to support SB 43. Renee Lonner seconded. The Committee voted unanimously (4-0) to pass the motion.*
H. Senate Bill 296 (Lowenthal)
Ms. Rhine presented a brief analysis of SB 296, Mental Health Services. This bill would require every health care service plan that offers professional mental health services to establish an internet Web site to provide consumer, patient, and provider access to plan procedures, policies, and network provider information. This bill also requires health care service plans subject to this bill to issue a benefits card to each enrollee for assistance with mental health benefits coverage information. The benefits card must include information such as the name of the of the benefit administrator or health care service plan issuing the card, the enrollee's identification number, and a telephone number that enrollees may call 24 hours a day, seven days a week, for assistance regarding health benefits coverage information. The bill prohibits the health care service plan from printing on the card any information that may result in fraudulent use of the card and any information that is otherwise prohibited from being included on the card. The intent is to improve access to mental health services.

Geri Esposito, California Society for Clinical Social Work (CSCSW), added that this bill does not require anything that is not already required by law. It is intended to clarify language with regard to mental health. All plans must have a website and must have specific mental health information on the website. The law requires coordination of care between primary and mental health practitioners. The requirements in law are made more specific to mental health.

Ms. Esposito asked the Committee for its support of this bill as a consumer protection measure.

*Ian Russ moved to recommend to the Board to support SB 296. Renee Lonner seconded. The Committee voted unanimously (4-0) to pass the motion.*

I. Senate Bill 389 (Negrete McLeod)
Ms. Rhine presented an analysis of SB 389 regarding fingerprint submission. This has been discussed in past Committee and Board meetings. BBS currently has approximately 30,000 licensees who have not submitted electronic fingerprints to the Department of Justice (DOJ). The Board has submitted a proposed rulemaking that would require those licensees to submit electronic fingerprints to DOJ beginning October 1, 2009, by their upcoming license renewals. The rulemaking has been approved by DCA. The rulemaking has been filed with the Office of Administrative Law (OAL). The process takes 45 days before staff hears if it has been approved by OAL.

The language in SB 389 and the board’s proposed fingerprint regulation are very similar. However, one major difference is that the Board-proposed regulation is not tied to license renewal. If a licensee fails to comply with the fingerprint requirements as set forth in the Board’s current regulations, it is a citable offense; fingerprint submission is not a condition of renewal.

Another significant difference between the Board regulation and the bill before the Committee is the implementation timeline. The Board’s regulation requires that all licensees and registrants subject to the regulatory requirements (those they have not submitted fingerprints previously or for whom an electronic record of their fingerprints do not exist with DOJ) to submit fingerprints by his or her license or registration renewal date that occurs after October 31, 2009. SB 389 fingerprint submission
requirement as a condition of renewal becomes operative for those renewing after January 1, 2011.

The Board’s proposed regulation does not make fingerprint submission a condition of licensure or registration for a number of reasons. First, due to the nature of the work Board licensees perform and the populations they serve, the Board did not feel that it was appropriate to take these professionals out of the workforce for failure to submit fingerprints by their renewal date.

Second, if fingerprint submission is a condition of renewal, and certification is required on the renewal form, then all licensees, 90 days before the expiration of their license, would get a renewal form asking for certification of fingerprint submission. In the Board’s case, 40,000 licensees who do not need to meet the new requirement will get a renewal form that asks for certification of fingerprint submission. The volume of inquiries that would result would be overwhelming to the Board staff and would take time away from processing new licenses and renewals. This could lead to fewer professionals being able to practice.

Ms. Rhine explained that these two issues are major concerns because, even if BBS regulation were approved, the legislation would supersede the regulation.

Mr. Riches added that this bill would require the Board to wait until January 2011 to begin the process. The budget act signed in February gives the Board four new staff positions to begin this work on July 1, 2009. Two of those positions were granted on a limited-term basis, so those positions will be eliminated by the time the legal authority is put in place. This will also create a workload problem at DOJ. The legislation could set the Board back by two years.

Ian Russ moved to recommend to the Board to oppose unless amended. Karen Roye seconded. The Committee voted unanimously (4-0) to pass the motion.

J. Senate Bill 543 (Leno)
Ms. Rhine presented an analysis of SB 543 regarding consent to mental health treatment for minors. This bill: 1) allows a minor who is 12 years of age or older to consent to mental health services on an outpatient basis or to a residential shelter facility if the minor is mature enough to participate intelligently in the counseling services or if the minor either would present a danger of serious physical or mental harm to self or other without receiving the services or if the minor is an alleged victim of incest or child abuse; 2) deletes the requirement that a professional person offering residential shelter services make his or her best efforts to notify the parent or guardian of the provision of services; 3) states that the mental health treatment or counseling of a minor shall include the involvement of the minor’s parent or guardian if appropriate, as determined by the professional person or treatment facility treating the minor.

According to the bill’s author, parental consent for mental health services can create a barrier, especially in prevention and early intervention programs where youth may not be experiencing serious physical or mental harm. This barrier is especially harmful to certain populations of youth including lesbian, gay, bisexual, and transgender (LGBT) youth. Many LGBT youth do not seek prevention or early intervention services due to the need for parental consent until there is a crisis.
One issue is that this bill would remove the right of a parent to consent to or be notified of mental health services that his or her child is receiving. Another issue is confidentiality. This bill presents questions as to the subsequent involvement of a minor’s parent or guardian in services and what information can be released to the parent or guardian.

Janlee Wong, National Association of Social Work (NASW), stated that NASW is one of the sponsors of this bill. He stated that he disagreed with the Ms. Rhine’s analysis of the author’s intent. He explained that it has nothing to do with parental rights or confidentiality – instead it’s about access to services, and access to service, as it is related to consumer protection, should be the Board’s focus. Mr. Wong stated that something in the law is preventing these children from receiving treatment, and he believes it is because of the issue of parental consent.

Mr. Riches talked about the impact this has on the role of a parent. There are cultural and family situations that are problematic, and which prevent people from receiving help; however, this bill does not just apply to those situations. There is an issue when talking about counseling and psychotherapy services for a minor as young as 12 years old. Part of the right and obligation of a parent is to rear their child whether one agrees with it or not. This bill affects populations other than those populations that it is intended for. It is a tough balance in respecting the needs for parents to rear their children and for respecting the need for children to get care.

Ms. Schieldge explained that the courts have recognized the parent’s rights in determining how they are going to medically treat their children. That is a liberty interest protected by the 14th Amendment to the U.S. Constitution and also the California Constitution. There is an issue with respect to constitutionality of depriving someone of their right to determine whether they are going to treat their child or not. When a right is restrained, the governmental objective has to be high and tailored to achieve the objective when infringing on someone’s rights.

Dr. Russ does not have a position on the issue. He expressed that he has concerns regarding parental rights issues; however, he is concerned about LGBT youth who experience themselves as disenfranchised.

Mary Riemersma, California Association of Marriage and Family Therapists (CAMFT), stated the CAMFT took a position of support; however, CAMFT expressed their fears to NASW. This could raise a lot of interest from family rights groups.

Ms. DiGiorgio expressed that she is comfortable with the allowing availability of care for this population and leaving it open on whether or not to involve the parents.

Mr. Riches responded that the law already provides access for this age group under certain threshold situations. This question is: What are the threshold situations? The proposed thresholds are very broad.

Ms. Roye expressed the importance of the breadth of the language for the population of youth that cannot involve their families. The language is broad enough to incorporate every family.

Ms. Lonner questioned the legality. She asked if this would emancipate the impacted minors. She also questioned if the minors are currently being turned away.
Ms. Esposito, CSCSW, commented that in her experience, the parents of the LGBT youth are fine, upstanding folks; they have a cultural and/or religious admonition against the direction that their child is choosing. The degree of shame and inner persecution that the child feels, and the community that the family is involved in, is what makes this population of youth have the highest suicide rate of any group. Ms. Esposito expressed that this is a critical bill.

Dr. Russ stated that he needs more time to ponder and discuss the specifics of this bill.

**Dr. Russ moved to forward SB 543 to the Board for further discussion. Karen Roye seconded. The Committee voted unanimously (4-0) to pass the motion.**

The Committee adjourned for lunch at 12:03 p.m. and reconvened at 12:47 p.m.

**K. Senate Bill 638 (Negrete McLeod)**
Ms. Rhine presented a brief analysis of SB 638 regarding board membership reconstitution. Existing law requires all consumer-related boards be subject to a Sunset Review every four years to evaluate and determine whether each board has demonstrated a public need for the continued existence of that board. It requires all boards to prepare a report to the Joint Committee on Boards, Commissions, and Consumer Protection (JCBCCP). The JCBCCP holds public hearings to receive testimony from the Director of Consumer Affairs, the board, the public and the regulated industry.

Over the past couple of years, the JCBCCP has not been funded. This has resulted in the Board’s operative date being extended until January 1, 2011. At that point, the statute relating to the Board would be repealed, and the Board would become a Bureau.

This bill would terminate the terms of office for each member of the Board on an unspecified date and successor members would be appointed. This bill would delete the sunset review process. It would require the Board to prepare and submit a report to the appropriate policy committee of the legislature, and would require more specific information to be contained in that report. This bill would also abolish the JCBCCP and delete the requirement that the final report is made public and a hearing to discuss the recommendations be held by JCBCCP.

Ms. Rhine explained that SB 963, Chapter 385, Statutes of 2007 similarly streamlined the sunset review process by making board reconstitution automatic when a board becomes inoperative on a specified date. The Board took no formal position on this legislation. SB 963 was later amended to extend the inoperative date the Board, at which time the Board adopted a support position on the legislation.

Mr. Riches stated that there is a value to the Sunset Review process; it is one forum where you get legislative attention on a particular profession which is a valuable opportunity if the entity does not exist in a hostile political context. Mr. Riches explained that this should be a collaborative process. The pattern in the past has been to holistically review independent entities. There can be value and limitations to that. The limitation is that the review is in comparison against itself at some previous point of time. The biggest problem is that there is an absence of a central body such as the
JCBCCP. This sets up a situation where if there is a hostile political environment, both houses will be conducting separate reviews simultaneously with different conclusions that would need to be reconciled.

Discussion continued regarding changes that would take place if the Board became a Bureau.

Ms. Riemersma, CAMFT, stated that CAMFT did not take an official position on this bill, but assured that CAMFT will take an official position to oppose.

**Dr. Russ moved to forward SB 638 to the Board for further discussion. Renee Lonner seconded. The Committee voted unanimously (4-0) to pass the motion.**

L. **Senate Bill 707 (DeSaulnier)**

Ms. Rhine presented an analysis of SB 707 regarding alcohol and other drug counselor licensing. She explained that last year, discussion took place about AB 1367 and AB 239 which were the drug and alcohol counselor bills. Those bills regulated the profession in private practice. This year’s bill, SB 707, actually regulates both practice in public facilities and private practice.

SB 707 creates three counselors in public facilities: supervised practitioner, advanced counselor who can practice without supervision, and a clinical supervisor. This bill creates a license for an alcohol and drug counselor in private practice. This bill provides that the Department of Alcohol and Drug Programs (ADP) shall administer and enforce the act, not the Board of Behavioral Sciences.

Ms. Rhine explained some of the issues: 1) The bill gives discretion to the ADP regarding the requirements for the practitioners. Regarding the private practitioner education requirements, the bill is quite general and not as detailed as last year’s bill. 2) The practice of alcohol and drug counseling is ambiguous. A list of services is provided in the bill but not defined; therefore it is unclear if licensure is needed to perform some of the services. What activities fall under assessment, and would those activities fall under the scope of LCSWs and MFTs? 3) This bill creates a license to treat only one diagnosis. Where does “alcohol and other drug problems” end and another distinct diagnosis begin? Does the practitioner have the skills to know when something is outside of their scope?

Ms. Rhine stated that there are technical issues with the bill that the Board can address if it decides to suggest changes.

Ms. DiGiorgio stated that alcohol and drug problems typically come with another medical health issue. If someone is going to work in private practice and is required to have a Masters Degree, why would they get an alcohol and drug counselor license rather than an MFT or LCSW with a specialty in alcohol and drug addiction, and be able to treat the whole person?

Ms. Riemersma, CAMFT, expressed that she preferred that last year’s language remain in this year’s bill. As it is currently written, there are many problems. CAMFT’s position on the bill is opposed unless amended.

Mr. Riches pointed out that the scope is an unexclusive scope of practice. Specifically, the language states that a person with a license may perform the services listed;
however, it does not state that a license is required to perform the services. Mr. Riches explained that the language provides for practitioners with radically different levels of preparation with identical scopes of practice. The only variance will be the setting and supervision. As a regulator, he is uncomfortable with a single diagnosis license. There will be a group of people providing services that are not accountable under the construct that the licenses that BBS issues are accountable.

Dr. Russ asked why the language was different from last year’s bill. Mr. Riches responded that this language is different because it is sponsored by the ADP. Last year’s bill was sponsored by the California Association of Alcoholism and Drug Abuse Counselors (CADAAC).

Jim Sellers, certified Chair of CADAAC, stated that there is a full analysis on their website regarding their concerns on the bill.

Ms. Rhine explained that last year’s bill was vetoed because the Governor did not want two different standards, which was what the Board also addressed. This year’s bill, she believes, is a response to that.

Dr. Russ suggested that BBS should have a conversation with ADP to discuss concerns with the bill.

M. Senate Bill 788 (Wyland)
Mr. Riches briefly reported that SB 788 regarding the Licensed Professional Clinical Counselors is a reintroduction of last year’s bill except that everything has been pushed out a year to allow implementation. The Board supported this bill, and it is the same bill as last year.

Renee Lonner moved to recommend to the board to support SB 788. Karen Roye seconded. The Committee voted unanimously (4-0) to pass the motion.

Item VI was taken out of order to accommodate a guest speaker.

VI. Discussion and Possible Legislative or Rulemaking Action Regarding Experience Requirements for Licensed Clinical Social Workers
Mr. Riches reported that last year the board was contacted by an individual trying to obtain licensure as a clinical social worker. This individual first obtained a license as a marriage and family therapist and has practiced under that license for some time. Subsequently, the individual completed a Masters Degree in social work. Current law requires that this individual complete another 3200 hours of supervised experience prior to taking the licensing examinations. Given that this individual has already completed 3000 hours of supervised experience and now acts as both a therapist and a supervisor for marriage and family therapy interns and associate clinical social workers, it is difficult to construct a rationale for requiring the additional supervised hours.

Nicole Walford gave an overview of her scenario. Ms. Walford has been licensed as an MFT since 1998. She has been supervising MFT interns and associate clinical social workers (ASW) since 2001, and has a small private practice. She has been active in the field for a number of years. Because of current regulations, she can only supervise an ASW for up to 1500 hours. When the ASW can no longer obtain supervision from Ms. Walford at her current agency, they run the risk of losing the ASW in search for a LCSW. This is the reason why she is seeking licensure for LCSW.
Ms. Roye asked if a change can be made. Ms. Schieldge responded that the Board would need to propose legislative amendments to its statutes.

Mr. Wong stated that while this may sound reasonable, there is a statutory issue. He also pointed out that although the Board may think that all of the hours are the same, by statute they are not the same. For example, the LCSW hours require 1200 hours of client-centered advocacy, consultation, evaluation, and research.

Mr. O’Connor clarified that currently candidates are not mandated to earn hours in the area of client-centered advocacy in order to sit for the LCSW exam; current law permits up to 1200 hours in this area.

Mr. Riches stated that the analogy staff used when thinking about this situation is the example of someone coming to California from another state. A few years ago, the Board changed the eligibility statute for social work licensure. If an individual had at least two years of licensure in another state, the individual would satisfy the experience requirement and would be allowed to sit for the examination.

Ms. Lonner asked about the educational requirement. Mr. Riches responded that the basic requirement, a Masters Degree from an accredited school, remains the same for all social workers.

The Committee directed staff to draft language and bring it back to the Committee.

IV. Discussion and Possible Legislative or Rulemaking Action Regarding the Definition of “Private Practice” for Marriage and Family Therapist Interns and Trainees

Mr. Riches reported that current law prohibits MFT trainees from working in “private practice” settings and also prohibits MFT interns from working in a “private practice” after their initial six year registration period. However, there is no definition of what constitutes a “private practice” in either statute or regulation. In the past, the traditional definition of private practice has been thought of as independent practice, owned by a private practitioner seeing clients who are either paying for their own therapy or billing third party insurance. The Board is receiving inquiries from supervisors, trainees and interns about how to define a practice site that is owned privately by therapists but does not fit the traditional mold of an independent private practice. Some examples include agency settings, which may not be non-profit organizations but may be working under government contracts, and non-profit, privately owned agencies.

Ms. Riemersma, CAMFT, explained that this was never a problem in the past because the work settings were defined in great detail. Ms. Riemersma believes that the list of different work settings should be brought back. This list is good for trainees and interns, and there were very specific settings listed and defined. The list became very confusing for people, which resulted in the change in law. When the list existed, private practice meant it was a sole proprietorship, a professional corporation owned by a MFT or a mental health professional, or a partnership. The list was much clearer before the law was changed to simplify the law.

Mr. Wong, NASW, stated that a law change would be required to establish the long list of settings.
Ms. Schieldge stated that there are two ways to regulate these areas: 1) Prescriptive – develop the “laundry” list, and state that only these areas will qualify as a permissible setting; 2) Performance – develop general criteria and look at each case on a case-by-case basis. The Board may also do a combination of both. Ms. Schieldge agreed that there needs to be further clarification.

Dr. Russ added that clarification would be helpful to the schools that need to place trainees.

Mr. Riches preferred that the setting be defined in regulation rather than in the Business and Professions statute. He added that it could be defined by negation, defining it by what private practice setting is not.

The Committee directed staff to draft language and bring it back to the Committee.

V. Discussion and Possible Legislative or Rulemaking Action Regarding Supervised Experience Requirements for Marriage and Family Therapists

Mr. Riches reported that this is a continuation of a discussion that the Committee began in February. A discussion draft of changes to MFT experience requirements was provided. The issues discussed were: 1) Double counting the first 150 hours providing family therapy; 2) Combine existing limits on telephone crisis counseling and telemedicine into a single category with a maximum of 375 hours allowed; 3) Allow MFT interns to collect hours for client-centered advocacy; 4) Change the supervision ratio for post-graduate experience to parallel that required of ASWs; allow hours of experience to be gained in any category as a trainee.

Ms. Riemersma, CAMFT, suggested a change in the language on page two, part (A) to “For up to 150 hours of treating couples and families in conjoint or family therapy…”

Olivia Loewy, American Association for Marriage and Family Therapy (AAMFT), commented that the current wording may not encompass the significant others/partners in the room or establishes that more than one will be in the room. She expressed concern that the language is inclusive.

The Committee confirmed that the terms “family” and “couples” as well as “conjoint” covers significant others, partners and the whole concept of family.

**Ian Russ moved to recommend to the Board that it sponsor legislation to change MFT experience requirements. Karen Roye seconded. The Committee voted unanimously (4-0) to pass the motion.**

VII. Budget Update

Mr. Riches reported. Since last meeting, a budget has been signed for fiscal year 2009-2010. Business resumes as of July 1\(^{st}\), and there is no wait for a budget to be signed. The budget includes funding to move forward with the fingerprinting. There is a continuation of funding for the Mental Health Services Act (MHSA). The furloughs have changed significantly and will continue to change. Furloughs are now self-directed, and offices will not be closed two days each month. Employee pay is reduced by 10% in exchange for two days of leave per month. A bargaining agreement has been approved, which will reduce the furlough to one day a month and 5% pay reduction. The agreement is pending ratification by the Legislature, which will require a two-thirds vote to pass.
Mr. Riches talked briefly about the ballot measures to be voted on during a special election. Much of the budget agreement reached is contingent on passing ballot initiatives on a May 19th special election. If the initiatives do not pass, it results in an additional 6 billion dollar hole in the budget. According to the Legislative Analyst Office, projections are about 8 billion dollars less than what the budget was based on. The ballot initiatives are not polling near 50 percent. If those initiatives do not pass, we're looking at another 15 billion dollar problem after May 20th.

The Board has a very healthy fund reserve; however, the political environment may affect the Board through additional executive orders.

VIII. Legislative Update
The legislative update was provided for review. Ms. Rhine stated the Omnibus Bill now has a bill number, SB 821. SB 33, the MFT curriculum bill, is set to be heard in Senate Business and Professions on April 20, 2009.

Mr. Riches added that the Board will begin the MFT training program for MFT faculty made possible by MHSA funding.

IX. Rulemaking Update
The legislative update was provided for review. Ms. Rhine briefly reported that the fingerprinting regulation was approved by the department and agency, and has been submitted to the Office of Administrative Law. The disciplinary guidelines, approved by the Board in February, are awaiting agency approval.

X. Suggestions for Future Agenda Items
No suggestions were made.

XI. Public Comment for Items Not on the Agenda
No public comments were made.

The Committee adjourned at 2:54 p.m.
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BUDGET UPDATE – OCTOBER 10, 2009

Summary

2008-2009 Fiscal Year

The board closed out the 2008-2009 Fiscal Year with total expenditures of $5,746,137 out of a total budget authority of $6,005,980. This nets a $259,843 in unexpended reserve for the fiscal year. The Board exceeded $6 million in revenue, brining in a total of $6,013,058, well in excess of its expenditures.

Our overall expenditures increased over 5% from $5,451,029 in FY 07/08 to $5,746,137 in FY 08/09 and have increased nearly 36% since FY 04/05. The Board’s Enforcement Unit expenditures have seen a decrease by nearly 2%, while our Exam Unit has seen a decrease in expenditures in the areas of exam site rental and subject matter experts. This decrease in expenditures from previous fiscal years can be attributed to the following:

- Use of the Board’s internal enforcement investigator’s, drastically reducing the need to use investigators from the Division of Investigation
- Reduced amount of enforcement cases referred for Administrative Hearing, which eliminates the need for court reporters and/or expert witnesses
- Cancellation or rescheduling of several exam workshops as a result of workshops being scheduled on furlough Fridays
- Cancellation of Item/Question Writing workshops
- Elimination of the need for a second confirming passing score for the Clinical Vignette exams

While the Board experienced an overall increase in expenditures, our revenue seems to have leveled out last fiscal year, from $6,112,930 in FY 07/08 to $6,013,058 in FY 08/09. Most noticeably was the 80% decrease of citation and fine fees collected by the Board. The majority of the Board’s citation and fines are a result of internal continuing education (CE) audits performed. During FY 08/09, the Board lacked staff resources to perform CE audits on a consistent basis, resulting in decreased citations issued. Additionally, the Board noticed a slight decrease in delinquent renewal fees collected in fiscal year 2008/09.
The Board is entering into Fiscal Year 2009-2010 with budget authority of $6,934,000 and to date our expenditures have reached $292,182. Additionally, our current fund condition report reflects 8.8 months in reserve and $9 million in outstanding general fund loans.

The Board has participated in various budget exercises in the past year, most notably Executive Order S-09-09. This order requires state departments, regardless of funding source, to submit a plan to their Agency Secretary that provides for a reduction of the amount of the department’s appropriation to be encumbered by new contracts, extended contracts or purchases from statewide master contracts in the 2009-10 fiscal year by at least 15%. The reduction can be through cancellation, suspension, or renegotiations of contracts. All purchasing was suspended until the spending reduction plans were approved. On August 6, 2009, the Board received approval from the Department, through SCSA, of our Fiscal Year 2009-10 proposed reduction plan and was able to resume normal business operations.

The Board has committed to a reversion of $219,000 in FY 2009-10 to our Operating Expense and Equipment budget. This approval allows the Board to return to making contracts, purchases, and other expenditures without the needing to request item-by-item exemptions. The proposed reduction represents the amount in which the board can implement without significantly impacting our ability to carry out our consumer protection mandate. The $219,000 includes both BBS and MHSA funds appropriated to the BBS in the current fiscal year.

Additionally in FY 2009/10 and as previously reported, the Board was approved for an increase of four staff, via a Budget Change Proposal (BCP) for retroactive fingerprinting. These four positions have
been filled and you can find the latest update in the retroactive fingerprint report. In addition to the staffing increase, this BCP includes an increase to the Board’s Attorney General budget by $409,556.

Further in FY 2009-10, Executive Orders S-16-08 and S-13-09 are still in existence, which directs all represented employees and supervisors to be furloughed three days per month. The Board office is closed the first, second, and third Friday of every month, until June 30, 2010.

Looking Ahead

It is likely that the state will continue to experience budget strains in the next two fiscal years. The BBS continues to be in sound fiscal condition, but we will continue to feel the impact of the statewide budget issues. The next likely pressure point is in November when the Legislative Analyst releases the November fiscal estimate. That estimate is likely to indicate another significant budget shortfall due to the approximately $8 billion hole in the current budget and ongoing deterioration in revenues.

Two documents are attached to provide the board with some additional context for our current budget situation. One is the monthly cash report from the State Controller and the other is a short summary of the July budget modifications from the Department of Finance.
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### BBS EXPENDITURE REPORT FY 2008/2009

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<td>(3,762)</td>
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**BLUE PRINT** indicates the items are somewhat discretionary. 09/28/2009
## BBS EXPENDITURE REPORT FY 2009/10

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<th>OBJECT DESCRIPTION</th>
<th>08/09 ACTUAL EXPENDITURES</th>
<th>FY 2009/10 BUDGET ALLOTMENT</th>
<th>CURRENT AS OF 8/31/2009</th>
<th>PROJECTIONS TO YEAR END</th>
<th>UNENCUMBERED BALANCE</th>
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<td>(79,547)</td>
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<td>Evidence/Witness Fees</td>
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<td>5,426</td>
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<td>21,334</td>
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<td><strong>TOTAL, OE&amp;E</strong></td>
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<td><strong>4,389,364</strong></td>
<td><strong>213,750</strong></td>
<td><strong>3,880,259</strong></td>
<td><strong>509,105</strong></td>
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<td><strong>TOTAL EXPENDITURES</strong></td>
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<td><strong>6,718,983</strong></td>
<td><strong>$595,478</strong></td>
<td><strong>$6,235,976</strong></td>
<td><strong>483,007</strong></td>
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<td>Fingerprints</td>
<td>(4,392)</td>
<td>(24,000)</td>
<td>2,615</td>
<td>(4,022)</td>
<td>(4,022)</td>
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<tr>
<td>Other Reimbursements</td>
<td>(16,044)</td>
<td>(26,000)</td>
<td>1,232</td>
<td>(4,022)</td>
<td>(4,022)</td>
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<td>Unscheduled Reimbursements</td>
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<td>5,205</td>
<td>(4,022)</td>
<td>(4,022)</td>
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<td>Total Reimbursements</td>
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<td>(50,000)</td>
<td>9,052</td>
<td>(4,022)</td>
<td>(4,022)</td>
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<td><strong>NET APPROPRIATION</strong></td>
<td><strong>5,690,394</strong></td>
<td><strong>6,668,983</strong></td>
<td><strong>$595,478</strong></td>
<td><strong>$6,235,976</strong></td>
<td><strong>483,007</strong></td>
</tr>
</tbody>
</table>

**BLUE PRINT INDICATES THE ITEMS ARE SOMEWHAT DISCRETIONARY.**
### BOARD OF BEHAVIORAL SCIENCES

**Analysis of Fund Condition**

(Dollars in Thousands)

**NOTE:** $9.0 Million General Fund Repayment Outstanding

<table>
<thead>
<tr>
<th></th>
<th>2008-09</th>
<th>Current Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2009-10</td>
</tr>
<tr>
<td><strong>BEGINNING BALANCE</strong></td>
<td>$7,048</td>
<td>$4,493</td>
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<tr>
<td>Prior Year Adjustment</td>
<td>$109</td>
<td>-</td>
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<tr>
<td><strong>TOTAL ADJUSTED RESERVES</strong></td>
<td>$7,157</td>
<td>$4,493</td>
</tr>
</tbody>
</table>

**REVENUES AND TRANSFERS**

- **Fees**
  - 2008-09: $5,829
  - 2009-10: $6,496
  - 2010-11: $6,846
  - 2011-12: $7,132
  - 2012-13: $7,406
  - 2013-14: $7,709
- **Interest**
  - 2008-09: $128
  - 2009-10: $144
  - 2010-11: $83
  - 2011-12: $71
  - 2012-13: $57
  - 2013-14: $45

**Transfers from Other Funds**
- F00683 Teale Data Center:
  - 2008-09: -
  - 2009-10: -
  - 2010-11: -
  - 2011-12: -
  - 2012-13: -
  - 2013-14: -

**Transfers to Other Funds**
- General Fund Loan (3000)

**TOTAL REVENUES AND TRANSFERS**
- 2008-09: $2,957
- 2009-10: $6,003
- 2010-11: $6,929
- 2011-12: $7,203
- 2012-13: $7,463
- 2013-14: $7,754

**TOTAL RESOURCES**
- 2008-09: $10,114
- 2009-10: $10,496
- 2010-11: $11,182
- 2011-12: $10,978
- 2012-13: $11,553
- 2013-14: $12,287

**EXPENDITURES**

- **State Controller (State Operations)**
  - 2008-09: $2
  - 2009-10: -
  - 2010-11: -
  - 2011-12: -
  - 2012-13: -
  - 2013-14: -

- **Program Expenditures (State Operations)**
  - 2008-09: $5,619
  - 2009-10: $6,715
  - 2010-11: $7,119
  - 2011-12: $6,624
  - 2012-13: $6,756
  - 2013-14: $6,892

- **Projected Expenses (BCPs)**
  - 2008-09: -
  - 2009-10: $288
  - 2010-11: $264
  - 2011-12: $264
  - 2012-13: $6
  - 2013-14: -

- **Furlough Savings (13.8%)**
  - 2008-09: -
  - 2009-10: $115
  - 2010-11: $115
  - 2011-12: $115
  - 2012-13: $115
  - 2013-14: $115

- **OE&E Savings (Approved by Agency)**
  - 2008-09: -
  - 2009-10: $236
  - 2010-11: $236
  - 2011-12: $236
  - 2012-13: $236
  - 2013-14: $236

**TOTAL**
- 2008-09: $5,621
- 2009-10: $6,243
- 2010-11: $7,407
- 2011-12: $6,888
- 2012-13: $7,020
- 2013-14: $6,898

**FUND BALANCE**

- Reserve for economic uncertainties
  - 2008-09: $4,493
  - 2009-10: $4,253
  - 2010-11: $3,775
  - 2011-12: $4,090
  - 2012-13: $4,533
  - 2013-14: $5,389

- Months in Reserve
  - 2008-09: 8.6
  - 2009-10: 6.9
  - 2010-11: 6.6
  - 2011-12: 7.1
  - 2012-13: 7.9

**NOTES:**

*Assumes flat line predicted values based on predictive model.
Assumes workload and revenue projections are realized for 2008-09 and ongoing.
Assumes appropriation growth of 2% per year.
Assumes interest rate at 2%.

9/29/2009
<table>
<thead>
<tr>
<th></th>
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<tr>
<td>PERSONAL SERVICES</td>
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<td></td>
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<tr>
<td>Salary &amp; Wages (Civ Svc Perm)</td>
<td>35,055</td>
<td>64,000</td>
<td>61,104</td>
<td>2,896</td>
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<td>Totals Staff Benefits</td>
<td>14,356</td>
<td>26,511</td>
<td>33,620</td>
<td>(7,109)</td>
</tr>
<tr>
<td>Salary Savings</td>
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<td></td>
<td>(3,083)</td>
<td></td>
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<tr>
<td><strong>TOTALS, PERSONAL SERVICES</strong></td>
<td><strong>49,411</strong></td>
<td><strong>87,428</strong></td>
<td><strong>94,724</strong></td>
<td><strong>(7,296)</strong></td>
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<tr>
<td>OPERATING EXP &amp; EQUIP</td>
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<tr>
<td>General Expense</td>
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<td>5,772</td>
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<td>817</td>
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<tr>
<td>Communication</td>
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<td>1,000</td>
<td>871</td>
<td>129</td>
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<tr>
<td>Postage</td>
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<td>800</td>
<td>5,000</td>
<td>(4,200)</td>
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<tr>
<td>Travel, In State</td>
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<td>3,580</td>
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<td>Training</td>
<td>550</td>
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<td><strong>TOTAL, OE&amp;E</strong></td>
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PCA - 18385
DGS Code - 057472
## MHSA EXPENDITURE REPORT FY 2009/10

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<th>OBJECT DESCRIPTION</th>
<th>2008/09 ACTUAL EXPENDITURES</th>
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<th>CURRENT AS OF 8/31/2009</th>
<th>PROJECTIONS TO YEAR END</th>
<th>UNENCUMBERED BALANCE</th>
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<td><strong>PERSONAL SERVICES</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Salary &amp; Wages (Civ Svc Perm)</td>
<td>61,104</td>
<td>64,000</td>
<td>10,158</td>
<td>60,948</td>
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<td>Totals Staff Benefits</td>
<td>33,620</td>
<td>26,511</td>
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<td>1,113</td>
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<td>Salary Savings</td>
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<td>(3,083)</td>
<td></td>
<td>(3,083)</td>
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<tr>
<td><strong>TOTALS, PERSONAL SERVICES</strong></td>
<td><strong>94,724</strong></td>
<td><strong>87,428</strong></td>
<td><strong>14,391</strong></td>
<td><strong>86,346</strong></td>
<td><strong>1,082</strong></td>
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<td>Printing</td>
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<td>800</td>
<td>0</td>
<td>800</td>
<td>0</td>
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<tr>
<td>Communication</td>
<td>871</td>
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<td>73</td>
<td>876</td>
<td>124</td>
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<tr>
<td>Postage</td>
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<td>800</td>
<td>0</td>
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<td>Travel, In State</td>
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</tr>
<tr>
<td>Training</td>
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<td>0</td>
<td>1,000</td>
<td>0</td>
</tr>
<tr>
<td>Facilities Operations</td>
<td>2,328</td>
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<td>380</td>
<td>2,280</td>
<td>(280)</td>
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<tr>
<td>Minor Equipment (226)</td>
<td>433</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>C&amp;P Svs - External (402)</td>
<td>118,197</td>
<td>200,000</td>
<td>1,402</td>
<td>93,690</td>
<td>106,310</td>
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<td>Statewide Prorata (438)</td>
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<td>10,674</td>
<td>(3,558)</td>
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<td><strong>TOTAL, OE&amp;E</strong></td>
<td><strong>144,360</strong></td>
<td><strong>218,572</strong></td>
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<td><strong>114,120</strong></td>
<td><strong>104,452</strong></td>
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<td><strong>TOTAL EXPENDITURES</strong></td>
<td><strong>239,084</strong></td>
<td><strong>306,000</strong></td>
<td><strong>16,796</strong></td>
<td><strong>200,466</strong></td>
<td><strong>105,534</strong></td>
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</tbody>
</table>

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State Finances in August 2009

⇒ The State began the fiscal year without enough cash to cover all of its payments, forcing the State Controller’s Office to issue Registered Warrants (IOUs) to any General Fund payment categories not protected by the State Constitution, federal law or court decision. In the month of August alone, $862 million worth of Registered Warrants were issued, and $471 million in scheduled payments were delayed into September.

⇒ The figures reported in August’s cash statement are distorted by $279 million in IOUs for personal income and corporate tax refunds that would have otherwise offset revenues, and $1.05 billion in other IOUs and payment delays that would have otherwise increased disbursements. This summary adjusts receipts and disbursements to account for IOUs and payment delays.

⇒ Compared to estimates found in the Amended 2009-10 Budget Act enacted on July 21, 2009, total General Fund revenues were down $237 million (-3.6%). This was driven by...

(Continued on page 2)

Budget vs. Cash

The State’s budget is a financial plan based on estimated revenues and expenditures for the State’s fiscal year, which runs from July 1 through June 30.

Cash refers to what is actually in the State Treasury on a day-to-day and month-to-month basis.

Monitoring the amount of cash available to meet California’s financial obligations is the core responsibility of the State Controller’s office. On average, the Controller’s office issues 182,000 payments every day.

The State Controller’s Office is responsible for accounting for all State revenues and receipts and for making disbursements from the State’s General Fund. The Controller also is required to issue a report on the State’s actual cash balance by the 10th of each month.

As a supplement to the monthly Statement of General Fund Cash Receipts and Disbursements, the Controller issues this Summary Analysis for California policymakers and taxpayers to provide context for viewing the most current financial information on the State’s fiscal condition.

This Summary Analysis covers actual receipts and disbursements for August 2009 and year to date for the first two months of Fiscal Year 2009-10. Data are shown for total cash receipts and disbursements, the three largest categories of revenues, and the two largest categories of expenditures.

This report compares actual receipts against historical figures from 2008 and estimated cash flows for the Amended 2009-10 Budget Act enacted on July 21, 2009.
September 2009 Summary Analysis

(Continued from page 1)

personal income tax revenues that were $247 million below (-8.9%) estimates and sales taxes that were down $185 million (-5.5%). Corporate taxes were $27.3 million above (22.6%) the estimates. The total for the three largest taxes was below the estimates by $405 million (-6.5%).

⇒ Compared to August 2008, General Fund revenue in August 2009 was down $486 million (-7.1%). The total for the three largest taxes was below 2008 levels by $518 million (-8.1%). Personal income taxes came in $401 million below (-13.7%) last August. Sales taxes were down $56.6 million (-1.7%), and corporate taxes dropped by $60 million (-28.8%) from last August.

Tax Revenue Fiscal Year to Date

⇒ Compared to the Amended 2009-10 Budget Act, General Fund revenues are below the year-to-date estimate by $237 million (-2.2%). Sales tax collections year-to-date were down $185 million (-4.2%), and income taxes were $247 million lower (-4.6%) than expected. Because the 2009-10 Budget Act estimates contain actual revenue through July, the deterioration in both sources of revenue occurred in August. Corporate taxes came in above estimates by $27.3 million (7.8%).

⇒ Compared to this date in August 2008, revenue receipts are down $851 million (-7.5%). This was driven by personal income taxes, which came in $736 million below (-12.6%) last year at this time.

⇒ Year-to-date collections for the three major taxes were down $649 million (-6.2%) and corporate taxes were down $41.1 million lower (-9.9%). Retail sales taxes were up $128 million (3.1%) from last year's total at the end of August.

What The Numbers Tell Us

Not Yet Time to Celebrate

Although there are general signs that the economy in the U.S. and California is feeling for the bottom, it is not yet time to celebrate. Residential construction appears to have leveled off and the pace of job declines has slowed significantly over the past several months. However, California’s General Fund Revenue came in below last August, and below the Amended 2009-10 Budget Act that was enacted less than two months ago.

Personal income taxes were driven below the Budget Act estimate and last August’s totals by lower-than-expected collections of withholding taxes. According to the Department of Finance, withholdings are down by 5.5% compared to their most recent projections for the 2009-10 fiscal year. Additionally, estimated tax payments are down by 16.4% relative to the Department’s estimates. This highlights the extent to which people all across the labor market — from wage and salary earners, to the self employed or corporate executive — are still feeling the pinch of this downturn in their pocketbooks despite some stabilization.

This seemingly near bottom also contrasts with the State’s collection of sales tax receipts. California collected 1.7% less sales tax revenue in August 2009 than it did in August 2008, and things are probably slightly worse than these numbers reflect. The Federal Government’s “Cash for Clunkers” program has been successful in boosting demand for new automobiles, and has almost certainly helped to generate additional tax revenues for California. This is a positive indicator, but it reflects policy changes in Washington D.C. more than a genuine rebound in consumer activity.

The silver lining is that the pace of job declines continues to slow. Although California’s unemployment rate increased in July, it did so at a slower pace. There are signs that many sectors are nearing a bottom, including construction, which should begin to stabilize as residential building permits have leveled off in recent months. Unfortunately, the return to growth may take longer than many expect, and when job growth does resume it will do so at a much slower pace.

(Continued on page 3)
Summary of Net Cash Position as of August 31, 2009

Through August, the State had total receipts of $10.8 billion (Table 1) and disbursements of $14.9 billion (Table 2).

The State ended last fiscal year with a deficit of $11.9 billion, and the combined current year cash deficit stands at $12.6 billion (Table 3). Those deficits are being covered with $11.1 billion of internal borrowing and $1.5 billion in external borrowing. Without IOUs and payment delays in July and August, the cash deficit would have grown to $16 billion.

Borrowable Resources
State law authorizes the General Fund to internally borrow on a short-term basis from specific funds, as needed.

Payroll Withholding Taxes
"Payroll Withholdings" are income taxes that employers send directly to the State on their employees' behalf. Those amounts are withheld from paychecks during every pay period throughout the calendar year.

Revenue Anticipation Notes
Traditionally, the State bridges cash gaps by borrowing money in the private market through Revenue Anticipation Notes (RANs). RANs are repaid by the end of the fiscal year.

Non-Revenue Receipts
Non-revenue receipts typically are transfers to the General Fund from other state funds.

Table 1: General Fund Receipts, July 1, 2009 - August 31, 2009 (in Millions)*

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Actual Receipts to Date</th>
<th>Amended 2009-2010 Budget Act Estimate</th>
<th>Actual Over (Under) Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporation Tax</td>
<td>$376</td>
<td>$349</td>
<td>$27</td>
</tr>
<tr>
<td>Personal Income Tax</td>
<td>$5,114</td>
<td>$5,361</td>
<td>($247)</td>
</tr>
<tr>
<td>Retail Sales and Use Tax</td>
<td>$4,265</td>
<td>$4,450</td>
<td>($185)</td>
</tr>
<tr>
<td>Other Revenues</td>
<td>$793</td>
<td>$625</td>
<td>$168</td>
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<tr>
<td><strong>Total General Fund Revenue</strong></td>
<td>$10,547</td>
<td>$10,748</td>
<td>($237)</td>
</tr>
<tr>
<td>Non-Revenue</td>
<td>$263</td>
<td>$370</td>
<td>($107)</td>
</tr>
<tr>
<td><strong>Total General Fund Receipts</strong></td>
<td>$10,810</td>
<td>$11,154</td>
<td>($344)</td>
</tr>
</tbody>
</table>

*Note: Personal income and corporate tax receipts are adjusted to account for Registered Warrants being issued for tax refunds. Some totals on charts may not add, due to rounding.

Table 2: General Fund Disbursements, July 1, 2009-August 31, 2009 (in Millions)**

<table>
<thead>
<tr>
<th>Recipient</th>
<th>Actual Disbursements</th>
<th>Amended 2009-10 Budget Act Estimate</th>
<th>Actual Over (Under) Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Assistance</td>
<td>$11,232</td>
<td>$11,722</td>
<td>($490)</td>
</tr>
<tr>
<td>State Operations</td>
<td>$3,392</td>
<td>$3,317</td>
<td>$76</td>
</tr>
<tr>
<td>Other</td>
<td>$294</td>
<td>$904</td>
<td>($610)</td>
</tr>
<tr>
<td><strong>Total Disbursements</strong></td>
<td>$14,919</td>
<td>$15,943</td>
<td>($1,024)</td>
</tr>
</tbody>
</table>

**Note: Disbursements are adjusted to account for IOUs and payment delays that pushed many August payments into September.
Of the largest expenditures, $11.2 billion went to local assistance and $3.4 billion went to State operations (See Table 3).

Local assistance payments were $490 million lower (-4.2%) than the Amended 2009-10 Budget Act projected and State operations were $75.8 million above (2.3%) those estimates (Table 2).

How to Subscribe to this Publication

This Statement of General Fund Cash Receipts and Disbursements for August 2009 is available on the State Controller's Web site at www.sco.ca.gov.

To have the monthly financial statement and summary analysis e-mailed to you directly, sign up at: http://www.sco.ca.gov/ard_monthly_cash_email.html

Any questions concerning this Summary Analysis may be directed to Hallye Jordan, Deputy Controller for Communications, at (916) 445-2636.

Table 3: General Fund Cash Balance As of August 31, 2009 (in Millions)

<table>
<thead>
<tr>
<th></th>
<th>Cash Balance July 2009</th>
<th>Cash Balance July 2008</th>
<th>Actual Over (Under)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning Cash Balance</td>
<td>($11,908)</td>
<td>($1,452)</td>
<td>($10,456)</td>
</tr>
<tr>
<td>July 1, 2009</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipts Over (Under)</td>
<td>($727)</td>
<td>($4,165)</td>
<td>$3,438</td>
</tr>
<tr>
<td>Disbursements to Date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Balance August 31,</td>
<td>($12,635)</td>
<td>($5,617)</td>
<td>($7,018)</td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total on August 31</td>
<td>($16,018)</td>
<td>($5,617)</td>
<td>($10,401)</td>
</tr>
<tr>
<td>without IOUs and Payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delays</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## California Economic Snapshot

<table>
<thead>
<tr>
<th>Category</th>
<th>July 2008</th>
<th>July 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Auto Registrations</strong></td>
<td>1,312,090</td>
<td>898,948</td>
</tr>
<tr>
<td>(Fiscal Year to Date)</td>
<td>Through April</td>
<td>Through April</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>2009</td>
</tr>
<tr>
<td><strong>Median Home Price</strong></td>
<td>$318,000</td>
<td>$250,000</td>
</tr>
<tr>
<td>(for Single Family Homes)</td>
<td>In July 2008</td>
<td>In July 2009</td>
</tr>
<tr>
<td><strong>Single Family Home Sales</strong></td>
<td>39,507</td>
<td>45,079</td>
</tr>
<tr>
<td></td>
<td>In July 2008</td>
<td>In July 2009</td>
</tr>
<tr>
<td><strong>Foreclosures Initiated</strong></td>
<td>121,673</td>
<td>124,562</td>
</tr>
<tr>
<td>(Notices of Default)</td>
<td>In 2nd Quarter</td>
<td>In 2nd Quarter</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>2009</td>
</tr>
<tr>
<td><strong>Total State Employment</strong></td>
<td>15,010,880</td>
<td>14,250,254</td>
</tr>
<tr>
<td>(Seasonally Adjusted)</td>
<td>In July 2008</td>
<td>In July 2009</td>
</tr>
<tr>
<td><strong>Newly Permitted Residential Units</strong></td>
<td>66,613</td>
<td>34,860</td>
</tr>
<tr>
<td>(Seasonally Adjusted Annual Rate)</td>
<td>In July 2008</td>
<td>In July 2009</td>
</tr>
</tbody>
</table>

Data Sources: DataQuick, California Employment Development Department, Construction Industry Research Board, State Department of Finance
Gloomy Consumers Are Cutting Back

By Esmael Adibi
Director, Anderson Center for Economic Research, Chapman University

After 16 consecutive years of increases, year-over-year real consumer spending declined in the third quarter of 2008 and the pace of decline accelerated through the second quarter of 2009. Unprecedented increases in consumer spending even during the recession of 2001 were astonishing but understandable. Lower interest rates engineered by the Federal Reserve Board during and after the 2001 recession, along with relaxed lending practices, fueled home buying and rapid home price appreciation. Consumers used their home equity to refinance mortgages, take out cash and spend it. Hence, between 2001 and 2006, higher home prices, an improving stock market and pickup in the job market boosted consumer confidence and spending.

The most recent gauge of consumer confidence nationally and a survey conducted by our Center measuring consumers’ sentiment shows California recently hit historical lows. Academic research does not fully support a significant correlation between small fluctuations in consumer confidence and consumer spending. There is, however, no doubt that sharp and continuous declines in consumer confidence have led to

(Continued on page 7)
cutbacks in consumer spending, further weakening the economy.

Consumers are suffering from a multitude of events that are negatively impacting their pocketbooks and their confidence with the current and future economic conditions. Erosion of confidence began when home prices showed sharp and precipitous declines. Lower home prices evaporated refinancing opportunities for those homeowners who bought homes that they could not have afforded under more traditional financing. Some are facing foreclosures, or at best, short sales. In addition, those homeowners who have no problems making their monthly payments have seen their biggest investment lose value. The negative wealth effect emanating from the loss of home values worsened when the stock market lost over 50 percent of its value from peak to trough. And finally, since December 2007, the national economy has experienced a severe recession placing upward pressure on the unemployment rate.

With disproportionate dependency on construction activity and the retail sector, this recession is hitting California particularly hard. It is important to remember that while the adjustment in the financial markets occurs very rapidly, the adjustment in the real economy, i.e., job creation and unemployment rates, is very slow. Although we expect the national economy to slowly emerge from the recession late this year, the unemployment rate is bound to go higher. Employers do not start hiring additional workers until they are confident that economic recovery is for real and is gaining momentum.

The good news is that the stock market reaches a trough about three to six months prior to the end of recession. Additionally, we believe median home prices will be near the bottom by the end of this year and that should bring some stability in the housing market. Obviously, these developments should help consumer confidence down the road. The most important factor affecting consumers’ sentiment, however, is the job market that is unfortunately a lagging indicator and will not improve until early 2010. When that happens, consumer confidence should be significantly boosted.

Meanwhile, we should not be surprised to see gloomy consumers acting cautiously about their spending plans. After years of borrowing, the deleveraging process will and should continue. And one should not expect to see significant increases in consumer spending anytime soon. The slower rate of growth in consumer spending suggests that taxable sales revenue for the state will not increase very rapidly over the next few years. The retreat in consumer spending, however, is not all bad news. Lower consumer spending growth leaves more savings and resources for business investment. In the long-run, higher levels of investment and innovation along with entrepreneurial spirit will enhance growth nationally and locally.
The amendments to the 2009-10 Budget are the culmination of California's effort to restore balance to a state budget that has been decimated by the worst budget crisis in the state's history.

In February, the state enacted $36 billion in solutions to what was then estimated to be a $42 billion General Fund budget gap (the additional $6 billion in solutions failed to pass at the special election in May). The amendments to the 2009-10 budget include another $24 billion in solutions to address the further deterioration of the state's fiscal situation identified in the May Revision. The $60 billion in budget solutions adopted this year addresses the largest budget gap the state has ever faced, both in dollar amount and in the percent of General Fund revenues it represents.

Components of the $60 Billion Budget Gap

Figure INT-01 displays the components of the $60 billion budget gap the state has faced in developing the budget for 2009-10. As the figure shows, the largest contributor to the budget gap is the reduction in the baseline revenue forecast for 2008-09 and 2009-10. This reduction is due almost entirely to the economic recession. In May 2008, the Department of Finance forecast the output of the state's economy (as measured by personal income) to be $1.589 trillion in 2008, $1.655 trillion in 2009 and $1.739 trillion
CLOSING THE $60 BILLION BUDGET GAP

In 2010. In the May 2009 forecast, the equivalent values were $1.559 trillion, $1.543 trillion and $1.564 trillion, reflecting reductions of 1.9 percent, 6.8 percent and 10.1 percent, respectively. General Fund revenues are very sensitive to changes in the economy, so these reductions in economic output translated into massive reductions in the baseline revenue forecasts between May of 2008 and May of 2009 of 20.4 percent for 2008-09 and 22.7 percent in 2009-10. Figure INT-02 shows General Fund revenues over the last decade and demonstrates how severely the recession has affected revenues in the last two years.

Figure INT-02

Impact of Recession on Revenue Trend

Figure INT-01

Development of the $60 Billion Budget Gap
(Dollars in Billions)

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 30, 2010 Reserve forecast in September 2008</td>
<td>-$1.0</td>
</tr>
<tr>
<td>Changes to Reserve:</td>
<td></td>
</tr>
<tr>
<td>Two-year Reduction in Baseline Revenues</td>
<td>-47.3</td>
</tr>
<tr>
<td>Two-year Change in Workload Spending</td>
<td>-10.8</td>
</tr>
<tr>
<td>Target Reserve at Budget Agreement</td>
<td>-0.9</td>
</tr>
<tr>
<td>Budget Gap</td>
<td>-$60.0</td>
</tr>
</tbody>
</table>
Spending growth also contributed to the budget gap. For much of the last decade, state spending grew faster than population and inflation. As Figure INT-03 shows the budget reduces spending below the population and inflation trends. While the figure shows that spending grew sharply in 2004-05 and 2006-07, it is important to note that about half of the increase was due to repayment of debts incurred during the last state budget crisis and to the loss of one-time solutions adopted during that crisis.

SOLUTIONS TO CLOSE THE $60 BILLION BUDGET GAP

Figure INT-04 displays the $60 billion in budget solutions enacted this year. The solutions are wide-ranging, touching all three of the state’s major revenue sources and cutting spending in virtually every state program that receives General Fund support.
CLOSING THE $60 BILLION BUDGET GAP

Figure INT-04
How the $60 Billion Budget Gap Was Closed
(Dollars in Millions)

<table>
<thead>
<tr>
<th></th>
<th>2009 Budget Act - enacted in February</th>
<th>Amendments to the Budget Act of 2009</th>
<th>Total Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuts</td>
<td>$14,893</td>
<td>$16,125</td>
<td>$31,018</td>
</tr>
<tr>
<td>Taxes</td>
<td>12,513</td>
<td>-</td>
<td>12,513</td>
</tr>
<tr>
<td>Federal Stimulus</td>
<td>8,016</td>
<td>-</td>
<td>8,016</td>
</tr>
<tr>
<td>Other</td>
<td>402</td>
<td>8,034</td>
<td>8,436</td>
</tr>
<tr>
<td>Total</td>
<td>$35,824</td>
<td>$24,159</td>
<td>$59,983</td>
</tr>
</tbody>
</table>

OUTLOOK FOR THE FUTURE

California’s budget situation is likely to remain challenging for some time for two reasons. First, while the economic forecast projects a recovery from the recession will begin next year, the recovery is not expected to be as robust as in past years. Second, some of the solutions to the budget crisis are one-time, or of limited duration. This is to be expected in the face of such a severe fiscal crisis. It would simply not have been possible to have balanced the budget entirely with permanent tax increases and ongoing spending cuts, given federal, constitutional and other limitations. Further, as much of the current budget shortfall is associated with a temporary economic downturn, the inclusion of some temporary solutions is appropriate. Preliminary projections for the coming fiscal year suggest that the state will face a significant budget shortfall; perhaps in the $7 to $8 billion range, with even larger shortfalls projected in out-years. However, the state’s ability to manage its way through the nadir of this economic cycle demonstrates a determination and ability to overcome future budget challenges. Moreover, the budget contains a wide range of reforms that will significantly reduce spending growth in the future.
To: Board Members                                      Date: September 29, 2009
From: Sean O’Connor                                    Telephone: (916) 574-7830
         Board of Behavioral Sciences

Subject: Update on Fingerprinting Requirement for Licensees and Registrants

Background

As a result of the adoption of recent regulations, all licensees and registrants who have previously not submitted fingerprints as a condition of licensure or registration for the Board of Behavioral Sciences (BBS), or for whom fingerprints do not exist in the California Department of Justice’s (DOJ) criminal offender record identification database, must do so prior to their next renewal date occurring on or after October 31, 2009. Failure to comply with this requirement can result in disciplinary action or the issuance of a citation, which may include a fine of up to $5,000.

Using data from DOJ and the BBS, staff identified 34,685 individuals in the BBS licensing population affected by this requirement.

Progress

BBS staff began the process of notifying and processing fingerprint results for those individuals required to comply in July 2009.

On July 13, 2009, staff sent 3,976 initial fingerprint notifications to individuals with license or registration expiration dates occurring between October 31, 2009 and December 31, 2009. The next batch of initial notifications is scheduled for mailing on October 31, 2009, and it will include individuals with expiration dates between January 31, 2010 and March 31, 2010.

During the week of September 28, 2009, BBS staff will send reminder notices to all individuals with expiration dates of October 31, 2009 who have yet to comply with the requirement. Licensees and registrants can access information relating to the requirement on the BBS Web site (http://www.bbs.ca.gov/licensees/licensee_fingerprint_requirement.shtml). Stakeholder groups have also been notified of the requirement and provided with information to distribute.

As of September 24, 2009, BBS staff has processed approximately 1,094 fingerprint results related to this new requirement.
Blank Page
Important: New Fingerprint Requirements for Licensees and Registrants

You are receiving this letter because records at the California Board of Behavioral Sciences (BBS) and the California Department of Justice (DOJ) indicate you have not previously submitted fingerprints as a condition of licensure or registration for the BBS, or a record of your fingerprints does not exist in the DOJ’s criminal offender record identification database. The BBS adopted regulations effective June 19, 2009 requiring you to complete a state and federal level criminal offender record information search by your next renewal date that occurs on or after October 31, 2009 (Please see the enclosed “BBS Licensee Fingerprint Requirement Fact Sheet” for an example). Failure to comply with this requirement is grounds for disciplinary action against your license or registration, or the issuance of a fine of up to $5,000.

If your license is currently on inactive status, you still must comply with this requirement.

Third parties are not allowed to share confidential information received as a result of a fingerprint submission. You will need to submit fingerprints for the BBS even if you have recently been fingerprinted for employment purposes.

If you completed fingerprints for the BBS using the ten-print fingerprint card method in the past, you will have to fingerprint again for the BBS using the Live Scan method (digitally scanned fingerprints) in order to establish a record in the DOJ’s criminal offender record identification database.

How to Comply

You can use the enclosed Live Scan Service Form (BCII 8016) to complete your fingerprinting requirement at one of the many Live Scan sites in the State of California. For a listing of approved Live Scan sites, visit the DOJ’s Web site at http://ag.ca.gov/fingerprints/publications/contact.php. Be sure to call the site to obtain hours of operation and to make an appointment if necessary. You must present valid photo identification (e.g. driver’s license or ID, military ID, or passport) at the Live Scan site. The BBS can only accept Live Scan completed in California. If you reside outside of California, please submit the enclosed ten-print fingerprint hard cards. If hard cards are not enclosed, please contact the BBS at bbswebmaster@bbs.ca.gov to request them to be mailed to you.

The new regulation requires a state and federal level of clearance. The fee for a state-level of clearance through the California DOJ is $32, and the fee for a federal-level of clearance through the United States Federal Bureau of Investigation (FBI) is $24. You are responsible for paying these fees in addition to any service provider fees associated with completing this requirement.

NOTE: A small portion of the population cannot use the Live Scan electronic fingerprint submission process due to worn fingerprints or other conditions. If you are unable to submit
fingerprints using the Live Scan method, you must complete the requirement using alternate means. Please contact the BBS at (916) 574 - 7859 if you believe you are unable to fingerprint using the Live Scan electronic submission process.

**How to Prove Completion**

Once your fingerprints are scanned, the Live Scan service provider will complete a portion of the Live Scan Applicant Submission form and provide two copies back to you. You are to mail one copy to the BBS (see letterhead for address) and retain one copy for your records as proof of completion. **Do not include proof of completion of the fingerprint requirement with your application for renewal. Please send it separately to the BBS.**

Individuals using the hard card method should refer to the enclosed instructions as this process differs from the Live Scan submission method.

IMPORTANT: The regulation requires you to retain a receipt proving completion of this requirement for at least three years.

Please reference the enclosed “BBS Licensee Fingerprint Requirement Fact Sheet” if you have additional questions or require more information regarding this new requirement. You can also email the BBS at bbswebmaster@bbs.ca.gov or call the Fingerprint Unit at (916) 574 – 7859.
BOARD OF BEHAVIORAL SCIENCES (BBS)
FINGERPRINT REQUIREMENT
- FACT SHEET-

As a result of the adoption of new regulations, all licensees and registrants who have previously not submitted fingerprints as a condition of licensure or registration for the BBS, or for whom fingerprints do not exist in the DOJ’s criminal offender record identification database, must do so prior to their next renewal date occurring on or after October 31, 2009. Failure to comply with this requirement can result in disciplinary action or the issuance of a citation, which may include a fine of up to $5,000.

1. How do I determine when I need to get this done?

The expiration date on your license or registration will determine when you need to comply. For example, if you have an expiration date of March 31, 2010, you need to submit fingerprints by March 31, 2010 since this is your first expiration date after October 31, 2009.

If your expiration date is October 31, 2009, you must submit fingerprints by October 31, 2009. The language of the regulation specifically refers to renewal dates on or after October 31, 2009.

2. My license is currently on inactive status. Do I still need to comply?

Yes. Even if your license is on inactive status, you must submit fingerprints before your next expiration date occurring on or after October 31, 2009.

3. I remember getting fingerprinted using the ten-print fingerprint card method, do I still have to get fingerprinted again using the Live Scan method?

Yes. If you completed fingerprints for the BBS using the ten-print fingerprint card method, you will have to fingerprint again for the BBS using the Live Scan electronic submission method in order to establish a record in the DOJ’s criminal offender record identification database.

4. Do I need to send the proof of completion in with my renewal? Where do I send the proof of completion?

No. Your renewal date establishes your deadline to submit the required fingerprints, but you will not need to do anything different when you renew your license or registration. Simply complete the application for renewal and send it in with the appropriate fee. Do not include proof of completion of the fingerprint requirement with your application for renewal. You should submit proof of completion of this requirement to the BBS as soon as possible after having your fingerprints taken. Please see the letterhead above for the correct mailing address.
address. You are required to retain a copy of proof of completion for your records for at least three years.

5. **How do I get the appropriate forms to complete the requirement?**

The appropriate forms are enclosed. Some portions of the form are already completed. Please refer to “Instructions for Completing Live Scan Applicant Submission Form” if you have questions. If you are using the hard card method, appropriate instructions are included.

6. **What if I am physically unable to complete Live Scan fingerprinting?**

If you cannot complete Live Scan fingerprinting due to a physical condition, please contact the BBS as soon as possible at (916) 574 – 7859.

7. **I just got my fingerprints done for a new job. Do I need to get them done again?**

Yes. Third parties are not allowed to share confidential information received as a result of a fingerprint submission. You will need to submit fingerprints for the BBS even if you have recently been fingerprinted for employment purposes.

8. **What do I do if I have already submitted fingerprints to the BBS using the Live Scan method?**

If you are certain that you have already submitted fingerprints using the Live Scan method for the BBS, please contact the BBS at (916) 574 – 7859.

9. **I reside outside of California, how will I comply?**

If you reside outside of California, you will not be able to complete the requirement using the Live Scan electronic submission method. You will need to complete the requirement using ten-print fingerprint cards. Appropriate forms are enclosed to complete this requirement if you have an address outside of the State of California. If hard cards are not enclosed, please contact the BBS at bbswebmaster@bbs.ca.gov.

If you have additional questions or require more information. You can also email the BBS at bbswebmaster@bbs.ca.gov or call the Fingerprint Unit at (916) 574 – 7859.
To: Board Members  
From: Christy Berger  
MHSA Coordinator  
Subject: Legislation Update

Date: September 17, 2009
Telephone: (916) 574-7834

BOARD-SPONSORED LEGISLATION

SB 33 (Correa) MFT Educational Requirements

This bill makes a number of changes relating to the educational and supervised experience requirements relating to Marriage and Family Therapist (MFT) licensure. *This bill has been signed by the Governor.*

The education-related changes, effective August 1, 2012, include:

- Increases the graduate degree’s total unit requirement from 48 to 60 semester units (72 to 90 quarter units);
- Provides more flexibility in the degree program by requiring fewer specific hours or units for particular coursework, allowing for innovation in curriculum design;
- Requires certain coursework, such as California law and ethics and child abuse assessment and reporting, which are currently required prior to licensure (and permitted to be taken outside of the degree program) to instead be completed prior to registration as an intern and within the degree program;
- Adds instruction in areas needed for practice in a public mental health environment which may be provided in credit level coursework or through extension programs;
- Infuses the culture and norms of public mental health work and principles of the Mental Health Services Act throughout the curriculum;
- Changes to practicum including:
  - An additional 75 client contact hours, which may include client centered advocacy
  - Training in the applied use of theory, working with families, documentation skills, and how to connect people with resources that deliver the quality of services and support needed in the community
  - Student must be enrolled in a practicum course while seeing clients;
- Permits schools who want to adopt the new curriculum prior to the effective date to do so effective January 1, 2010; and,
• “Sunsets” the “old” educational requirements effective January 1, 2019.

The supervised experience-related changes, effective January 1, 2010, include:

• Permits MFT interns working in certain types of settings to gain supervision via teleconferencing;
• Allows applicants to count experience for performing “client centered advocacy” activities toward licensure as a MFT;
• Requires applicants for MFT licensure to submit W-2 forms and verification of volunteer employment for each setting in which the applicant gained experience as an intern;
• Requires group supervision to be provided in either one two-hour session or in two one-hour segments. All group supervision must be provided during the same week as experience claimed;
• Modifies the supervision ratio for interns;
• Combines the telemedicine and telephone counseling categories for a combined maximum of 375 hours;
• Permits trainees to gain hours administering and evaluating psychological tests of counselees, write clinical reports, progress notes or process notes; and,
• Provides an incentive for interns and trainees to gain hours providing conjoint treatment of couples or families by allowing the first 150 hours of such work to be double-counted.

SB 819 (Committee on Business, Professions and Economic Development) - Board Omnibus Bill

This proposal incorporates all of the following changes approved by the Board and included in SB 1779 last year. This bill is currently awaiting action by the Governor.

• Enforcement
Prohibits the board from publishing on the internet for more than five years the final determination of a citation and fine of one thousand five hundred dollars ($1,500) or less against a registrant or licensee.

• Marriage and Family Therapist Act Title
Adds the following title to Chapter 13 of Division 2 of the Business and Professions Code: “This chapter shall be known, and may be cited, as the Marriage and Family Therapist Act.”

• Out-of-State Licensed Clinical Social Worker (LCSW) Eligibility
Makes a technical change to language relating to eligibility for out of state LCSW applicants that clarifies that an applicant must currently hold a valid license from another state at the time of application.

• MFT Experience Requirements
Clarifies that no hours of experience gained more than six years prior to the date of application for MFT examination eligibility can be counted towards the experience requirements.

• Unprofessional Conduct
Adds to the provisions of unprofessional conduct for all licensees the act of subverting or attempting to subvert any licensing examination or the administration of an examination.
  o Deletes the following language from the unprofessional conduct statutes:
    Conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances or any combination thereof.
• Adds to the unprofessional conduct statute for LEP’s failure to comply with telemedicine statute.

• Associate Clinical Social Worker (ASW) Supervision
  Permits ASWs to gain up to 30 hours of direct supervisor contact via videoconferencing and allows group supervision to be provided in one-hour increments, as long as both increments (full two hours) are provided in the same week as the experience claimed.

• Miscellaneous Provisions
  Repeals code sections containing obsolete language

SB 821 (Committee on Business, Professions and Economic Development) - Board Omnibus Bill
A second omnibus bill was introduced by the Senate Business, Professions and Economic Development Committee and includes the following statutory changes approved by the Board at its November 18, 2009 meeting. This bill is currently awaiting action by the Governor.

• Supervision in Private Practice
  Limits the number of MFT Interns and ASWs that may work under the supervision of a licensed professional in private practice to two total registrants, irrespective of registrant type, at one time.

• ASW Employment in Private Practice
  Prohibits an ASW issued a subsequent registration from being employed or volunteering in a private practice setting.

• Leasing or Renting Space by an ASW
  Prohibits an ASW from leasing or renting space, paying for furnishings, equipment or supplies, or in any other way paying for the obligations of their employers.

• Reinstatement or Modification of Penalty for Registrants
  Adds a reference to clarify that registrants may petition for reinstatement or modification of penalty when his or her registration has been revoked or suspended or been placed on probation.

• Unprofessional Conduct of a Supervisor
  Clarifies that unprofessional conduct includes any conduct in the supervision of a registrant by any licensee that violates licensing law and regulations adopted by the board, irrespective of the field of practice of the supervisee and the supervisor.

• Record Retention
  Adds record retention provisions to Licensed Educational Psychologist (LEP) and LCSW licensing law that do the following:
  o Prohibits the board from denying an applicant admission to the written examination or delaying the examination solely upon receipt by the board of a complaint alleging acts that would constitute grounds for denying licensure.
  o Requires the board to allow an applicant that has passed the written examination to take the clinical vignette examination regardless of a complaint that is under investigation. This same provision would allow the board to withhold results of the examination pending completion of the investigation.
  o Allows the board to deny an applicant that previously failed either the written or clinical vignette examination permission to retest pending completion of an investigation of complaints against the applicant.
  o Provides that no applicant shall be eligible to participate in a clinical vignette examination if his or her passing score on the standard written examination occurred more than seven years ago.
• Miscellaneous Provision
  Deletes incorrect reference to an “annual” license renewal.

BILLs monitored by the board

AB 244 (Beall) Mental Health Parity
This bill would require health care service plan contracts which provide hospital, medical, or surgical coverage, and health insurance policies issued, amended or renewed on or after January 1, 2010 to provide coverage for the diagnosis and treatment of mental illness of a person of any age under the terms and conditions applied to other medical conditions. At its meeting on May 22, 2009, the Board adopted the position of “support” on this bill. This bill is currently awaiting action by the Governor.

AB 484 (Eng) Business and Professional Licenses: Suspension: Unpaid Taxes
This bill would allow the Franchise Tax Board (FTB) to suspend a license issued by the Board if the licensee has unpaid tax liabilities. The Board adopted a position of “oppose unless amended” at its meeting on May 22, 2009. The board asked the author to amend the bill to instead allow the licensing entity that issued the license (the Board) to suspend the license of an individual with outstanding tax liabilities. This bill failed passage in the Assembly Business and Professions Committee.

AB 681 (Hernandez) Confidentiality of Medical Information: Psychotherapy Exemption
This proposal would allow a psychotherapist to disclose information related to the patient’s outpatient treatment, if the psychotherapist in good faith believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims, and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, without a written request, as specified in current law. At its meeting on May 22, 2009, the Board took a position of “support” on this legislation. This bill is currently awaiting action by the Governor.

AB 1113 (Lowenthal/Anderson) Department of Corrections and Rehabilitation: MFT Intern Experience
This proposal would allow marriage and family therapist interns to gain clinical experience in state correctional facilities. At its meeting on May 22, 2009, the Board took a position of “support” on this legislation. This bill was signed by the Governor and takes effect on January 1, 2010.

AB 1310 (Hernandez) Data Survey Requirement for Healing Arts Boards
This proposal would require specified boards under the Department of Consumer Affairs to add and label as “mandatory” certain fields on an application for initial licensure or renewal. The Board adopted a position of “oppose unless amended” at its meeting on May 22, 2009. This bill was amended June 29, 2009 to require the boards to collect this information “in a manner deemed appropriate by the board,” but not make the disclosures a condition of licensure or renewal. This bill was held under submission in the Senate Appropriations Committee.

SB 296 (Lowenthal) Mental Health Services
This proposal would require health care service plans that offer professional mental health services to establish a website that includes plan policies and procedures related to enrollee benefits, modified contracts, providers, continuity of care, independent reviews and grievances. Additionally, this bill would require health care service plans subject to this bill to issue benefits cards or the equivalent to each enrollee to include specified information. At its meeting on May
22, 2009, the Board took a position of “support” on this legislation. *This bill is currently awaiting action by the Governor.*

**SB 389 (Negrete-McLeod) Fingerprint Submission**

This proposal would require, beginning January 1, 2011, specified entities under the Department of Consumer Affairs to require, as a condition of licensure renewal, the submission of fingerprints by licensees for whom an electronic record of the submission of fingerprints no longer exists with the Department of Justice. The Board adopted a position of “oppose unless amended” at its meeting on May 22, 2009. The Board has asked the author’s office to exempt the Board from the requirements of the bill. Recently approved regulatory changes will allow the Board to require the submission of fingerprints by licensees beginning October 31, 2009. *This bill failed passage in the Assembly Committee on Public Safety.*

**SB 543 (Leno) Minors: Consent to Mental Health Treatment**

This proposal would allow a minor who is 12 years of age or older to consent to mental health services on an outpatient basis or to a residential shelter facility if the minor is mature enough to participate intelligently in the counseling services or if the minor either would present a danger of serious physical or mental harm to self or others. This bill would expand the definition of a “professional person” to include a licensed clinical social worker and a board-certified or board eligible psychiatrist. The Board adopted a position of “oppose” at its meeting on May 22, 2009. This bill was amended June 1, 2009 to address the primary concerns of the Board. This bill was amended again on July 7, 2009, to require the professional to consult with the minor before determining whether parental involvement or consent is appropriate. *This bill is currently being held in the inactive file in the Assembly.*

**SB 638 (Negrete-McLeod) Regulatory Boards: Board Membership Reconstitution**

This proposal would delete the requirement that a board become a bureau under the Department of Consumer Affairs (DCA) if it sunsets, and instead requires the removal of a board's members and appointment of a successor board. Revises and recasts sunset review law to remove references to the Joint Committee for Boards Commissions and Consumer Protection, and instead authorize the appropriate standing policy committees of the Legislature to carry out the sunset review functions. Terminates the terms of office of each board member and bureau chief within DCA upon an unspecified date, and authorizes successor board members and bureau chiefs to be appointed, as specified. *This bill is currently awaiting action by the Senate Rules Committee.*

**SB 788 (Wyland) Licensed Professional Clinical Counselors**

This proposal would establish title protection and licensure for Licensed Professional Clinical Counselors, with the program to be administered by the Board of Behavioral Sciences. At its meeting on May 22, 2009, the Board took a position of “support” on this legislation. *This bill is currently awaiting action by the Governor.*
Blank Page
To: Board Members  
From: Christy Berger  
MHSA Coordinator  

Subject: Regulation Update  

Date: September 17, 2009  
Telephone: (916) 574-7834  

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**PENDING REGULATORY PROPOSALS**

*Title 16, CCR Sections 1807, 1807.2, 1810, 1819.1, 1887 to 1887.14, Continuing Education Requirements: Licensed Educational Psychologists, Exceptions from and Providers*

This proposal would amend the continuing education (CE) exception criteria in order to clarify and better facilitate the request for exception from the CE requirement; make minor clean-up amendments to continuing education regulations; and implement a CE program for Licensed Educational Psychologists. *The board approved the originally proposed text at its meeting on May 31, 2007. Staff expects to file the regulation package with the Office of Administrative Law for Notice the week of September 21, 2009.*

*Title 16, CCR Sections 1815 and 1886.40, Fingerprint Submission Requirements*

This proposal would require all Board licensees and registrants for whom an electronic record of his or her fingerprints does not exist in the Department of Justice (DOJ) criminal offender record identification database to successfully complete a state and federal level criminal offender record information search conducted through the DOJ. *The Board approved the originally proposed text at its meeting on December 19, 2008. The Notice of Proposed Changes in Regulation was published in the California Regulatory Notice Register on January 2, 2009. The final rulemaking package was approved by the Board at its February 26, 2009 Board meeting. This package was submitted to the Office of Administrative Law for review on April 9, 2009. The language was approved and took effect on June 19, 2009.*

*Title 16, CCR Section 1888, Revision of Disciplinary Guidelines*

This proposal will revise the Disciplinary Guidelines set forth by the Board and utilized in a disciplinary action against a licensee under the Administrative Procedures Act. *The Board approved the originally proposed text at its meeting on November 18, 2009. The Notice of Proposed Changes in Regulation was published in the California Regulatory Notice Register on January 2, 2009. The final rulemaking package was approved by*
the Board at its February 26, 2009 Board meeting. This package was submitted to the Office of Administrative Law for review on April 22, 2009. The language was approved and took effect on July 3, 2009.

**Title 16, CCR Section 1811, Revision of Advertising Regulations**

This proposal would revise the regulatory provisions related to advertising by Board licensees and registrants. The Board approved the originally proposed text at its meeting on November 18, 2009. This proposal is currently on hold due to staff workload.
To: Board Members

From: Laurie Williams
Personnel Liaison

Date: September 21, 2009

Telephone: (916) 574-7850

Subject: Personnel Update

New Employees:

Michelle Eernisse promoted to the level of Management Services Technician in the Enforcement Unit effective June 1, 2009. She vacated an Office Technician position in the Licensing Unit as an MFT Evaluator. Michelle is performing the duties of support staff for the Enforcement Unit.

Vicki Baumbach joined the Board on July 13, 2009 to fill an Office Technician position within the Licensing Unit. She is responsible for LEP Evaluations and backup to the front office and public counter. Vicki transferred to the Board from the Richard J. Donovan Correctional Facility in San Diego, California.

Jessica Lissner transferred to the Board on July 13, 2009 from the California State Prison in Folsom, California. She is performing the duties of a Marriage & Family Therapist Evaluator. She has filled the vacated position of Gena Beaver who transferred to the Enforcement Unit.

Sean O’Connor was promoted to an Associate Governmental Program Analyst effective July 1, 2009. Sean will continue in his role as the Board’s Outreach Coordinator and develop the monthly newsletter and publications. In association with the growth of our operations, the scope of his responsibilities has expanded in regards to policy analysis and as a performance measurement specialist.

Departures:

Due to budget constraints the Board was unable to retain our retired annuitant and three of our student assistants. These staff members were separated effective June 30, 2009. The Board still employs one student assistant that is responsible for continuing education audits.

Vacancies:

The Board currently has filled all vacant positions.
To: Board Members  Date: September 25, 2009
From: Paul Riches  Telephone: (916) 574-7840
Executive Officer

Subject: Marriage and Family Therapy Bibliography

During the work of the MFT Education Committee, we received consistent feedback from educators that they needed a thorough bibliography addressing recovery oriented practice. Such a resource would provide educators at each program with a valuable stepping off point in developing the new curriculum mandated in Senate Bill 33 (Chapter 26, Statutes of 2009). To address this need, the board entered into an interagency agreement with CSU Northridge to develop such a bibliography. This effort was paid for by Mental Health Services Act funds that were appropriated to the BBS in the 2008-09 Fiscal Year.

Attached to this memo is the draft bibliography for the board’s review.
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DRAFT

ANNOTATED BIBLIOGRAPHY OF RESOURCES
FOR CALIFORNIA MARRIAGE AND FAMILY THERAPY EDUCATORS
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Acknowledgements

Author

Diane R. Gehart, Ph.D., Professor, Marriage and Family Therapy Program, California State University, Northridge.

Diane Gehart is the author of *Mastering Competencies in Family Therapy: A Practical Approach to Theories and Clinical Case Documentation* and *The Complete Marriage and Family Therapy Core Competencies Assessment System*, the co-editor of *Collaborative Therapy: Relationships and Conversations that Make a Difference* and the co-author of *Theory-Based Treatment Planning for Marriage and Family Therapists*. She has also published numerous articles and presents internationally on competency-based education; collaborative, strength-based therapies; mindfulness in therapy; child and family therapy; and philosophical issues in therapy.

Expert Reviewers

The following experts provided consultation for this project.

**Charles Arokiasamy, Rh.D.,** Department Chair and Professor of Rehabilitation Counseling; Counseling, Special Education, and Rehabilitation, California State University, Fresno.

**Chad Costello, MSW,** Director of Public Policy, The Village, Long Beach, California.

**Julie Diaz, M.S., LMFT,** Supervising Mental Health Clinician, Madera County Department of Mental Health.

**Milena Esherick, Ph.D.,** Director, Marriage and Family Therapy Program, Wright Institute.

**Patricia White Lopez, LMFT,** Director of Training, Los Angeles County Department of Mental Health.

Funding

This project was funded by California Mental Health Service Act (MHSA) State Administration dollars.
Purpose of This Bibliography

This annotated bibliography of resources is intended to assist marriage and family therapist (MFT) educators in locating resources to implement the new MFT curricular requirements that will take effect on August 1, 2012 in California. The contents of this bibliography are suggestions only and do not constitute mandatory requirements for MFT educators or students. Deviations from these suggestions do not mean that a course will not meet the new MFT curriculum requirements.

This bibliography is organized by curriculum content areas and provides educators with descriptions of key textbooks, articles, videos, and web resources that they can use in redesigning their curricula to meet the new state standards.

Purpose of the New MFT Curriculum

The BBS describes the purpose of the new curriculum as follows:

The MFT education legislation was developed mainly in response to changes in public mental health required by the Mental Health Services Act (MHSA), passed by voters as Proposition 63 in November 2004. The MHSA is transforming the delivery of public mental health services statewide. Specifically, it requires the development and implementation of client and family driven, integrated, culturally competent, and recovery/resiliency oriented services within a collaborative environment. It requires involving people with mental illness in the system as stakeholders with an equal voice. These new services are guided by a promise to do “whatever it takes” to help people fully recover from mental illness. This transformation demands that those employed in public mental health and related settings have a different perspective and be able to provide different approaches to treatment. (BBS, Statement of Work Bibliography, p. 1).

Organization of Bibliography

The bibliography is divided into two sections: content readings and community resources. The content readings include resources for teaching the new subject areas of the curriculum. The community resources section includes the listing and Internet links to state and county resources, including a listing of county departments of mental health in the state.

The major content areas include:

- Recovery-Oriented Treatment and Community Mental Health
- Substance Abuse, Co-Occurring Disorders, and Addiction
- Documentation
- Evidence-Based Practices and Treatments
- Diversity and Socio-Economic Status
- Law and Ethics
- Pedagogical Resources for Educators
Criteria for Material Selection

The materials in this bibliography were selected on the following criteria:

The selected resource:
- Supports the new BBS curriculum’s emphasis on recovery-oriented treatments and the evidence-base.
- Embodies a strength-based, recovery-oriented, evidence-based, and/or MFT perspective on a given topic (e.g., diversity or substance abuse written from one of these perspectives was selected over other possibilities).
- Provides recent and up-to-date information on a given topic.
- Delivers material in a way that resonates and uses language familiar to MFTs.

In areas that had numerous articles or books on a given subject, such as diversity and substance abuse, the selection was carefully limited based on the above criteria to avoid an unfocused and unwieldy list of resources.

Videos and DVDs

As publishers rarely provide examination copies of videos, most videos were reviewed based on publisher’s descriptions only.

Format for Resources

Each reference includes the following:
- APA Citation or Title
- Description of the resource.
- Website Links: one or more of the following
  - Publisher’s Website is included to assist in locating text in case the direct link to the book’s website is changed by the publisher.
  - Book’s Website provides a direct link to the book’s website to allow instructors to order an examination copy directly from the publisher.
  - Journal’s Website is provided to locate an article; if an educator’s university has a subscription to an electronic copy of the journal, he/she can often download the article for free from the university’s library resources.
Introduction to Bibliography Highlights:

The following list of “highlights” identifies the most uniquely and/or relevant readings related to the new curriculum.

Criteria for inclusion in highlights:

- Comprehensively and/or uniquely covers key areas of content required in the new curriculum.
- Few if any comparable text(s) for covering the same material.

**RECOVERY ORIENTED-TREATMENT**


*Description:* Developed in collaboration with Connecticut’s Department of Mental Health and Addiction Services that received the number one rating from NAMI, this book focuses on the practical elements of implementing recovery-oriented treatment. The text focuses on providing an alternative model to traditional clinical case management and offers tools for practitioners to self-assess their recovery-oriented practices. Recovery concepts are explained in clear, concise language that makes it ideal for those new to the ideas. It includes a list of the Top 10 Concerns about Recovery with responses to each as well as a list of the Top 10 Principles of Recovery-Oriented, Community-Based Care.

*Why a Highlight:* This text stands out as one of the most useful to MFTs by providing a highly informative history that created meaningful links to the clinical work that is the heart of MFT. In addition, the lists of Top 10 Concerns and Top 10 Principles clearly laid out a practical vision for recovery-oriented care.

*Publisher’s Website:* [www.oup.com/us](http://www.oup.com/us)


*Description:* This article describes the basic theories and methods of Community Family Therapy, an approach for treating low-income, urban families that integrates developmental and motivational theories. The model includes three levels of
engagement: (a) personal and family growth, (b) accessing community resources, and (c) leadership and civic action. The article specifically addresses issues of poverty and the socioeconomic context.

*Why a Highlight:* This article is the first to define the practice of community family therapy, providing a clear vision for MFT practice in community mental health contexts. This article should provide a useful bridge for students between MFT practice and community work.

*Journal’s Website:* www.familyprocess.net


*Description:* This free, two-page tri-fold outlines the USDHHS definition of recovery and its ten components.

*Why a Highlight:* This free resource informs students of the broader context of recovery-oriented treatment and provides a formal definition that will shape mental health policy for years to come.


**EVIDENCE-BASED PRACTICE AND TREATMENT**


*Description:* This classic article defines evidence-based practice based on how the term is used in the field of medicine: using research to provide treatment that best meets the needs of each client or family. The article provides a five-step model for implementing evidence-based practice in family therapy as well as a detailed outline to help students evaluate individual research studies for their application with clients.

*Why a Highlight:* This article provides a clear and concise description of evidence-based practice for family therapists, making it a useful text in research and/or fieldwork courses for teaching students how to use research to support their clinical work.

*Journal’s Website:* [www.jmft.net](http://www.jmft.net)

*Description:* This edited volume describes the extensive evidence base for family therapy practice and reviews numerous evidence-based family therapy treatments. The chapters are organized by presenting problem and include: conduct disorders, substance abuse, childhood behavioral and emotional problems, alcohol abuse, marital problems, relationship enhancement, domestic violence, severe mental illness affective disorders, physical disorders, and meta-analysis of MFT interventions.

*Why a Highlight:* This book provides the most comprehensive overview of the evidence-based and research literature, providing a resource for covering the entire evidence-base for the field. It can easily be used in numerous classes, making it a cost-effective text as well.

*Publisher Website:* [www.aamft.org](http://www.aamft.org)


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*Description:* This competency-based textbook teaches family therapy theories using clinical case documentation, including case conceptualization, clinical assessment, treatment planning, and progress notes. The first half of the book covers clinical documentation; the second half covers the major schools of family therapy and includes extensive examples of clinical case documentation for each. The book also includes an introduction to recovery-oriented treatment, evidence-based practice and treatment, common factors models, the evidence base for each theory, philosophical foundations of family therapy, and diversity issues. Grounded in a learning-centered, outcome-based pedagogical model, the book enables programs to measure student learning and includes both case documentation forms and scoring rubrics that are aligned with the nationally defined MFT Core Competencies. This text can be used in theory courses, practical skill, and fieldwork courses to teach case documentation and theories as students move through the curriculum. All clinical forms can be downloaded from the book’s website and used in class activities.

*Why a Highlight:* Written with the new California MFT curriculum in mind, this book covers many of the key elements: evidence-based practice, evidence-based treatment, common factors, recovery, and documentation. The case examples illustrate how MFTs can integrate traditional theories in today’s practice environments and treat severe mental illness and crisis issues. The inclusion of scoring rubrics simplifies the process of measuring student-learning outcomes.
DIVERSITY


*Description:* A classic in family therapy, *Bread and Spirit*, describes a structural, strengths-based approach to working with poor families. In this book, Aponte describes the unique life and relational issues faced by poor and minority families. The text includes specific chapters on “family therapy and the community,” “home/community based services,” “the family-school interview: an ecosystemic approach,” “the negotiation of values in therapy,” “about forgiving,” and “strength and vulnerability.” Numerous case examples and transcripts of sessions are included to illustrate key concepts. Although the evidence-base is not highlighted in this book, the eco-structural approach described is an evidence-based approach for working with families with teens with conduct and/or substance abuse issues.

*Why a Highlight:* Based on the pioneering work of Salvador Minuchin and colleagues in the area of poverty, the work of structural and ecostructural family therapists, such as Aponte, are recognized in the field of mental health as among the best for working with poor and diverse families. The eco-structural model is an evidence-based approach for working with this population.

*Publisher’s Webpage:* [wwnorton.com](http://www.wwnorton.com)


*Description:* A classic in family therapy, this edited volume arguably provides the most comprehensive coverage of ethnicity of any text on the market. The book includes over 53 chapters, each detailing the family dynamics of a unique ethnic group. In particular, this book is indispensable for students working with diverse populations in urban areas as it includes content on ethnic groups not included in many other diversity texts. The book, however, does not directly cover other areas of diversity, such as sexual orientation, socioeconomic status, ability, etc., although religion is generally discussed in relation to ethnicity in most chapters. It also does not address broader issues of cultural theory, which McGoldrick does in *Re-visioning Family Therapy*. Thus, a second text that addresses these additional diversity issues should be included in the curriculum.
Why a Highlight: As the new curriculum requires that MFT education include training in the cultures commonly found in California, standard multicultural texts that cover 5-6 major cultural groups are insufficient. McGoldrick et al.'s text is the only one that covers the range of cultural groups that MFTs regularly work with in California.

Publisher's Website: [www.guilford.com](http://www.guilford.com)


Description: In this substantially revised and updated edition, Minuchin et al. detail a family systems approach to conceptualizing and facilitating change with poor and diverse families. The first half of the book provides a clear theoretical description for family-centered work, including family supportive-skills and procedures for promoting change. In the second half of the book, specific models for working with services systems are presented, including substance abuse and foster care. Finally, a description of family-oriented service systems is presented. In addition to addressing issues of socio-economic class and diversity, the book also provides practical depictions of key public service systems.

Why a Highlight: Cited regularly by professionals in other disciplines, Minchin’s work represents a model for working with the poor and diverse families.

Publisher’s Webpage: [www.guilford.com](http://www.guilford.com)


LAW AND ETHICS


Description: This user-friendly handbook for students clearly describes a) how to obtain a degree in marriage and family therapy that qualifies for licensure, b) how to apply and become a Marriage and Family Therapy Intern, c) how to gain hours of work experience towards the license, and d) how to apply to take the licensing exams. The book includes numerous useful “tips” and suggestions for making the process run smoothly each step of the way. This resource will be helpful in addressing the new requirement that MFT programs provide instruction in the licensing process. Programs may also contact the Board of Behavioral Sciences,
which will generally provide speakers on the topic of licensing to individual programs.

*Why a Highlight:* Published by the licensing board, this is the authoritative resource on the MFT licensing process in California.

*Publisher’s Website:* www.bbs.ca.gov

*Book’s Website:* http://www.bbs.ca.gov/forms.shtml
Introduction to Recovery Oriented Treatment:

The new curriculum calls for integrating principles of recovery-oriented care across the MFT curriculum. Common courses where recovery may be integrated include:

- **Community mental health courses**: Recovery in public mental health.
- **Diagnosis courses**: Recovery approaches to diagnosis; new research on prognosis of severe mental illnesses.
- **Practical skill courses**: Collaborative therapeutic relationship skills; strength-based assessments and interventions.
- **Theory courses**: How to implement traditional theories within in recovery-oriented treatment environments.
- **Law and ethics courses**: Dual relationships, boundaries, etc. in recovery-oriented treatment contexts.
- **Introduction to the profession courses**: International and professional trends related to recovery-oriented mental health and the related consumer trends.

The readings and resources below were selected with these courses in mind, allowing for the possibility of a text to be used in more than one course.

New Curriculum Description:


Diagnosis, assessment, prognosis, and treatment of severe mental disorders. *(BPC § 4980.36(d)(2)(A))*

BOOKS


*Description*: This book provides a comprehensive overview of recovery, its research foundations, consumer experiences, and treatment options, the authors defining recovery as primarily a process. The text includes sections on recovery basic concepts, consumer experiences, diagnosis issues, research issues, and clinical responsibilities. Examples of recovery-based practice from the US, UK, Europe, and Australia are included as are first person narratives from consumers. The text provides an in-depth discussion of the implications of recovery for mental health diagnosis and prognosis as well as measures such as the Recovery Self Assessment, Recovery Knowledge Inventory, and Developing Recovery Enhancing Environments Measure. An e-version of the book is available. Practical implications focus more on issues related
to psychiatry, diagnosis, and psychopharmacology than therapy, making the text appropriate for introductions to community mental health practice rather than clinical skills courses.

Publisher’s Website: www.wiley.com


*Description:* A compendium of previously published research, *Recovery from Severe Mental Illness* provides an excellent overview of the key studies on the subject and includes first person narratives from consumers. The first section of the book explores the research that supports the move to a recovery paradigm, while the second section reviews studies that support the theory that schizophrenia is a clinical syndrome rather than a disease. This book has a strong research focus, yet the information is foundational to this new area of work, making it a good text for introducing the rationale for recovery-oriented treatment of severe mental health disorders.

Publisher’s Website: http://www.bu.edu/cpr/products/books/index.html

Book’s Website: http://www.bu.edu/cpr/products/books/titles/rsmi-1.html


*Description:* Developed in collaboration with Connecticut’s Department of Mental Health and Addiction Services that received the number one rating from NAMI, this book focuses on the practical elements of implementing recovery-oriented treatment. The text focuses on providing an alterative model to traditional clinical case management and offers tools for practitioners to self assess their recovery-oriented practices. The “practical” element is geared more at the larger system rather than therapeutic techniques. Recovery concepts are explained in clear, concise language that makes it ideal for those new to the ideas. It includes a list of the Top 10 Concerns about Recovery with responses to each as well as a list of the Top 10 Principles of Recovery-Oriented, Community-Based Care.

Publisher’s Website: www.oup.com/us

Book’s Website:
http://www.oup.com/us/catalog/general/subject/Medicine/PsychiatryPsychology/?view=usa&ci=9780195304770

Description: This book reports on the long-term, cross-national study sponsored by the World Health Organization on schizophrenia with over 1000 subjects in 14 countries. The data from this project has provided much of the impetus for rapid adoption of the recovery movement. The most significant outcome of this series of studies was to disprove the long-held assumption that schizophrenia is a chronic and deteriorating condition; instead, this study demonstrated that outcomes are heterogeneous and diverse, with an average of half of all persons diagnosed with the illness achieving meaningful recovery. The detailed research findings may make this text daunting for some students, but it nonetheless provides depth to class discussions of recovery.

Publisher's Website: www.oup.com/us

Book's Website:
http://www.oup.com/us/catalog/general/subject/Medicine/PsychiatryPsychology/?view=usa&ci=9780195313673


Description: A well-organized text that lays a foundation for understanding recovery by providing an overview of empowerment, powerlessness, individual rights, and coercion as it relates to persons diagnosed with severe mental illness. The book describes how to empower consumers with specific chapters on treatment planning, housing, organizational decision making, planning and policymaking, employment, research, and service provision. The focus is on the broad level of conceptualization of empowering consumers and identifying large system organizations and practices that promote this goal. This book also provides a practical introduction to the various elements of case management from a recovery orientation. Treatment planning addresses case management issues and is covered at a more theoretical than practical level (i.e., few examples). Additionally, this text provides an introduction to the larger context of mental health services in the US.

Publisher's Website: www.oup.com/us

Book's Website:

Description: This edited volume provides a comprehensive review of the theories and research related to recovery-oriented treatment, with an emphasis on schizophrenia. Chapter topics include “recovery as a consumer vision and research paradigm,” “research methods for exploring and assessing recovery,” “findings from long-term follow-up studies of schizophrenia,” “sociological models of recovery,” “recovery from schizophrenia: a criterion-based definition,” “verbal definitions and visual models of recovery,” “qualitative studies of recovery,” “mutual help groups and recovery,” “a consumer-survivor model of healthy from childhood sexual abuse,” and “recovery from addiction and from mental illness.” Either in its entirety or using selected chapters, this text may be useful for introducing the foundations of recovery-oriented treatment in community mental health or diagnosis courses.

Publisher's Website: www.apa.org/books

Book's Website: http://books.apa.org/books.cfm?id=4316038


Description: Drawing upon the perspectives of consumers, this book describes how mental health professionals can approach treatment with those diagnosed with severe mental illness, emphasizing the importance of social inclusion and acceptance. Part 1 of the book addresses the lived experience of those diagnosed with severe mental illness and introduces the concept of recovery. Part 2 describes how mental health professionals can most meaningfully support persons in recovery, addressing barriers to forming a therapeutic relationship, creating hope, and facilitating personal adaptation. Part 3 provides guidelines for promoting social inclusion, such as developing services that promote access and social connection. The final section addresses issues of power, discrimination, and involvement of consumers in the mental health system.

Publisher's Website: www.us.elsevierhealth.com

Book's Website: http://www.us.elsevierhealth.com/product.jsp?isbn=9780702026010

ARTICLES


Description: A seminal piece in the field, this article describes the essential services in a recovery-oriented system as well as identifies the key principles that define recovery-
oriented treatment. In addition, Anthony defines recovery as it applies to the treatment of severe mental illness and compares it to substance abuse and disability approaches. This article provides an introduction to recovery, its key principles, and implementation issues. Numerous charts and graphs make the concepts accessible to the reader.

**Journal’s Website:**


**Description:** This two-page article is packed with practical advice about how to create a service environment more recovery friendly. Tips include creating a welcoming entry, specific recovery-focused consumer surveys, and designing physical space that acknowledges the personhood of all involved. This short piece can help students reflect on less obvious factors that impact treatment, and may be useful in community mental health or practical skills courses.

**Journal’s Website:** www.gale.cengage.com/


**Description:** This article describes a study that investigated program costs and community functioning of individuals discharged from mental institutions. The study reports on the purpose of discharging patients, evaluation of residential and vocational status of patients discharged, the importance of program support for maintaining independent living, and the ability of patients to maintain residential gains during hospital transition project.

**Journal’s Website:** http://www.bu.edu/cpr/prj/


**Description:** This article reports on the outcomes of a qualitative study of lived experience of people in recovery from severe mental illness, providing therapists with an “insider’s perspective” of what matters in the process of recovery. The analysis includes quotes from consumers about their personal experiences of recovery, highlighting themes of “having a normal life,” “just doing it,” “making life easier,” and “being good to yourself.” Consumers in the study described recovery occurring within the context of “normal” environments and activities. The discussion section explores the benefits of conceptualizing mental health problems as an integrated part of a person’s life.
Breeding, J. (2008). To see or not to see “schizophrenia” and the possibility of full “recovery.” *Journal of Humanistic Psychology, 48*, 489-504.

*Description:* In a harsh critique of current practices, Breeding argues that the current view of schizophrenia (and other serious mental health illnesses) as an “illness” has had grave consequences. He includes controversial evidence, including reviews of court cases related to antipsychotic medications and discusses non-medical treatments with case study evidence. Although this article has a strong, clear anti-establishment agenda, its primary point, that how we view schizophrenia is useful for students to reflect upon when learning about diagnosis.


*Description:* This article carefully delineates the definitions of recovery in various contexts, including the definitions that have evolved from WHO research projects on schizophrenia and the consumer-based recovery movements. Davidson and colleagues express their concerns that recovery may become a shibboleth, or frequently cited term that denotes insider status with no significant practical meaning. More specifically, Davidson et al. argue that the lack of consensus around the term recovery has led to inconsistent practical implications. They provide definitions of recovery from physical disorders, trauma, addictions, and mental illness. Davidson and colleagues also warn practitioners about the dangers of giving recovery lip service without substantively changing practice.


*Description:* This article details the findings of a quantitative study that compared competitive work, community-based activities, and no regular daily activities with persons diagnosed with chronic mental illness. Consumers engaged in competitive work reported and observers noted significantly higher levels of wellbeing and functionality. Surprisingly, there was no difference between consumers enrolled in community-based activities and those with no daily activities scheduled.

*Description:* In this short but information-dense article, Gagne et al. argue that recovery in the fields of mental health and addictions share more similarities than differences. The article includes a comparison chart that illustrates the similar values, principles, and strategies in both approaches to recovery. It also contains rich citations to recovery literature that include writings by persons in recovery and the longitudinal studies that provide the initial research foundation for recovery. The discussion of similarities of recovery in both disciplines can help students build a shared framework for working with these two populations.


*Description:* In this relatively short article, Farkas et al. attempt to bridge the gap between recovery-oriented approaches to severe mental illness and evidence-based approaches by using recovery as a “value base” for evidence-based treatments. They detail a model that addresses theoretical, practical, and programmatic issues.


*Description:* In this classic family therapy article, Haley discusses the limitations of organic, psychodynamic, systems, and double-bind theories for working with youth diagnosed with schizophrenia and instead discusses recovery for therapists from these unhelpful theories. He concludes by identifying contemporary practices that have been found to be more effective and/or a theory courses to relate MFT practices to recovery. Although 30 years old, this article clearly outlines the concerns that have given rise to the recovery movement in mental health and also identifies the types of solutions promoted by its proponents. Written by a founder in the field, this article clearly identifies MFT’s central role in recovery-oriented contexts and provides a theoretical foundation for such work.

*Description:* The article reports on findings from a randomized control study of a recovery-oriented treatment program in Israel. Consumers in the recovery-oriented program demonstrated significantly improved progress toward personal goals compared to those in treatment-as-usual programs. Both groups showed improved coping; neither group showed improved social support. The mixed findings provide fertile ground for class discussion on future limits and potentials of recovery-oriented treatment.

*Journal’s Website:* [http://psychservices.psychiatryonline.org](http://psychservices.psychiatryonline.org)


*Description:* This article provides an overview of how religious orientation can be used to support the recovery process in the area of mental health, emphasizing how both recovery and religious approaches emphasize the potential of change during times of difficulty. The article includes an analysis of five interviews with consumers. The themes identified in the interviews were self-esteem, empowerment, hope, community connections, and comfort. Hugen’s discussion of religious orientation and recovery in mental health provides an alternative to the more common and structured use of religion in addiction recovery, emphasizing how a consumer’s religious beliefs can be used in a variety of ways to support his/her unique journey.

*Journal’s Website:* [http://www.worldcat.org/oclc/61124454](http://www.worldcat.org/oclc/61124454)


*Description:* This article argues for a narrative approach to recovery and understanding experiences of people with severe mental illness. Drawing on the work of Jerome Bruner, the author describes how the narrative approach to creating a life narrative that is coherent and provides meaning is an invaluable tool for recovery-oriented treatment and discusses strategies for addressing dominant discourses related to severe mental illness. Although it does not draw from the narrative literature most familiar to family therapists, this article describes how narrative, collaborative, and postmodern approaches can be used in family therapy to address the life narratives of persons with severe mental illness from a recovery perspective.

*Journal’s Website:* [http://www.psychiatricnursing.org](http://www.psychiatricnursing.org)


Description: This article clarifies several myths related to treating older adults with mental illness and outlines 12 principles for treatment promoted by the Older Adult Consumer Mental Health Alliance. Miller offers practical guidelines for working with this unique population.

Available:


Description: This article reviews the current literature on recovery from severe mental illness and identifies key elements across models using an ecological framework that takes into account the individuals and their contextual barriers. The concepts outlined in this article provide a comprehensive overview of the broader implications of recovery-oriented treatment.

Journal's Website: http://www.bu.edu/cpr/prj/


Description: Grounded in postmodern and narrative theories, Roberts argues that recovery-oriented care needs to keep narratives of client experience at the heart of treatment and that overemphasis on the evidence base risks obscuring the personhood of consumers in treatment. He includes a discussion of the construction of narratives about psychopathology, therapy as narrative, narratives of recovery, and qualitative research.

Journal's Website: http://apt.rcpsych.org/


Description: Roberts and Wolfson provide a definition of recovery for persons with severe mental illness that emphasizes the process of personal discovery and includes a comparison chart contrasting principles in the recovery and medical models. The article also provides an operational definition of recovery from schizophrenia as well as a useful description of clinically relevant practices that characterize recovery-based treatment. Although written for psychiatrists, the authors describe guidelines for recovery-oriented practice for all mental health professionals, including the role of the professional, the significance of hope, timing of interventions, uses of...
medication, risk sharing, etc. This article is a practical reading for courses on community mental health or psychopharmacology.

*Journal's Website:* http://apt.rcpsych.org/


*Description:* This brief introductory editorial to the inaugural issue of *Early Intervention in Psychiatry* provides an overview of the potentials and limits of early prevention in the treatment of psychosis, including some hopeful statistics along with realistic cautions. This article emphasizes the potential of *prevention* and *early intervention* in recovery-oriented treatment.

*Journal's Website:* http://www.wiley.com/bw/journal.asp?ref=1751-7885&site=1


*Description:* This short but provocative article strongly cautions mental health care providers about the possibility of the notion of recovery, arguing that the common understanding of the term (that the person will be back to “normal”) is often misleading and may be counterproductive. A counter-voice in the recovery dialogue, this article offers a reminder to avoid an overly simplistic view of recovery and points out that full recovery from severe mental illness is difficult and not always an attainable goal.

*Journal's Website:* http://pb.rcpsych.org/

### FEDERAL PUBLICATIONS


*Description:* Commissioned by SAMHSA, this paper outlines a plan for how consumers can catalyze a transformation of the mental health system from an institutional culture to one of recovery by creating a consumer-led National Recovery Initiative. It addresses how to develop and finance services needed for recovery-oriented care. This highly technical paper outlines numerous goals and initiatives, and the reading is more technical than is typical in graduate level courses. Nonetheless, it can be added to reading lists on community mental health and consumer advocacy to introduce students to the latest developments in this area.


*Description:* This publication is the final report of the President’s New Freedom Commission on Mental Health, which recommended that the U.S. formally adopt recovery-oriented services in public mental health. This extensive report is divided into six major sections that address the following goals: (a) Americans understand that mental health is essential to overall health, (b) mental health is consumer and family driven, (c) disparities in mental health services are eliminated, (d) early mental health screening, assessment, and referral to services are common practices, (e) excellent mental health care is delivered and research is accelerated, and (f) technology is used to access mental health care and information. This highly technical and detailed report provides students with the political foundations of the recovery movement in the U.S.


*Description:* This free, two-page tri-fold outlines the USDHHS definition of recovery and its ten components.


**JOURNALS**

**Community Mental Health Journal**

*Description:* This journal is written for mental health professionals who work in community settings and includes numerous articles and research studies on recovery-oriented programs and practices.


**Journal of Psychiatric Rehabilitation**

*Description:* The *Journal of Psychiatric Rehabilitation* includes numerous articles on recovery oriented treatment and research in every volume. It is written for a range of mental health professionals.

*Website:* [http://www.bu.edu/cpr/prj/](http://www.bu.edu/cpr/prj/)
REFERENCE LISTS

Board of Behavioral Sciences

_Description:_ The California Board of Behavioral Sciences is compiling resources for MFT educators on its webpage that includes resources on the legislation status, recovery-oriented care, substance abuse, and the mental health workforce. This resource list provides links and downloads of various presentations, unpublished articles, websites, and government publications.

_Website:_ http://www.bbs.ca.gov/bd_activity/mftEducCommUpdate.shtml

Online Reference Guide for Recovery

_Description:_ A thirteen-page reference list of online and standard recovery resources, this list includes readings for both practitioners and consumers.

_Website:_ http://mhrecovery.com/resources.htm

www.bbs.ca.gov/pdf/mhsa/resource/recovery/recovery_oriented_resources.pdf

_Description:_ This reference list on recovery covers topics such as advance directives, employment, dual diagnosis, peer run drop-in centers, recovery, resilience stigma, homeless, and evidence-based practices. It also includes links to websites and readings.

_Website:_
www.bbs.ca.gov/pdf/mhsa/resource/recovery/recovery_oriented_resources.pdf

ONLINE RESOURCES

Building a Culture of Recovery

_Description:_ With resources for consumers and professionals, this website describes a Canadian-based program for transforming mental health culture to be more recovery-oriented. It includes numerous readings, models, and links related to recovery, with an emphasis of transforming mental health culture.

_Website:_ www.cultureofrecovery.org

CASRA: California Association of Social Rehabilitation

_Description:_ This website has content resources that define recovery and social rehabilitation as well as announcements of training, workshops, and advocacy on
recovery in California. The site includes a link to eLearning resources and certificate programs in rehabilitation.

Website: http://www.casra.org/

California Network of Mental Health Clients

Description: A consumer-run group, CNMHC hosts a website that provides free resources to mental health consumers in California, including newsletters for and by consumers, announcements for events for consumers, and other publications on recovery.

Website: www.californiaclients.org

Center for Psychiatric Rehabilitation

Description: A leading research and training center in recovery, the website for the Center for Psychiatric Rehabilitation at Boston University has numerous resources for faculty, students, and practitioners on the subject of recovery. The center supports the work of William Anthony and colleagues.

Website: http://www.bu.edu/cpr/about/

Fountain House

Description: Website for one of the premiere recovery-oriented programs in the United States, this resource describes the organization’s history, theory of recovery, programs, and training opportunities with links to related resources.

Website: http://www.fountainhouse.org

National Alliance on Mental Illness: NAMI

Description: The NAMI website has extensive resources related to severe mental illness and recovery, including information on mental health disorders for consumers, trainings and conventions, as well as links to state, local, and national resources. NAMI has numerous resources for MFT educators teaching in the area of severe mental illness. In particular, local NAMI organizations can often arrange for opportunities for students to meet with consumers, a requirement of the new curriculum.

Website: www.nami.org

National Empowerment Center

Description: This website has numerous resources on recovery, including videos and books for purchase, listings of consumer-run groups, articles, and program listings.
National Institutes of Mental Health

*Description:* The NIHM website has numerous resources on federally sponsored programs and research related to recovery, including numerous grant opportunities and the results of federally funded studies on recovery-based practices. The site also has links to numerous publications on recovery.

*Website:* [www.nimh.nih.gov](http://www.nimh.nih.gov)

Program for Recovery and Community Mental Health

*Description:* Housed at Yale University and directed by Larry Davidson, the website for the Program for Recovery and Community Mental Health provides numerous resources on research and projects supported by the program.

*Website:* [http://www.yale.edu/PRCH/about/index.html](http://www.yale.edu/PRCH/about/index.html)

SAMSHA Free Resources Webpage

*Description:* On this website you can download free pamphlets, brochures, and DVDs from SAMSHA.


Stamp Out Stigma

*Description:* This website provides educational material aimed at ending the stigma associated with severe mental illness and provides a list of related resources.

*Website:* [www.stampoutstigma.com](http://www.stampoutstigma.com)

The Village: Mental Health America

*Description:* Located in Long Beach, the Village is a model recovery program in the United States. The Village is operated by Mental Health America, which has projects throughout the country. The webpage contains numerous resources, including a description of their programs, philosophy, services, and trainings. The Village offers trainings that faculty and students can attend and provides an opportunity for students to meet with consumers to learn about their experiences of recovery.

*Webpage:* [www.mhala.org/mha-village.htm](http://www.mhala.org/mha-village.htm)
VIDEOS/DVDs

* Examination copies were unavailable for videos or DVDs marked with an asterisk (*) due to company policies; thus, the evaluation is based on published description of the resources.


Description: In this 30-minute DVD that accompanies the book, *Toward a Vision of Recovery*, William Anthony, a leader in the recovery movement, describes the vision of recovery for persons diagnosed with severe mental illness. The DVD targets mental health professionals and consumers.

Publisher’s Webpage: www.bu.edu/cpr


Description: Targeting mental health workers, this is a 60-minute video of Patricia Deegan describing the process of recovery from mental illness.

Website:


Description: This 70-minute video was created by ex-patient filmmakers Pat Deegan and Terry Strecker and reports the stories of eight people who had histories of institutionalization and made the transition to recovery and community living.


Description: In this 46-minute video, Dan Fisher describes his journey of recovery after being diagnosed with schizophrenia at age 25. He eventually recovered, earned a medical degree, became a psychiatrist, and currently directs the National Empowerment Center.

*Description:* This major motion picture depicts the life of John Nash, a brilliant mathematician who was diagnosed with schizophrenia. The movie depicts his triumphs and struggles and how he was able to win the Noble Prize for his work.

*Video’s Website:* http://www.abeautifulmind.com


*Description:* This 95-minute video features Scott Miller who demonstrates how to create a therapeutic relationship using client strengths to facilitate change.


*Description:* Created by a psychiatrist, this dramatic monologue captures the lived reality of schizophrenia and is scripted to increase practitioner understanding and empathy.


*Description:* This 91-minute video shares three different views of recovery from severe mental illness, featuring Ed Knight, Sheila La Gaey, and Nancy Kehoe.


*Description:* Targeting people with severe mental illness and promoting a recovery perspective, this 39-minute video includes first-hand accounts of three people living schizophrenia and one with schizoaffective disorder.

*Publisher’s Website:* www.guilford.com

*DVD’s Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/livingwith.htm&dir=videos/psych&cart_id=239610.19538
Client Advocacy, Case Management, and Systems of Care

Introduction to Client Advocacy, Case Management, and Systems of Care

The new curriculum requires course content on client-centered advocacy, which refers to helping clients identify and successfully access community and social resources. These activities, sometimes referred to as case management, require that MFTs understand the systems of care, both public and private, for the severely mentally ill in their communities and that MFTs know how to work collaboratively with other professionals. A comprehensive list of community resources in California is included as part of this bibliography to enable educators to acquaint their students with national, state, and local resources.

New curriculum description:

Performing client-centered advocacy including researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and supports for clients or groups of clients receiving psychotherapy or counseling services. (BPC § § 4980.03(b) and 4980.36(d)(1)(B)(ii))

How to connect people with resources that deliver the quality of services and support needed in the community. (BPC § 4980.36(d)(1)(B)(iv)(V))

Systems of care for the severely mentally ill. (BPC § 4980.36(e))

Public and private services and supports available for the severely mentally ill. (BPC § 4980.36(e))

Community resources for persons with mental illness and for victims of abuse. (BPC § 4980.36(e))

Advocacy for the severely mentally ill. (BPC § 4980.36(e))
Case management. (BPC § 4980.36(e))

Collaborative treatment. (BPC § 4980.36(e))

Also see National, State, and County Resources.

BOOKS


Description: This book provides a comprehensive overview of current case management practice, including the evolution and history and definition of practice. Specific case management skills are introduced, including defining one’s role as a case manager, interviewing skills used in case management, specialized case management skills, and applications with special populations.

Publisher’s Website: [www.lyceumbooks.com](http://www.lyceumbooks.com)

Book’s Website: [http://lyceumbooks.com/icasemgt.htm](http://lyceumbooks.com/icasemgt.htm)


Description: This book prepares students for working in human service organizations by providing a detailed account of the organizational structure and functioning of these large systems. The text addresses issues such as human service organizations, the roles of various parties, the power structure, work conditions, and changing environment. Written with social workers in mind, this book describes many of the practical realities of working large human service organizations, helping to prepare students with knowledge and realistic expectations of working in these systems. The text can be used in whole or part in community mental health courses.

Publisher’s Website: [www.lyceumbooks.com](http://www.lyceumbooks.com)

Book’s Website:


Description: This text provides a strength-oriented approach to case management and includes detailed descriptions of the history, research base, and principles of this approach. Rapp and Goscha include chapters on building a therapeutic relationship, strengths assessment, personal planning, and resource acquisition. It provides a
history and an overview of case management but does not provide details on how to find specific resources.

Publisher’s Website: www.oup.com/us

Book’s Website:


Description: This edited volume provides a comprehensive overview of community mental health history, highlighting the Community Mental Health Act of 1963, treatment of vulnerable populations, and the impact of September 11 on community mental health. The book includes sections on recovery and consumer movement, best practices in community mental health, community mental health with underrepresented populations (e.g., oppressed groups generally, GBTLQ, African-American, Chinese-American, Hispanic), treatment with the homeless, and organization and policy issues. It is one of the few texts to directly address service needs of diverse populations.

Publisher’s Website: www.routledge.com

Book’s Website: http://www.routledge.com/books/Community-Mental-Health-isbn9780415950114


Description: This book provides a comprehensive overview of how mental health practitioners can collaborate with medical and other professionals. The text is divided into four sections: routine collaboration, intensive collaboration, clinical examples, and collaboration in the real world. Specific guidelines are provided for private practice, primary care medical practice, managed care, primary care mental health, and crisis services.

Publisher’s Website: www.apa.org/books

Book’s Website: http://books.apa.org/books.cfm?id=4317152&about=yes


Description: In this text, Spindel presents an empowerment-based approach to case management. She defines empowerment as a process in which the social service worker interacts with consumers to reduce their feelings of powerlessness and
stigma. The text has a workbook feel that goes into detail on issues such as what consumers describe as helpful, empowerment philosophies, ethical considerations, consumer advocacy, and community building.

Publisher’s Website: Self published. Available at Amazon.com.

Book’s Website: http://www.amazon.com/Management-Empowerment-Perspective-Patricia-Spindel/dp/0968815030/ref=sr_1_1?ie=UTF8&s=books&qid=1242168251&sr=8-1


*Description:* This book provides a comprehensive overview of community mental health systems using an ecological and prevention model. The text includes a history of community mental health, explanation of deinstitutionalization, introduction to managed care, discussion of evidence-based trends, and detailed program evaluation strategies.

Publisher’s Website: www.pearsonhighered.com

Book’s Website: http://www.pearsonhighered.com/educator/academic/product/0,3110,0205486657,00.html

**ARTICLES**


*Description:* This article describes the pragmatics of client advocacy in marriage and family therapy practice, using a case study to provide a description of the effects of advocacy on consumers. Specific guidelines for how to conduct client advocacy are included.

*Journal’s Website:* http://www.ifta-familytherapy.org/journal.html


*Description:* One of the few articles on the subject that targets therapists, this article details a solution-focused approach to case management for recovery from severe mental illness. The article provides a brief but detailed overview of case management, reviews common factors in recovery practice, and defines a strength-based
perspective for case management. Greene et al. also detail specific solution-focused strategies that can be used in case management, including specific questions and techniques for facilitating the process.

Journal’s Website: http://www.familiesinsociety.org/


Description: Drawing on solution-based and narrative therapies, motivational interviewing, appreciative inquiry, and signs of safety approach to child protection work, Madsen presents a five-step model for collaborative family-centered practice. This approach emphasizes cultural curiosity, enhancing family resourcefulness, working in partnership with families, and making clinical work accountable to those served. Numerous example questions and detailed interventions are provided to illustrate clinical applications.

Journal’s Website: www.familyprocess.org


Description: This article reviews thirteen studies of consumer involvement in the evaluation of their case management. The findings of the study include that consumer experiences of recovery were inadequately assessed and the discussion encourages practitioners to increase consumer involvement in their own case management.

Journal’s Website: http://psychservices.psychiatryonline.org

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**Recovery-Oriented Skills and Treatments**

**Introduction to Recovery-Oriented Skills and Treatments**

The new curriculum requires that MFT programs include instruction in recovery-oriented methods of service delivery. While few texts have been specifically written on micro-skills in “recovery” oriented mental health, the field of MFT has numerous resources within its core literature base that competently achieves this end. In fact, the field of MFT arguably has the most extensive, long-standing, and well-developed therapeutic methods for promoting recovery.

Recovery-oriented methods emphasize the following:

- Developing a collaborative working relationship
- Promoting consumers’ agency in their journeys of recovery and lives more generally
• Maintaining a non-pathologizing view of human behavior
• Harnessing consumer strengths to achieve goals

The texts below have been selected based on these criteria.

New Curriculum Description:
Integrate the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, among others. (Business and Professions Code [BPC] § 4980.36(c)(1)(B))

BOOKS


Description: This book describes a collaborative, dialogical approach to therapeutic relationships, which is characterized by working alongside clients in their journeys of transformation. Avoiding textbook techniques, collaborative therapy focuses on creating relationships in which clients feel heard and regain a sense of agency and autonomy. The book covers the historical and philosophical foundations of collaborative therapy and describes the guiding principles for inviting clients to co-explore their situation. Collaborative therapy relies more on a philosophical stance than technique to promote change, thus the book focuses on theoretical descriptions of the work rather than descriptions of micro-skills.

Publisher’s Webpage: http://www.perseusbooksgroup.com/basic/home.jsp

Book’s Webpage:


Description: This edited volume includes a highly accessible description of collaborative therapy as well as its applications in therapy, community, educational, and research settings. Of particular interest is the chapter by Haarakangas, Seikkula, Alakare, and Aaltonen, Finnish therapists who have used a collaborative-based recovery-oriented approach with psychotic patients that has resulted unprecedented recovery rates from schizophrenia. Other chapters cover a wide range of clinical issues and contexts in which collaborative therapy has been successfully implemented.

Publisher’s Webpage: http://www.routledge.com/

Book’s Webpage: http://www.routledge.com/books/Collaborative-Therapy-isbn9780415953276

*Description:* Drawing on evidence-based practices, evidence-based treatments, common factors research, and outcome research, Bertolino describes a detailed integrative helping model for developing strengths-based, collaborative partnerships with clients. The text teaches the specific skills needed to build a collaborative therapeutic relationship, engage clients in an active partnership, determine a direction for treatment, motivate clients for change, help clients change their viewing and doing related to the problem, and support clients in transitioning out of therapy. The text draws heavily on solution-based and collaborative approaches to therapy.

*Publisher's Website:* http://www.pearsonhighered.com

*Book's Website:* http://www.pearsonhighered.com/educator/academic/product/0,3110,0205569048,00.html


*Description:* This introductory skills textbook is one of the first to use a competency, strengths-based perspective, teaching the micro-skills of collaborating with clients. In addition to covering the common factors research, the text provides practical instruction in creating a collaborative therapeutic relationship, collaboratively setting strength-based goals, assessing for strengths and resiliency, avoiding iatrogenic injury during assessment, changing the viewing of problems, changing the doing of problems, and changing contextual propensities associated with the problem. Furthermore, Bertolino and O'Hanlon discuss how to respond to various setbacks, amplify change, and end therapy successfully. Numerous transcripts are used to illustrate interventions.

*Publisher's Website:* www.pearsonhighered.com

*Book's Website:* http://www.pearsonhighered.com/educator/academic/product/0,3110,0205326056,00.html


*Description:* This edited book provides a strength-based, community approach to working with children with severe disorders and their families. The text covers a wide range of intervention approaches, such as case management, wrap around services, multisystemic therapy, treatment foster care, mentoring, family education and also addresses special education, substance abuse, psychopharmacological interventions, and community policy.

35

*Description:* This solution-focused introductory skills text describes a collaborative, strengths-based approach to working with clients. Chapters cover solution-focused micro-skills such as basic interviewing skills, attending to what the client wants, amplifying what clients want, identifying exceptions and strengths, formulating feedback for clients, and measuring client progress. In addition, the text includes specific chapters on working with involuntary clients, interviewing in crisis situations, measuring outcomes, professional values and diversity, and issues in diverse work contexts.

Publisher’s Website: http://www.cengage.com/highered/


*Description:* This text provides a detailed overview of common factors approach to therapy advocated by Miller, Duncan, and colleagues. Specifically, the book examines the practical aspects of implementing a client-directed, outcome-informed approach to therapy using ultra-brief measures of client progress available for free download on their webpage: www.talkingcure.com.

Publisher’s Website: www.josseybass.com


*Description:* One of the few texts of its kind, this book is a strength-based (solution-oriented) approach for working with severe mental illness. The book outlines key arguments and research that support a hopeful approach to chronic and severe
mental illness and also provides a comprehensive treatment philosophy and approach. The text includes chapters on “rewriting spoiled identity stories,” “revaluing people’s experiences,” “collaborating with clients, their families, and others in their social environment,” “handling dangerous and violent situations,” “effective and respectful treatment of ‘borderline’ clients,” “relapse recovery and prevention,” and “general principles for working with chronic and severe mental illness.”

Publisher’s Website: www.wiley.com


Description: In this short, thought-provoking piece, Watzlawick uses literary references, historical anecdotes, exercises, and clinical examples to illuminate how both common and severe forms of psychopathology are often self-fulfilling prophesies that we unwittingly buy into and perpetuate. This piece explains the non-pathologizing foundations of systemic and strategic therapies in a language that is more accessible than many other writings on the topic.

Publisher’s Website: www.wwnorton.com

Book’s Website: None.


Description: This classic family therapy text describes a non-pathologizing approach to working with client problems. The first half of the text examines linguistic and relational patterns that contribute to problem formation; the second half identifies established techniques and strategies that can be used for problem resolution.

Publisher’s Website: www.wwnorton.com

Book’s Website: http://www.wwnorton.com/NPB/nppsyxch/001104.html
VIDEOS/DVDs

*Examination copies were unavailable for videos or DVDs marked with an asterisk (*) due to company policies; thus, the evaluation is based on published description of the resources.*

Alexander Street Videos.

*Description:* This online collection of over 300 counseling and psychotherapy videos includes several videos on strength-based micro-skills, such as interviews by Insoo Berg and other solution-focused and narrative therapists.

*Publisher’s Website:* [www.alexanderstreet.com](http://www.alexanderstreet.com)


*Description:* Based on de Jong and Berg’s work, this DVD demonstrates interviewing skills discussed in the text of the same title.


*Description:* The first disk of this three CD-ROM set includes an overview of the major MFT theories with links to related websites and clips from major theorists. Disk two introduces Client-Focused Family Therapy, which, similar to solution-focused approaches to assessing client motivation, is an approach to adapting one’s style to match the family based on their “cooperation style.” The final disk follows a family therapy case from the referral to termination.


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**Recovery-Oriented Group Treatments**

**Introduction to Recovery-Oriented Group Treatments**

This section provides resources for common recovery-oriented group treatments, including psychoeducational groups and peer groups.

**New Curriculum Description:**

BOOKS


*Description:* Supported by a strong and consistent research base, this text provides a step-by-step psychoeducational curriculum for families with a schizophrenic member. It focuses on a comprehensive and preventative treatment to psychosis that actively involves and educates the family. Topics covered include connecting with the family, psychoeducational workshop outline, the first year out, social and vocational rehabilitation, relapse prevention, and administrative issues.

*Publisher’s Website:* www.guilford.com

*Book’s Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/anderson.htm&dir=pp/acpp&cart_id=228359.15730


*Description:* This treatment manual provides an overview of the social skills training evidence-base, assessment strategies, teaching strategies, practical issues of starting a group, and troubleshooting common problems. A curriculum for teaching social skills is provided, including conversational, assertiveness, conflict management, communal living, friendship, dating, health maintenance, vocational, and coping skills. The text also addresses using the curriculum when working with consumers who abuse substances.

*Publisher’s Website:* www.guilford.com

*Book’s Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/bellack.htm&dir=pp/acpp&cart_id=228359.15730


*Description:* An edited volume, this book provides detailed descriptions of numerous peer programs for the severely mentally ill, including programs in the Mental Health Client Action Network in Santa Cruz, the Friends Connections in Philadelphia, and Building Recovery of Individual Dreams through Education and Support in Tennessee. The text emphasizes practices and concepts that make these groups effective.

*Publisher’s Website:* http://www.vanderbiltuniversitypress.com/


*Description:* This self-help book can be used with individuals or in groups to develop a personal wellness recovery action plan (WRAP). The development of a WRAP includes a wellness “toolbox,” a daily maintenance plan, trigger identification, list of early warning signs, and crisis plans. The book includes detailed instructions on various tools, such as relaxation exercises, journaling, diet, exercise, creativity, and peer groups.

*Publisher’s Website:* www.mentalhealthrecovery.com

*Book’s Website:* http://www.mentalhealthrecovery.com/shop/index.php


*Description:* McFarlane’s book presents a practical guide to his evidence-based approach to family psychoeducation. Divided into three sections, the book presents (a) an overview of the theoretical and research foundations for multifamily groups with severe mental illness, (b) a detailed description of the practice and curriculum of these psychoeducational groups, and (c) applications with other disorders and populations, family-aided assertive community treatment (ACT), bipolar, major depression, borderline personality disorder, obsessive compulsive, and medical disorders.

*Publisher’s Website:* www.guilford.com

*Book’s Website:* http://www.guilford.com/cgi-bin/cartsctipt.cgi?page=pr/mcfarlane2.htm&dir=pp/fac&cart_id=551102.1807


*Description:* Written for consumers and their families, this workbook provides resources for understanding mental illness and recovery, increasing control, managing life stressors, enhancing personal meaning, building personal support, and setting personal goals. Practitioners can also purchase the corresponding *Leader’s Guide,* designed for leading groups or workshops. This book is integrated into the Center for Psychiatric Rehabilitation’s series of books and DVDs on recovery. A Spanish version is also available.

*Publisher’s Webpage:* www.bu.edu/cpr

*Book’s Webpage:* http://www.bu.edu/cpr/products/curricula/recovery.html
ARTICLES


*Description:* This study explored the effects of a minimally guided peer support group for people with psychosis. The results indicated that these groups had a positive effect on social support, self-efficacy, and quality of life, especially for “high attenders.”

*Journal’s Website:* http://www.wiley.com/bw/journal.asp?ref=0001-690x


*Description:* In this article, Cohen and Graybeal outline how solution-focused techniques can be used in mutual aid groups (self-help groups) to shift from problem-saturated discourse to solution-oriented discourse.

*Journal’s Website:* http://www.aaswg.org/journal-subscription


*Description:* This article describes the outcomes of a cognitive-behavioral group designed for persons diagnosed with severe mental illness and posttraumatic stress disorder. Those consumers who finished treatment improved significantly in regards to PTSD symptoms and other mental health symptoms. The results include a discussion of feasibility and clinical benefits of such groups.

*Journal’s Website:* http://www.springer.com/medicine/psychiatry/journal/10597

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**Home and Community-Based Therapy**

**Introduction to Home and Community-Based Therapy**

When preparing students for working in recovery-oriented environments and public mental health more generally, instructors should include instruction on in-home and community-based therapy models, increasingly preferred practice contexts when working with the severely mentally ill and lower socio-economic consumers.

**New Curriculum Description:**
Integrate the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, among others. (Business and Professions Code [BPC] § 4980.36(c)(1)(B))

BOOKS


*Description:* This book describes a solution-focused approach to family-based programs in children’s welfare. Family-based programs were developed as an alternative to foster care when possible. The text addresses the unique issues of establishing a therapeutic relationship with these mandated families, defining the problem in situations where the referring county agencies and families disagree, setting goals and defining a contract, conducting family sessions, and designing interventions for this specific population.

*Publisher’s Website:* www.wwnorton.com

*Book’s Website:* http://www.wwnorton.com/orders/nph/070162.htm


*Description:* This text teaches family therapists how to transfer what they know to working with families in their homes and communities, skills that are increasingly used in recovery-oriented public mental health. Divided into four sections, the first part of the book discusses issues of culture, race, and socioeconomic status. The second section details home-based therapy with specific chapters on children, teens, and families; the third covers working in schools and community settings. Finally, the authors review the evidence based for in-home and community interventions.

*Publisher’s Website:* www.guilford.com

*Book’s Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/boyd-franklin3.htm&dir=pp/fac&cart_id=551102.1807


*Description:* This solution-focused book details a strengths-oriented approach to working with children and families in the child protective service system. Berg and Kelly describe how to provide hopeful services, beginning with the first phone call. They offer specific tools and techniques for this population, including a chapter on how investigation can be used as intervention and prevention opportunities. Numerous appendices provide additional support, including client handouts, focus group processes, and worker/supervisor surveys.

Description: This book describes a strength-focused, evidence-based approach to home-based services using the ecosystemic structural family therapy approach used at the Philadelphia Child and Family Therapy Training Center, which was founded by Salvador Minuchin. With a clear practical focus, this text describes the theoretical foundations, assessment, treatment planning, and intervention aspects of the model as well as addressing the evaluation of treatment outcomes. The appendices include numerous clinically useful resources, including a satisfaction survey, follow-up survey, agency satisfaction survey, permission for video taping release, strength-based behavior checklist, release of information, and attendance confidentiality statement.

Publisher's Website: www.wwnorton.com
Book's Website: http://www.wwnorton.com/orders/npbC/070310.htm


Description: This edited volume provides a coherent approach for working with families involved in public mental health systems, emphasizing a strength-based approach for helping the family successfully navigate the system. Chapter topics include theoretical foundations of family-based services, ecosystemic conceptual framework, cultural competencies, assessment, goal setting, developmental issues, home-based services, and extended family involvement.

Publisher’s Website: http://cup.columbia.edu/

ARTICLES


Description: Coffey describes a postmodern ecosystemic approach to Wraparound Service Delivery that promotes family resilience. Drawing on the work of Auerswald as well as Goolishian and Anderson, Coffey describes combining ecosystemic and
collaborative language system approaches to support families receiving public mental health services. The article emphasizes the quality and types of conversations needed between caregivers and families to promote better outcomes. Numerous studies and programs are cited and reviewed.

*Journal’s Website*: www.familyprocess.org


*Description*: This article describes the basic theories and methods of Community Family Therapy, an approach for treating low-income, urban families that integrates developmental and motivational theories. The model includes three levels of engagement: (a) personal and family growth, (b) accessing community resources, and (c) leadership and civic action. The article specifically addresses issues of poverty and the socioeconomic context.

*Journal’s Website*: www.familyprocess.net

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**Disaster, Trauma, and Resilience**

**Introduction to Disaster, Trauma, and Resilience**

The new curriculum calls for instruction in community disaster and trauma response as well as training in resiliency models for recovering from trauma. As a discipline with a long history of system-based and strength-based models, family therapists have many resources from within the discipline for teaching this material.

**New curriculum description:**

*Disaster and trauma response. (BPC § 4980.36(e))*

*The broad range of matters and life events that may arise within marriage and family relationships and within a variety of California cultures, including instruction in all of the following: (BPC § 4980.36(d)(2)(C)(iii, viii-∞))*

- Effects of trauma.

*An understanding of resilience, including the personal and community qualities that enable persons to cope with adversity, trauma, tragedy, threats, or other stresses. (BPC § 4980.36(d)(2)(G))*
BOOKS


*Description:* A comprehensive text on trauma intervention, this book provides an overview of diagnosis, models of treatment, empowering interventions, traumatic stress debriefing, group work for trauma victims, community interventions, and secondary trauma. In addition, the book includes specific chapters on working with children, interpersonal violence, political refuges, and terrorism. Emphasizing real world skills, the book also includes handouts and instructions for interventions such as breathing exercises, client safety worksheet, progressive muscle relaxation, and counselor self-care.

*Publisher’s Website:* [www.sagepub.com](http://www.sagepub.com)

*Book’s Website:* [http://www.sagepub.com/booksProdDesc.nav?prodId=Book227704](http://www.sagepub.com/booksProdDesc.nav?prodId=Book227704)


*Description:* This edited text addresses the unique challenges of providing counseling services to individuals, children, and families affected by crisis and disasters. Individual chapters cover topics such as community-based crisis counseling in Africa, children and crisis, families affected by hurricanes, older adults and natural disasters, needs of displaced disaster survivors, federal government and disaster response, spiritual dimensions of disaster counseling, dislocation and relocation, and rural communities in crisis. Additional chapters examine practical implementation issues encountered when providing therapy services after Hurricane Katrina, September 11, and Virginia Tech.

*Publisher’s Website:* [www.sagepub.com](http://www.sagepub.com)


*Description:* This classic text presents a comprehensive solution-focused approach to working with sexual abuse, an outstanding example of recovery-oriented treatment. The text emphasizes the importance of hope and utilizing client resources. The majority of the book describes highly practical interventions for treating a wide range of common sexual abuse issues, such as dealing with unsupportive family members, dissociation, safe remembering, relating to one’s body, and relapse prevention.

*Publisher’s Website:* [www.wwnorton.com](http://www.wwnorton.com)

*Description:* With a forward by Paul Watzlawick, this book describes brief therapy techniques for people experiencing crisis, trauma, and disaster. Divided into two sections, the book has one section on crisis, which includes chapters on domestic violence, child abuse, hospitalization, and suicide, and another section on trauma, which covers child sexual assault, disasters, violence, and adult rape. Each section includes chapters on assessment and treatment strategies.

*Publisher's Website:* [www.routledge.com](http://www.routledge.com)

*Book's Website:* [http://www.routledge.com/books/Strategic-Interventions-for-People-in-Crisis-Trauma-and-Disaster-isbn9780415950718](http://www.routledge.com/books/Strategic-Interventions-for-People-in-Crisis-Trauma-and-Disaster-isbn9780415950718)


*Description:* A classic on the subject, this book covers a comprehensive overview of crisis counseling across the lifespan and addresses cross-cultural differences in response to crisis. The book is divided into three sections: (a) understanding the practice of crisis intervention, (b) crisis related to developmental and situational states, and (c) suicide, violence, and catastrophic events. Specific chapters address the psychology of crisis, helping people in crisis, family and community involvement, stress of developmental life stages, workplace violence, suicide, disaster, and violence. The book also warns against pathologizing “normal” responses to war and discusses the intersection of individual healing and the broader socio-political context.

*Publisher's Website:* [www.routledge.com](http://www.routledge.com)


*Description:* This solution-oriented book describes a hopeful and strength-based approach to treating trauma. The text details specific techniques for building a safe, respectful relationship using permission, validation, and inclusion and for intervening with common trauma symptoms, such as dissociation, devaluing of self, self-harm, and flashbacks. O’Hanlon and Bertolino provide numerous techniques for helping clients more toward a more hopeful future while acknowledging past realities.

Description: Extensively revised in response to September 11, this comprehensive edited text with 32 chapters provides up-to-date crisis counseling models and discusses a broad range of specific populations and situations. The book is divided into six sections: (a) an overview of treatment models and approaches, (b) disaster mental health and crisis intervention, (c) crisis assessment and intervention with children and youth, (d) crisis intervention with violence, (e) crisis intervention with health and mental health issues, and (e) evidence-based practices and research. The book provides strength-based, solution-oriented, and evidence-based models of crisis intervention.


Description: This recently revised classic family therapy text, describes the family resilience approach and how it applies in a diverse society. Divided into four sections, this book begins by defining resilience and describes a model for use with individuals and families. The second section identifies key family processes that characterize resilience, including belief systems, organization patterns, and community processes. The third section addresses practical applications, both in traditional therapy and community-based programs. In the final section, Walsh discusses resilience in the context of loss, chronic illness, multistressed families, disasters, and reconciliation.


Description: In addition to discussing typical signs and symptoms of trauma after a
disaster, this article presents a three-phase multimodal treatment model for working with children after a natural disaster and includes cognitive-behavioral therapy, play therapy, and family play therapy.

Journal’s Website:  
http://www.informaworld.com/smpp/title~content=t713722633~db=all


*Description:* Citing research on trauma, Bannink argues that trauma need not be as debilitating as is often assumed. Therapists can reduce the impact of trauma by highlighting sources of resilience and possibilities for posttraumatic growth. The article provides specific exercises for use in session to promote resiliency, discusses specific treatment interventions, and uses interesting stories and case examples to illustrate points.

Journal’s Website: http://brief-treatment.oxfordjournals.org/


*Description:* This article describes the philosophical foundations and practice strategies of Linking Human Systems, a resiliency-based approach to helping individuals, families, and communities facing crisis, trauma, and disaster. Specific interventions for working with individuals, families, and communities are detailed.

Journal’s Website: www.jmft.net


*Description:* In this article, Walsh outlines a strength and resiliency-based model for working with families and communities dealing with traumatic loss and major disasters, identifying risk factors for maladaptation as well as strategies for facilitating resiliency in numerous contexts. She identifies several successful programs and uses case examples to illustrate interventions.

Journal’s Website: http://www.familyprocess.org/


*Description:* Drawing on developmental, systemic, and resiliency perspectives, this article describes a framework for working with a broad range of clients experiencing crisis and trauma. The article details an approach that encourages resilience through
meaning making, positive outlook, and spirituality.

*Journal’s Website:* http://www.smith.edu/ssw/admin/studies.php


*Description:* This article discusses treatment of families after a disaster or terrorist attack, emphasizing how it necessarily differs from standard treatments designed to treat dysfunctional family patterns. A case illustration is included to provide practical guidelines.

*Journal’s Website:* http://www3.interscience.wiley.com/journal/31171/home

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**Meeting with Consumers and Their Families**

**Introduction to Meeting with Consumers and Their Families**

The new curriculum includes the requirements that programs provide students with an opportunity to meet with consumers and their families to learn about their experiences of mental illness, treatment, and recovery. To supplement these meetings, educators can also include readings of first-person accounts of severe mental illness.

**New curriculum description:**

*Provide students with the opportunity to meet with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.* *(BPC § 4980.36(c)(5))*

**BOOKS**


*Description:* Based on an extensive qualitative study using a postmodern approach privileging participants’ voices, Cohen has collected first-person narratives of consumer's experiences of institutional and home treatment of severe mental illness in the UK. Topics include experience of illness, psychiatric treatment, recovery, and self-coping techniques such as drug taking, spiritualism, alternative healing, sleep, and watching television. In addition to consumer narratives, the book also includes a short history of mental illness and psychiatry, an overview of postmodern approach to narrative, and a detailed description of crisis intervention and home treatment as it relates to the study.

*Publisher’s Website:* www.palgrave.com

*Book’s Website:* http://us.macmillan.com/narrativesofmentalhealth

*Description:* In this book, twelve members of the Fountain House, a highly successful treatment program for severe mental illness, document their stores of recovery and beyond. Each chapter describes the journey of one consumer, highlighting the challenges and solutions each found to living with mental illness.

*Publisher's Webpage:* http://www.hazelden.org/web/landing.view

*Book's Webpage:* None


*Description:* This book describes the experience of in-patient care from the perspective of both consumers and professionals. The majority of the book is dedicated to describing the experiences of consumers, carers, and mental health professionals, touching on a wide spectrum of experiences ranging from humiliation to appreciation. The afterword identifies things professionals can do to make in-patient care a better experience.

*Publisher's Website:* www.routledge.com

*Book's Website:* http://www.routledge.com/books/Experiences-of-Mental-Health-In-patient-Care-isbn9780415410823


*Description:* Divided into four sections, this book reviews the history and launches thought-provoking critique of treating severe mental illness in the United States from 1750 to the present. Written by an award-winning journalist, this book scrutinizes the treatment of schizophrenia and uses comparative international research to support his claim that “treatment” in the United States has been used to silence persons diagnosed with severe mental illness.

*Publisher's Website:* http://www.perseusbooksgroup.com/basic/about_us.jsp

ARTICLES


*Description:* This phenomenological study examined the experiences of 45 adults with severe mental illness in the recovery process. Results address reintegration in the community, relationships with family and friends, relationships with the case management, and the relationship with oneself as well as barriers to social inclusion. The discussion of results emphasizes the unmet needs of consumers and practice implications.

*Journal’s Website:* http://qsw.sagepub.com/


*Description:* This article describes a recovery-oriented approach to shared decision making related to the issue of psychiatric medications. The article describes the conflicts and problems related to medications reported by persons with chronic mental health problems and proposes a model for supporting consumers in deciding how medications can best support them in recovery.

*Journal’s Website:* http://www.bu.edu/cpr/prj/


*Description:* This article reports on a consumer satisfaction study in a recovery-oriented treatment program for severe mental illness. The most striking finding of the study was that “staff teaching efforts” (psychoeducation) related to medication, illness management, substance abuse, outpatient living, and living skills were most highly correlated with consumer satisfaction.

*Journal’s Website:* http://www.springer.com/medicine/psychiatry/journal/10597


*Description:* This article presents a qualitative analysis of one consumer’s experience of recovery, including a detailed discussion of what worked in therapy, the role of medications, and dealing with the mental health system.

*Journal’s Website:* http://www.psychosocial.com/

*Description:* In this article, two consumer leaders describe their own experiences with recovery, highlighting the role of hope, personal responsibility, education, advocacy, and peer support. The article also addresses issues related to medication, therapeutic relationships, attitudes of mental health service workers, learned helplessness, and personal safety. Specific recommendations for symptom relief are included.

*Journal’s Webpage:* http://www.springer.com/medicine/psychiatry/journal/10597

**DATABASE OF CLIENT NARRATIVES**


*Description:* A unique product, Sage Publications and Alexander Street Publishing have jointly released a database that includes therapy transcripts, client narratives, and referenced works. The transcripts are fully searchable and new content is constantly added. It includes over 40,000+ pages of first person accounts of therapy as well as over 2,000 previously unpublished therapy transcripts.

*Publisher’s Webpage:* www.sagepub.com

*Database Webpage:* http://www.sagepub.com/db.nav
Introduction to Substance Abuse, Co-Occurring Disorders and Addictions

The new curriculum includes extensive and specific requirements in the area of addictions. In particular, training co-occurring disorders (simultaneous diagnosis of substance abuse and mental health disorders) is emphasized. In most programs, this content will be included in a single course on substance abuse and addictions, but it may also be taught across several courses.

New curriculum description:

Substance abuse, co-occurring disorders, and addiction, including, but not limited to, instruction in all of the following: (BPC § 4980.36(d)(2)(I))

- The definition of substance use disorders, co-occurring disorders (a mental illness and substance abuse diagnosis occurring simultaneously in an individual), and addiction.
- Medical aspects of substance use disorders and co-occurring disorders.
- The effects of psychoactive drug use.
- Current theories of the etiology of substance abuse and addiction.
- The role of persons and systems that support or compound substance abuse and addiction.
- Major approaches to identification, evaluation, and treatment of substance use disorders, co-occurring disorders, and addiction, including, but not limited to, best practices.
- Populations at risk with regard to substance use disorders and co-occurring disorders.
- Community resources offering screening, assessment, treatment, and follow up for the affected person and family.
- Recognition of substance use disorders, co-occurring disorders, and addiction, and appropriate referral.
- The prevention of substance use disorders and addiction.

Alcohol and Substance Abuse and Addiction


Description: The first solution-focused book on working with drinking, this book describes the approach developed at the Brief Family Therapy Center, which emphasizes client strengths, practical steps, and client motivation. Berg and Miller describe how common solution-focused techniques can be successfully used with persons struggling with drinking. Miller wrote a book for consumers based on the same topic, The Miracle Method: A Radically New Approach to Problem Drinking.

Publisher’s Website: www.wwnton.com

Book’s Website: http://www.wwnton.com/orders/npcb/070134.htm

*Description:* This treatment manual describes how to use solution-focused therapy with persons needing to manage substance abuse issues. The text is highly pragmatic, with specific interventions and numerous case examples. A companion videotape is available that demonstrates the relational approach and techniques described in the book.

*Publisher’s Website:* www.wwnorton.com

*Book’s Website:* http://www.wwnorton.com/NPB/nppych/70260X.html


*Description:* Using a recovery-orientation and based on their research with families, this book details a four-stage developmental model for families recovering from alcohol dependence. The stages are (a) drinking, (b) transition for couples and families, (c) early recovery, and (d) on-going recovery. In addition, the text includes sections on assessing family functioning and identifying resources that promote recovery. Case studies of families in transition and early recovery are used to illustrate the process. Their model incorporates the use of AA, advocates for abstinence, and distinguishes abstinence from recovery.

*Publisher’s Website:* www.guilford.com

*Book’s Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/brown5.htm&dir=pp/addictions&cart_id=894740.3542


*Description:* This treatment improvement protocol (TIP) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) was designed to provide practitioners with best practices guidelines for treatment of substance abuse. Based on the strong evidence base, this monograph describes how clinicians can more effectively involve families in substance abuse treatment to improve outcomes. The TIP describes an integrated treatment model and discusses specific diversity issues, including age, gender, sexual orientation, race, ethnicity, cognitive ability, co-occurring diagnoses, and rural populations.


*Description:* Using a narrative therapy approach, Diamond describes a unique approach to working addictions. The book includes discussions of harm-reduction approaches, twelve-step approaches, and spirituality as it relates to a narrative-based approach to addictions and includes numerous written and narrative-based interventions for all phases of addictions treatment. Special interventions for food addictions, trauma, children, adolescents, and families are addressed as well as a discussion of therapists in recovery.

*Publisher’s Website:* www.guilford.com

*Book’s Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/diamond4.htm&dir=pp/addictions&cart_id=956154.7261


*Description:* This highly practical text provides a comprehensive overview of conceptualizing the treatment of alcoholism. Providing a balanced perspective, the book addresses physiological, psychological, and sociological theories of alcoholism as well as an overview of diverse treatment philosophies and approaches, specifically addressing recovery-based models. In addition, the Lawsons provide detailed chapters on working with the family, including topics such as viewing the family as the client, diagnosis, violence, sexual dysfunction, divorce, children of alcoholics, art therapy, and treatment of the spouse. The book also covers evaluation of treatment, models for public health, and prevention.

*Publisher’s Webpage:* www.proedinc.com


*Description:* A comprehensive book on chemical dependency treatment, this text covers a wide range of issues, including the role of chemical dependency counselors, legal and ethical issues, the counseling process, consumer assessment, group counseling options, family therapy options, diversity issues, aftercare, the harm reduction model, and reluctance to recover. The book contains several useful questionnaires for assessment and treatment of alcohol and drug abuse/use as well as an excellent section on common questions with answers.

*Publisher’s Webpage:* www.proedinc.com

*Description:* Designed for therapists in practice, this book provides an evidence-based approach to working with youth and adults who abuse substances. Each treatment chapter provides a detailed step-by-step guide for intervention, lists of indicators and contra-indicators, case examples, and additional resources. Clinical approaches covered include motivational interviewing, youth and family treatments, and adult cognitive behavioral approaches.

*Publisher's Website:* [www.wiley.com](http://www.wiley.com)


*Description:* This classic text describes the systemic dynamics of alcoholic families. In addition to discussing prevalence and diagnosis, the book outlines a three phase developmental model of how an alcoholic family develops, reorganizes, and copes. Steinglass also includes chapters on how behavior is regulated within the system and the effects on individual growth and development. A chapter describing treatment options is included.

*Publisher’s Website:* [www.perseusbooksgroup.com/](http://www.perseusbooksgroup.com/)


**ARTICLES**


*Description:* This chapter reviews the evidence-base for family therapy interventions that address alcohol abuse. The article/chapter includes a review of numerous evidence-based couple and family treatments for alcohol abuse, including models for when the alcoholic resists treatment and when the alcoholic seeks treatment.


*Description:* This article/chapter reviews the evidence-base for family therapy interventions that address substance abuse. It includes treatments for substance-abusing adolescents—including Brief Strategic Family Therapy, Functional Family Therapy, Multisystemic, and Multidimensional Family Therapy—and treatments for adults, including Behavioral Couples Therapy.


*Description:* This study compares solution-focused group therapy with a traditional problem-focused approach for level 1 substance abusers. The results indicated that participants in the solution-focused group score significantly higher on the Beck Depression Inventory and Outcome Questionnaire following treatment. The article also distinguishes solution-focused treatment from motivational enhancement therapies. An outline of the therapy session format is included in the article.


*Description:* Yeager adapts Roberts’ seven-stage crisis intervention model for use with mentally ill substance abusers using a solution-focused, strength-based perspective. The first half of the article discusses at length the larger context of mental illness treatment, including rates of mental illness, its impact on health care costs, and broad system effects. Numerous case studies illustrate points throughout the discussion.

*Description:* The text outlines an “integrated” model for treating persons dually diagnosed with mental illness and substance abuse. The text includes chapters on assessing substance abuse, axis I and axis II disorders, motivation enhancement, adolescent treatment, and family involvement.

*Publisher’s Website:* www.guilford.com

*Book’s Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/evans.htm&dir=pp/addictions&cart_id=894740.3542


*Description:* This book provides an overview of how to design services for persons diagnosed with co-occurring disorders. Chapters include a history of co-occurring treatment, essential program features, identifying the target population, planning and implementing services, hiring staff, supervising staff, day-to-day program management, and operating within a larger system.

*Publisher’s Website:* www.routledge.com


*Description:* *Treating Co-Occurring Disorders* is a comprehensive text that covers definitions, history, theories, philosophies, assessment, individual treatment, family treatment, psychoeducation, relapse prevention, recovery orientation, supervision, systems issues, and outcome measurement. The text focuses on practical applications for clinicians.

*Publisher’s Website:* www.routledge.com

*Book’s Website:* http://www.routledge.com/books/search.asp

*Description:* This text provides a comprehensive overview of treating persons with dual diagnoses and includes an overview of dual diagnosis, assessment, individual approaches (including case management and motivational interviewing), group interventions (including social skills and self help groups), and family approaches (including family collaboration and multifamily groups). Additionally, residential programs, involuntary interventions, vocational rehabilitation, psychopharmacology, and research are addressed. The appendices include educational handouts for consumers, assessment instruments, and other forms.

*Publisher’s Website:* www.guilford.com

*Book’s Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/mueser.htm&dir=pp/addictions&cart_id=239610.19538


*Description:* This edited volume provides a comprehensive overview of dual diagnosis treatment. Divided into three sections, the book addresses a) the contemporary context of dual diagnosis treatment and its history, including consumers’ perspectives; b) treatment issues, including risk assessment, motivational interviewing, psychological interventions, polysubstance abuse, personality disorders, elderly persons, and women; c) international perspectives, policies, and development, including an overview of treatment in North America, Australasia, and Europe.

*Publisher’s Website:* www.wiley.com


**ARTICLES**


*Description:* Reporting on a focus-group student with 35 consumers, this article describes consumers’ perspectives of co-occurring disorder treatment. The analysis yielded four significant themes: system barriers, factors facilitating recovery, consumer challenges, and specific treatment needs. The article includes a discussion of practical implications for clinical practice.

*Journal’s Website:* http://www2.criminology.fsu.edu/~jdi/

*Description:* Reviewing four large-scale studies on women with co-occurring disorders, Brown and Melchior identify specific needs of different subpopulations within this treatment group, such as victims of violence and those with postpartum depression. They review the effectiveness of specific interventions and make recommendations for improved treatment in the future.


*Description:* In this review of the literature, Hawkins provides an overview of co-occurring disorder treatment with adolescents. Her discussion includes a review of treatment models and outcomes; overview of epidemiology, etiology, and characteristics; specific considerations for treating adolescents with co-occurring disorders; barriers to treatment; and best practice strategies.

*Journal’s Website:* [http://arjournals.annualreviews.org/loi/psych?cookieSet=1](http://arjournals.annualreviews.org/loi/psych?cookieSet=1)


*Description:* This article reports on the findings of a qualitative study on the use patterns of dually diagnosed patients with bipolar and substance use disorders. Results included five thematic categories: experimenting in the early illness, living with serious mental illness, enjoying the effects of substances, feeling normal, and managing stress. The conclusions highlight the idiosyncratic patterns of substance use in the persons interviewed.


*Description:* This article reviews and critiques the current studies on psychosis and co-occurring substance use disorders. It identifies the promising treatments, which include motivational interviewing, contingency management, relapse prevention, cognitive-behavioral therapy, case management, and skills training. The article also
discusses the importance of well-coordinated care regardless if the treatment follows an integrated or parallel treatment approach.

Journal’s Website:
http://www.informaworld.com/smpp/title~content=t713723043~db=all


Description: This article reports on an interview-based study that examined the prevalence, patterns of onset, and demographic covariates for dual diagnosis in the U.S. Latino population. The study reports on differences between immigrants and native-born Latinos and well as Latinos and the general population.

Journal’s Website:
http://www.elsevier.com/wps/find/journaldescription.cws_home/506052/description#description

Behavioral Addictions

BOOKS


Description: In this book, Grant addresses disorders currently classified as impulse control disorders, such as pathological gambling, kleptomania, trichotillomania, intermittent explosive disorder, and pyromania, as well as other proposed disorders, such as compulsive Internet use, compulsive sexual behavior, and compulsive buying. The book includes definitions of the disorders, models for understanding impulse control, co-morbidity with drugs and alcohol, etiology, assessment, treatment, role of the family, and legal issues.

Publisher’s Website: www.wwnton.com

Book’s Website: http://npbcatalog.com/nppych/070521.html
ARTICLES


*Description:* This article reports on two studies that evaluated self-esteem, anxiety, flow, and importance of Internet use. The results indicated that low self-esteem, anxiety, and importance of Internet activities were positively correlated with problematic Internet use. The article concludes with a theory to guide future research on problematic Internet use.


*Description:* This article provides a DSM-like description of compulsive sexual behavior, including its prevalence, etiology, prognosis, associated psychological disorders, medical complications, and research findings.


*Description:* This article presents three case studies that illustrate the obsession, compulsion, and consequences of compulsive cybersex as well as describes a model for comprehensive treatment that would include relapse prevention, intimacy enhancement, arousal reconditioning, dissociative states therapy, and coping skills training.


*Description:* This article reviews the literature related to compulsive, impulsive, and addictive models of hypersexual disorders and proposes a model with three components of sexual addiction: (a) emotional dysregulation, (b) behavioral addiction, and (c) cognitive dyscontrol.


_Description_: This article reviews the evolving body of literature on Internet addiction, outlining two schools of thought: one that proposes that Internet addiction merits classification as a psychiatric disorder and another that identifies certain individuals as having problematic Internet use related to a specific area, such as email or pornography.

*Journal’s Website:*  
http://www.elsevier.com/wps/find/journaldescription.cws_home/759/description#description

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**Harm Reduction Model**

**BOOKS**


_Description_: This book provides a thorough overview of the harm reduction model, including its principles, history, and moral issues. Denning presents a treatment model that includes a multidisciplinary assessment, motivational interviewing, and dual diagnosis applicability. Numerous clinical cases are used to illustrate treatment options, and extensive appendices provide practitioners with useful resources for treatment and further training.

*Publisher’s Website:* [www.guilford.com](http://www.guilford.com)


_Description_: This edited volume provides a comprehensive overview of the harm reduction model, including an overview of principles and global applications; use with alcohol, smoking, substance abuse, and sexual behaviors; strategies for use with diverse communities; and implications for federal policies.

*Publisher’s Website:* [www.guilford.com](http://www.guilford.com)


*Description:* This book provides an overview of the harm reduction model and a review of ten case studies treated by different therapists to illustrate the potentials of the model. The book focuses on how harm reduction can be used to dramatically reduce the negative consequences of alcohol and substance use for persons who refuse to quit.

*Publisher's Webpage:* http://www.rowmanlittlefield.com/aronsonp/aboutus/


**ARTICLES**


*Description:* This classic article on the subject introduces the harm reduction model, how it developed, how it works, and why it is becoming a major approach to treating addictions. The article emphasizes the pragmatic and compassionate foundations of the approach and identifies the four basic assumptions of the model: (a) it is a public health alternative to the disease or criminal models, (b) it recognizes abstinence as the ideal outcome but accepts the alternative of reduced harm, (c) it has emerged as a consumer-driven model, and (d) it promotes a “low threshold” access to services.


*Description:* This article describes how a harm reduction approach to treating substance abuse can be used to expand treatment options and thus broaden the range of consumers who would/could seek substance abuse treatment. The article cites and reviews the outcomes of harm reduction studies in the area of substance abuse and argues that this model has the potential to benefit a large number of persons who have not benefited from traditional abstinence-based treatment.

*Journal's Website:* http://www.journalofpsychoactivedrugs.com/

*Description:* Proposing that harm reduction is an orientation rather than intervention strategy, this article reviews empirical research studies on harm reduction interventions for alcohol abuse and dependence. The article includes a review of the history of harm reduction, behavioral interventions, goal setting, self-help options, pharmacological interventions, harm reduction psychotherapy, and resources for further reading and research.

*Journal's Website:*  
http://www.elsevier.com/wps/find/journaldescription.cws_home/600949/description#description

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### Motivational Interviewing


*Description:* This book describes the popular substance abuse technique of motivational interviewing for use with a wide range of psychological disorders including dual diagnosis, gambling, eating disorders, depression, obsessive disorders, schizophrenia, and suicide, making it broadly applicable in MFT.

*Publisher's Website:* www.guilford.com


*Description:* This classic text provides an overview of motivational interviewing, a supportive, non-confrontational approach to motivating people to make difficult changes. The method has been widely used in alcohol and substance abuse treatment. The book includes chapters on its applications with youth, couples, dual diagnosis, criminal justice systems, and groups.

*Publisher's Website:* www.guilford.com


Description: This booklet details a three-phase motivational interviewing model for working with alcohol abuse developed by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and includes sections on how to deal with treatment setbacks, assessment, risk factors, and consumer feedback.

Publisher’s Website: www.niaaa.nih.gov

Book’s Website: http://pubs.niaaa.nih.gov/publications/match.htm

<table>
<thead>
<tr>
<th>Substance Abuse and Co-Occurring Disorder Websites</th>
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<tbody>
<tr>
<td><strong>NIAAA: National Institute on Alcohol Abuse and Alcoholism</strong></td>
</tr>
<tr>
<td>Description: NIAAA’s website has extensive resources on alcohol abuse and dependence research, including professional and consumer education materials, reports on research trials, and national statistics.</td>
</tr>
<tr>
<td>Website: <a href="http://www.niaaa.nih.gov">www.niaaa.nih.gov</a></td>
</tr>
<tr>
<td><strong>NIDA: National Institute on Drug Abuse</strong></td>
</tr>
<tr>
<td>Description: NIDA’s website has extensive resources on substance abuse research and treatment, including information for youth, parents, teachers, medical professionals, and Spanish speakers.</td>
</tr>
<tr>
<td>Website: <a href="http://www.nida.nih.gov/">http://www.nida.nih.gov/</a></td>
</tr>
<tr>
<td><strong>SAMHSA: Substance Abuse and Mental Health Services Administration</strong></td>
</tr>
<tr>
<td>Description: SAMHSA’s website provides extensive resources on substance abuse and mental health treatment, including the treatment of children and families, co-occurring disorders, disaster response, evidence-based practices, faith-based initiatives, and workforce development. The site also lists current grant opportunities through SAMHSA.</td>
</tr>
<tr>
<td>Website: <a href="http://www.samhsa.gov/">http://www.samhsa.gov/</a></td>
</tr>
<tr>
<td><strong>SAMHSA (Substance Abuse and Mental Health Services Administration) Co-Occurring Center for Excellence</strong></td>
</tr>
<tr>
<td>Description: Sponsored by the National Substance Abuse and Mental Health Services Administration, the Co-Occurring Center for Excellence provides a wide range of</td>
</tr>
</tbody>
</table>
resources to practitioners and agencies, including assessment information, treatment planning, treatment approaches, and recent research findings.

Website: http://coce.samhsa.gov

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**Videos/DVDs**

*Examination copies were unavailable for videos or DVDs marked with an asterisk (*) due to company policies; thus, the evaluation is based on published description of the resources.*

**Alexander Street Videos**

*Description:* This online collection of over 300 counseling and psychotherapy videos includes 13 videos for working with addictions, covering topics such as the harm reduction model, motivational interviewing, cultural issues, micro skills, and couples.

*Publisher's Website:* www.alexanderstreet.com


*Description:* In this video, Berg and Reuss demonstrate the interventions in their book of the same title with several different clients.

*Publisher's Website:* www.wwnorton.com

*Video's Website:* http://npbcatalog.com/nppsy/70260X.html


*Description:* In this video, Dr. Marlatt demonstrates Relapse Prevention, a cognitive-behavioral approach to helping clients avoid substance abuse relapse. This series of three videos follows the course of treatment over six sessions with a man in his 30s working on overcoming cocaine addiction.

*Publisher's Website:* www.apa.org/videos

*Video Website:* http://www.apa.org/videos/4310805.html


*Description:* In this 1 hour 55 minute video, Marlatt demonstrates a session using harm reduction therapy with a heroin-addicted client who is considering a methadone
program. Jon Carlson and Judy Lewis interview Marlatt about his model and his reflections on the session.

*Publisher’s Website: www.psychotherapy.net

*Video Website: http://www.psychotherapy.net/video/marlatt_harm_reduction


*Description:* In this 1 hour 42 minute video, Miller demonstrates motivational interviewing in a session with a man who is considering changing his alcohol and smoking habits. The video includes an interview of Miller by Jon Carlson and Judy Lewis before and after the session in which Miller describes his approach and shares his reflections on the session.

*Publisher’s Website: www.psychotherapy.net

*Video Website: http://www.psychotherapy.net/video/miller_motivational_interviewing
Introduction to Documentation

The new curriculum requires that university programs include professional writing, specifically treatment plans, progress notes, and documentation of services, in their curriculum. Historically, much of the documentation training has occurred at fieldsites, as each site has its own documentation forms. However, with the passage of HIPAA, national standards and regulations for documentation have been established, creating greater uniformity of content if not form.

New curriculum description:
Professional writing, including documentation of services, treatment plans, and progress notes. (BPC § 4980.36(d)(1)(B)(iv)(IV))

BOOKS


Description: This treatment planning text is designed for recovery-oriented mental health and substance abuse treatment in public mental health systems. It includes the recovery-oriented definition of “person-centered care,” which is not grounded in existential-humanistic therapy but consumer-oriented mental health. Written for practitioners, the text includes a chapter on assessment and understanding the client's narrative as well as chapters on setting goals, specifying objectives, and designing interventions.

Publisher's Website: http://www.elsevierdirect.com/brochures/academicpress/

Book's Website: http://www.elsevierdirect.com/product.jsp?isbn=9780120441556


Description: This competency-based textbook teaches family therapy theories using clinical case documentation, including case conceptualization, clinical assessment, treatment planning, and progress notes. The first half of the book covers clinical documentation; the second half covers the major schools of family therapy and includes extensive examples of clinical case documentation for each. The book also includes an introduction to recovery-oriented treatment, evidence-based practice and treatment, common factors models, the evidence base for each theory, philosophical foundations of family therapy, and diversity issues. Grounded in a learning-centered, outcome-based pedagogical model, the book enables programs to measure student learning and includes both case documentation forms and scoring rubrics that are aligned with the nationally defined MFT Core Competencies.

**Description:** Presenting treatment planning from a recovery perspective, this book is divided into three sections: a) the foundations of care planning, including ethical issues, therapeutic risk, and organizational considerations; b) personal experiences of care planning, including perspectives from practitioners and consumers, and c) an overview of how to provide recovery-oriented care planning, including engagement, assessment, promoting inclusivity, and evaluation.

**Publisher's Website:** [www.wiley.com](http://www.wiley.com)


**Description:** Jongsma and colleagues offer an extensive series of treatment planners, progress note planners, homework planners, and handout planners. The treatment planning series includes specific books on severe and persistent mental illness, family therapy, couples psychotherapy, and addictions.

**Series Website:** [www.jongsma.com](http://www.jongsma.com)


**Description:** This textbook provides a comprehensive and detailed overview of documentation standards and practices in mental health. The book has four sections: (a) the importance of record keeping in psychotherapy, (b) the clinical record, (c) documentation of safety issues, and (d) special topics relevant to record keeping, which includes treatment of minors, access to records, and retention of records.

**Publisher's Website:** [http://www.sagepub.com/home.nav](http://www.sagepub.com/home.nav)

**Book's Website:** [http://www.sagepub.com/booksProdTOC.nav?prodId=Book6721](http://www.sagepub.com/booksProdTOC.nav?prodId=Book6721)

*Description:* This sourcebook contains 52 different clinical forms, many with examples of completed forms, including payment contracts, release of information, request for records, personal history, couple information form, treatment plans, progress notes, and discharge summaries. A CD-ROM with digital versions of the forms is provided.

*Publisher’s Website:* http://www.wiley.com/WileyCDA/


*Description:* This textbook provides an introduction to biopsychosocial assessment, mental status exams, diagnosis, treatment planning, and progress notes, providing a discussion of the rational and legal/ethical issues related to each. One example chart is used to provide an sample of clinical documentation.

*Publisher’s Website:* http://www.wiley.com/WileyCDA/

Introduction to Evidence-Based Practices and Treatments

This section covers evidence-based practices (the use of research to design treatment for individual clients and consumers) and evidence-based treatments (carefully designed and researched treatments that are shown to be effective with a specific population) in the field of MFT specifically and mental health more generally.

As the focus of this review is to identify textbooks for classroom use, the following list of references includes resources that provide an introductory overview of these approaches.

Evidence-based Practice

Providing training in evidence-based practice techniques can be easily integrated into MFT courses, such as practicum, theory, and research courses. Key resources are identified for instructing students in this practice.

Evidence-based Treatments

As there are over one hundred evidence-based treatments (or empirically supported treatments), programs cannot train students in all of these and should therefore strive for a more moderate goal of preparing students to understand what these treatments are and how they work. Since all are based on some combination of traditional psychotherapeutic and family theories, training students in these classic approaches is the first step. At minimum, programs should include instruction in how evidence-based models are developed and used as well as address practical issues and controversy related to implementation. In addition, programs may want to include more detailed instruction in one or more commonly used evidence-based treatments in the area of couple and family therapy.

Common Factors

Additionally, training in evidence-based practices and treatments should also cover common factors research in the field. Based primarily on meta-analyses, this strand of research attempts to identify common elements across models that are correlated to successful therapy outcomes.

New curriculum description:

Evidence-based practices and promising mental health practices that are evaluated in peer-reviewed literature. (BPC § 4980.36(d)(2)(A))

Evidence-Based Practice in MFT


Description: This classic article defines evidence-based practice using the medical definition of the term: using research to provide treatment that best meets the needs of each client or family. The article provides a five-step model for implementing
evidence-based practice in family therapy as well as a detailed outline to help students evaluate individual research studies for their application with clients.

*Journal's Website: [www.jmft.net](http://www.jmft.net)*


*Description:* Designed to help clinicians become better consumers of research, this article details a six-step model for using research in clinical contexts as well as outlining different models for consuming research. In addition, the authors include a list of “short cuts” to make accessing research easier; a case study is used to illustrate the concepts.

*Journal's Website: [www.jmft.net](http://www.jmft.net)*

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The Evidence Base for MFT


*Description:* An essential text, this edited volume comprehensively describes the extensive evidence base for family therapy practice and reviews numerous evidence-based family therapy treatments. The chapters are organized by presenting problem and include: conduct disorders, substance abuse, childhood behavioral and emotional problems, alcohol abuse, marital problems, relationship enhancement, domestic violence, severe mental illness affective disorders, physical disorders, and meta-analysis of MFT interventions. An updated version of the book is currently in production.

*Publisher Website: [www.aamft.org](http://www.aamft.org)*

*Book’s Website: [http://www.familytherapyresources.net/cgi-shl/twserver.exe/run:FTRUPD_2:TradeWinds_KEY=672](http://www.familytherapyresources.net/cgi-shl/twserver.exe/run:FTRUPD_2:TradeWinds_KEY=672)*

*Journal Article Versions:* Each of these chapters is also published in the 2002 *Journal of Marital and Family Therapy*.

*List of articles presented in sequence of publication:*


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**Evidence-Base for General Mental Health**

**BOOKS**


*Description*: This edited volume covers evidence-based treatments for severe mental illness and community mental health services. The book is divided into four sections: background on severe mental illness and community services; principles of evidence-based mental health care; implementation issues; and specific evidence practices, which include assertive community treatment, dual disorder treatment, supported
employment, illness management, family-based treatments, and medication management.

Publisher’s Website: www.wwnorton.com

Book’s Website: http://www.wwnorton.com/NPB/npsych/704432.html


Description: This edited volume reviews many of the questions surrounding evidence-based treatments and practices. Chapter topics include criteria that define evidence-based treatments, research necessary to define an evidence-based treatment, effects of the manualization of therapy, diversity and evidence-based practice, and transporting laboratory-validated practices to the field.

Publisher’s Website: www.apa.org/books

Book’s Website: http://books.apa.org/books.cfm?id=4317087&toc=yes


Description: This pocket-sized reference book provides practitioners with a concise, user-friendly guide for accessing, interpreting, and applying evidence-based practices in clinical settings. The book includes easy-to-read graphics, glossary of essential terms, and numerous case vignettes to facilitate learning.

Publisher’s Website: www.oup.com/us

Book’s Website: http://www.oup.com/us/catalog/general/subject/Psychology/Clinical/?view=usa&ci=978019535323#reviews


Description: This text provides a comprehensive approach to implementing evidence-based practice in mental health treatment. The book is divided into four sections: a) an overview of evidence-based practices, including a five-step model for implementation; b) critically appraising studies for evidence-based practices and intervention effectiveness, including an extensive review of validity, statistics, and research design issues; c) critically appraising studies for alternative evidence-based practice questions, which includes case study and qualitative studies; and d) assessing and monitoring client progress.

Description: This edited volume covers evidence-based practices with an emphasis on treatment of severe mental illness. The book includes chapters on supported employment, evidence-based family services for adults with severe mental illness, evidence-based psychopharmacology, evidence-based treatment for dual diagnosis, evidence-based treatments for children and adolescents, and recovery and the evidence-base. The final chapters of the book address controversies, implementation, and evaluating outcomes.

ARTICLES


Description: This article discusses the problems of trying to implement evidence-based practices in recovery-oriented environments. Anthony et al. argue that most evidence-based practices were developed without awareness or understanding of recovery’s vision and approach. Thus, they suggest that many of these evidence-based approaches are not appropriate for these treatment environments. They identify the deficiencies of these models for recovery contexts and identify future directions for practice.


Description: A definitive article in the field of mental health evidence-based treatments, this unique resource describes the most widely adopted system for determining when a treatment for a specific population or problem is to be considered empirically supported, efficacious, or possibly efficacious.

Also available [www.apa.org/divisions/div12/journals.html](http://www.apa.org/divisions/div12/journals.html).

**Description:** This article provides an update on the American Psychological Association’s task force’s report on empirically validated treatments and includes an extensive but admittedly not exhaustive list of empirically supported treatments as well as extensive discussion about the limits of such treatments, ethical issues, and implementation concerns.


**Description:** This article reviews the evidence-base for psychoeducation with families who have members diagnosed with a severe mental illness, including an overview of key characteristics for these programs. Dixon et al. also identify the barriers to more effective implementation of family psychoeducation and future directions for this evidence-based practice.

**Journal's Website:** [http://psychservices.psychiatryonline.org/](http://psychservices.psychiatryonline.org/)


**Description:** This up-to-date article defines empirically supported therapies and clearly details the training process and options to several key approaches in the field. The highlight of the chapter is an extensive table comparing eight evidence-based approaches in terms of costs, training requirements, time to implementation, materials, fidelity issues, and contact information. Common barriers to implementation are also discussed.

**Journal's Website:** [http://www.ifta-familytherapy.org/journal.html](http://www.ifta-familytherapy.org/journal.html)


**Description:** This article reports on a study of APA-accredited programs and training issues related to empirically supported treatments. The results indicated that while classroom education in empirically supported treatments increased, practical training in these treatments actually decreased. The numerous challenges in training and
education are discussed along with future directions. The article also includes a helpful list of current empirically supported treatments.

Journal's Website: http://www3.interscience.wiley.com/journal/117990269/home

Common Factors

Introduction to Common Factors

In the past decade, the common factors movement has gained significant momentum in the field of marriage and family therapy. Proponents of the common factors model argue that the effectiveness of therapy has more to do with similarities across models than unique factors of a specific model. Two common factors models are readily cited, Lambert’s and Wampold’s, with Lambert’s model having been applied more commonly in practice.

Given the new curriculum requirements to provide instruction on the evidence base of family therapy, programs will want to offer training in the common factors, which can be easily added to courses on theory, practical skills, and/or research.

BOOKS


Descriptions: This edited volume reviews the research foundations of Lambert’s common factors model and provides extensive chapters on each of the four factors: client and extra-therapeutic factors, the therapeutic relationship, therapeutic models, and hope. In addition, it includes several chapters on special applications, including marriage and family therapy, medicine, psychiatric drug treatment, and school settings. Finally, the text includes two chapters on implications of the common factors for third-party payers.

Publisher’s Website: www.apa.org/books

Book’s Website: http://books.apa.org/books.cfm?id=431723A&toc=yes


Description: One of the earliest resources on the subject, this book introduces the common factors as a unifying language for psychotherapy practice. The authors argue that effective therapies have more commonalities than differences. The book goes into detail on each of Lambert’s four common factors, discussing implementation and practice issues and includes numerous case examples.

*Description:* Written by leaders in the field, this book provides an outstanding and balanced view of the common factors research and approach, arguing for a “moderate” view of common factors. The text includes an overview of the research, discusses unique factors in couple and family therapy, proposes a meta-model of change in couples therapy, and reviews the case against common factors. In addition, Sprenkle et al. discuss practical issues, such as matching therapist behavior with client motivation, the importance of a strong therapeutic alliance, and the role of theory. Implications for training, supervision, treatment, and research are also discussed.

ARTICLES


*Description:* Situating their discussion in the common factors debate, Blow et al. review the research findings on the role of the therapist and its relation to treatment outcomes. The article includes recommendations for training and research, including suggestions of how to train for competence in common factors.


*Description:* In this seminal article on common factors in the field of MFT, Sprenkle and Blow argue that treatment effectiveness is more closely related to common factors across models than distinctive features of individual approaches. They present a “moderate” approach to common factors, arguing that individual treatment theories still have an important role in MFT training, albeit a different role than most typically expect.
Introduction to Evidence-Based Treatments

The resources below include readings for programs that want to include more extensive training in one or more evidence-based treatment. While far from a complete review of the over one hundred or more evidence-based treatments, this list provides ideas for specialized readings in family therapy on this topic. Programs may want to contact their local county mental health departments and agencies to learn which evidence-based treatments are currently in use in students’ potential field placement and work sites.

Note: Additional evidence-based treatment resources are also reviewed in Recovery-Oriented Treatment and Substance Abuse Treatment sections above.

BOOKS


Description: Technically an evidence-based practice rather than evidence-based treatment, Gottman’s research on marriage and divorce is an essential component of the marriage and family evidence base. The Marriage Clinic is a treatment manual for Gottman’s couples therapy approach and includes numerous questionnaires used for assessment and determining the focus of treatment. The book also includes several interventions and exercises for use with clients as well as a comprehensive review of his research on divorce and stable marriages.

Publisher’s Website: www.wwnorton.com

Book's Website: http://www.wwnorton.com/NPB/nppsych/702820.html


Description: A pragmatic treatment text, this book provides a practical description of multisystemic therapy, a structural-strategic evidence-based treatment for antisocial and substance abusing youth. This updated version includes an overview of outcome studies and research as well as the latest practice techniques.

Publisher's Website: www.guilford.com

Book's Website: http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/henggeler.htm&dir=pp/cpap&cart_id=299547.13819

*Description:* This book is a treatment manual for perhaps the best researched couples therapy approach, emotionally focused couple therapy. The text provides an overview of the theoretical foundations, descriptions of each stage of therapy, and detailed explanations of the assessments and interventions used in each stage.

*Publisher's Website:* [www.routledge.com](http://www.routledge.com)


*Description:* This SAMHSA treatment manual provides a detailed description of multidimensional family therapy, an evidence-based, structural-strategic treatment for teen substance abuse; this particular manual targets cannabis abuse.


*Description:* This book provides a detailed and practical description of mindfulness-based cognitive therapy, which shows promising outcomes for preventing depression relapse. Given that over 50% of persons successfully treated for Major Depression relapse within 12 months, the issue of depression relapse is critical in the treatment of severe and persistent mental illness. Mindfulness is also used for relapse prevention with anxiety, substance abuse, and other mental health disorders.

*Publisher's Website:* [www.guilford.com](http://www.guilford.com)


*Description:* This text is the treatment manual for functional family therapy, which systematically combines elements of strategic, structural, and cognitive-behavioral therapies as part of an evidence-based approach to working with troubled youth. The text includes a detailed description of the approach, clinical interventions, and applications in community environments.

Description: This online book provides the best description of how brief strategic family therapy is conducted. This structural-strategic approach to working with substance abusing minority youth is clearly organized for practitioners wanting to implement BSFT, including an introduction to basic concepts, assessment, intervention, family engagement, and outcome research.


Description: This edited volume provides an outstanding overview of evidence-based practices for a range of mental health issues, including substance abuse, depression, anxiety disorders, schizophrenia, PTSD, eating disorders, self-harm, and sexual offending. The book also addresses special populations, such as families, ethnic and racial minorities, adolescent substance abuse, the elderly, and incarcerated persons.


Description: This article reviews the research literature on the effectiveness of mindfulness for a range of physical and mental health disorders, including depression, anxiety, substance abuse, eating disorders, and personality disorders. Of particular interest, mindfulness practices are gaining increasing support for preventing relapse of depression, a severe and typically chronic disorder that has a high rate of relapse.

Description: This chapter describes the Open Dialogue Approach to treating psychosis, a postmodern, collaborative approach that shares many recovery principles. Implementation of this approach over the past 20 years in the Lapland region of Finland has dramatically reduced the incident of chronic psychotic disorders and resulted in impressive recovery rates as high as 77%. This chapter provides an overview of the treatment approach and research findings.

Book’s Webpage: http://www.routledge.com/books/Collaborative-Therapy-isbn9780415953276


Description: This article reviews more than 30 randomized trials on family psychoeducation in the treatment of schizophrenia, bipolar, depression, and other disorders and identifies common interventions, such as empathic engagement, education, ongoing support, client resources, social network enhancement, problem solving, and communication skills. In addition, McFarlane and colleagues discuss implementation in routine treatment settings.

Online Resources

American Psychological Association: Empirically Supported Treatments

Description: This website provides up-to-date information on empirically supported treatments, include several journal articles, reports for task forces, and links to useful resources.

Website: http://www.apa.org/divisions/div12/cppi.html

Institute for the Study of Therapeutic Change: Outcome Rating Scale and Session Rating Scale

Description: Featuring the work of Scott Miller, Barry Duncan and associates, this website provides numerous resources on the common factors and related outcome-based research. Of particular interest, the site provides free access to two brief rating scales for measuring treatment effectiveness: the Outcome Rating Scales and the Session Rating Scales. These are outstanding training tools that can be integrated into fieldwork experiences to help students better address the needs of those they serve.
Website: www.talkingcure.com

SAMHSA Registry of Evidence-based Programs and Practices

Description: Clinicians can search this online database for evidence-based practices for specific populations, including presenting problem, age, and ethnicity.

Website: http://www.nrepp.samhsa.gov/
Introduction to Diversity, Socio-economic Status, and Poverty Section

Marriage and family therapy education has included diversity issues for years. In fact many programs in California have extensive training in this area, some offering bilingual training and multicultural emphases.

The new curriculum contains all of the former requirements and adds a new emphasis on how poverty and economic status impact mental health and recovery. In addition, the curriculum addresses the interaction between various elements of diversity, such as ethnicity, class, gender, immigration status, spirituality, sexual orientation, etc. The effects of diversity on individual and family development must also be included in the updated curriculum. Finally, the requirements also include specific training in the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.

The following resources were selected to address only these new areas of instruction.

New curriculum description:

Integrate an understanding of various cultures and the social and psychological implications of socioeconomic position, including an understanding of how poverty and social stress impact an individual's mental health and recovery. (BPC § 4980.36(c)(1)(C))

Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California. (BPC § 4980.36(d)(2)(D))

Multicultural development and cross-cultural interaction, including experiences of race, ethnicity, class, spirituality, sexual orientation, gender, and disability, and their incorporation into the psychotherapeutic process. (BPC § 4980.36(d)(2)(E))

An understanding of the effects of socioeconomic status on treatment and available resources. (BPC § 4980.36(d)(2)(F))

The broad range of matters and life events that may arise within marriage and family relationships and within a variety of California cultures, including instruction in all of the following: (BPC § 4980.36(d)(2)(C)(iii, viii-x))

- Cultural factors relevant to abuse of partners and family members.
- Poverty and deprivation.
- Financial and social stress.

Developmental issues from infancy to old age, including instruction in: (BPC § 4980.36(d)(2)(B)(iv-vii))

- A variety of cultural understandings of human development.
- The understanding of human behavior within the social context of socioeconomic status and other contextual issues affecting social position.
- The understanding of human behavior within the social context of a representative variety of the cultures found within California.
- The understanding of the impact that personal and social insecurity, social stress, low educational levels, inadequate housing, and malnutrition have on human development.
BOOKS


*Description:* This text provides an in depth description of how to effectively work with black families. Divided into three major sections, the book begins by describing the cultural and racial context of African-American families, including issues such as extended family patterns, role flexibility, gender, spirituality, and divorce. The second section discusses treatment issues, such as the therapist's use of self, value conflicts, and appropriateness of various therapeutic models. In the final section, socioeconomic class and diverse family structures are covered in detail.

*Publisher's Website:* www.guilford.com

*Book's Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/boydfranklin2.htm&dir=pp/fac&cart_id=400650.13370


*Description:* This book provides a comprehensive overview of working with Latino families in therapy. Falicov discusses a wide range of issues, including sub-populations, migration, adaptation, racism, religion, health, family organization, couples, and family life cycle issues.

*Publisher's Website:* www.guilford.com


*Description:* This edited volume provides a theoretical foundation for working with immigrant children and families in various treatment contexts and specifically addresses treatment with the following immigrant groups: Filipino, Korean, Lao, Hmong, Asian-Indian, South Asian Muslim, Latino, Cuban, Dominican, Ecuadorian, Columbian, Nicaraguan, Salvadoran, Balkan, and Russian.

*Publisher's Website:* www.guilford.com

*Book's Website:* http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/fong.htm&dir=pp/fac&cart_id=400650.13370

Description: Written for practitioners in a range of helping professionals, this text provides a detailed discussion for how to work cross-culturally. Fontes discusses issues related to rapport building, non-verbal communication, language competence, interpretation options, authority issues, divulgence of information, and common misunderstandings.

Publisher’s Website: www.guilford.com

Book’s Website: http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/fontes2.htm&sec=summary&dir=pp/acpp&cart_id=400650.13370


Description: A readable and experiential text, this book uses a constructivist lens to explore issues of race, ethnicity, social justice, and critical consciousness. Gender, religion, class, and sexual orientation are included in the traditional discussions of race and ethnicity. The book is divided into three parts: an introduction that defines culturally alert counseling, race, and ethnicity; a section on race and ethnicity; and a final section on social diversity. A series of six DVDs with demonstration therapy sessions is available to accompany the text.

Publisher’s Webpage: www.sagepub.com

Book Webpage:
http://www.sagepub.com/booksProdDesc.nav?prodId=Book232244&


Description: A classic in family therapy, this edited volume arguably provides the most comprehensive coverage of ethnicity of any text on the market. The book includes over 53 chapters, each detailing the family dynamics of a unique ethnic group.

Publisher's Website: www.guilford.com

Book's Website: http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/mcgoldrick.htm&sec=summary&dir=pp/fac&cart_id=835339.13747


Description: This edited volume offers a solid foundation for discussing issues of race, class, culture, and gender and addresses critical theory, therapist experiences, and implications for practices. Divided into five sections, the book begins with a theoretical discussion of immigration, social class, spirituality, race, and oppression.
The second section includes therapists’ personal stories of racial identity development and its impact on clinical work. The third section covers race and racism in the therapy process, and the forth focuses on clinical implications and includes chapters on gay, lesbian, bisexual, and transgendered families; immigration; interracial issues; homelessness; and reconciliation. The final section focuses on training and social justice issues.

Publisher’s Website: www.guilford.com

Book’s Website: http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/megoldrick2.htm&dir=pp/fac&cart_id=835339.13747


Description: Offering a fresh theoretical perspective, this book uses social constructionist and narrative ideas to better understand the dynamics of culture in therapy. This text explores diversity issues using concepts such as colonization and decolonization; discourse, positioning, and deconstruction; power and privilege; globalization of identity; cultural identity development; and identity construction. In addition, the issues of class, poverty, and the American dream are included.

Publisher’s Website: www.sagepub.com

Book’s Website:
http://www.sagepub.com/booksProdDesc.nav?prodId=Book227746&


Description: This book introduces therapists to working with persons with physical disabilities using the minority model of disability. The first half of the text details the lived experience of disability, including stereotypes, everyday events, and family issues. Olkin then describes how to approach clinical work with persons with disabilities, including etiquette, interview techniques, assessment, and diagnosis. In addition, issues related to dating, sexuality, birth, and assistive technology are addressed.

Publisher’s Website: www.guilford.com

Book’s Website: http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/olkin.htm&sec=toc&dir=pp/mad&cart_id=400650.13370

Description: This edited volume provides an up-to-date and comprehensive overview of working with multicultural couples. Part 1 introduces theoretical principles, including issues of power, privilege, and oppression. Part 2 addresses issues of race, socially segregated identities, religious minorities, and evidence-based models with multicultural couples. Part 3 focuses on ethnicity and multicultural issues, including black, Asian, Latino, and Native/First Nation couples.

Publisher’s Website: www.sagepub.com

Book’s Website:
http://www.sagepub.com/booksProdDesc.nav?prodId=Book232048&


Description: Using a broad and multifaceted perspective, this book examines the complexity of developing therapeutic relationships across a range of diversity issues, including race, ethnicity, gender, socio-economic status, sexuality, and ability. The book is divided into four sections. The first section addresses multicultural competencies and explores the social construction of multiple identities. The second section explores specific ethnicities, including Native American and Alaskan Natives, Latinos, Peoples of African Decent, Peoples of Asian Decent, and Peoples of the Middle East. The third section explores other areas of diversity, such as the social construction of race, multiracial identities, gender, socioeconomic class, sexuality, and disability. The final section examines the implications for the therapeutic relationship, social justice, and spirituality.

Publisher’s Website: www.pearsonhighered.com

Book’s Website:
http://www.pearsonhighered.com/educator/academic/product/0,3110,0132337169,00.html


Description: An original approach to multicultural counseling issues, Schwartzbaum and Thomas offer a collection of life stories to raise and explore issues of multiculturalism in therapy. The book is divided into six sections: conceptual frameworks, dimensions of race and ethnicity, dimensions of immigration and acculturation, dimensions of spirituality and religion, dimensions of social class, and dimensions of sexual orientation. Each chapter includes a section on clinical applications.

Publisher’s Website: www.sagepub.com

Book’s Website:
http://www.sagepub.com/booksProdDesc.nav?prodId=Book230818&

*Description:* This recently revised edited volume includes extensive resources on how spirituality can be used as a resource to promote resiliency in family therapy practice. Chapter topics include using spirituality to cope with suffering, death, poverty, and various forms of trauma. In addition, spirituality is explored in the context of African-American, Latino, and Jewish cultures and its implications for daily family living and morality are also discussed.

*Publisher’s Website:* www.guilford.com

*Book’s Website:* http://www.guilford.com/cgi-bin/cartscripct.cgi?page=pr/walsh4.htm&dir=pp/fac&cart_id=51770.14194


*Description:* This edited volume provides a comprehensive overview of therapy with same-sex couples, including a review of the literature, issues with gay male couples, identity in lesbian couples, bisexual issues in same-sex couples, transgender issues, sex therapy, gay and lesbian parenting, and heterosexual spouses coping when partner comes out.

*Publisher’s Website:* www.routledge.com


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**Social Economic Status and Poverty**

**BOOKS**


*Description:* A classic in family therapy, *Bread and Spirit*, describes a structural, strengths-based approach to working with poor families. In this book, Aponte describes the unique life and relational issues faced by poor and minority families. The text includes specific chapters on “family therapy and the community,” “home/community based services,” “the family-school interview: an ecosystemic approach,” “the negotiation of values in therapy,” “about forgiving,” and “strength and vulnerability.” Numerous case examples and transcripts of sessions are included to illustrate key concepts.

Description: This edited volume addresses the psychological impact of poverty, covering issues of power, justice, psychopathology, unemployment, community, prejudice, economic crisis, and youth. The text’s emphasis is on helping the reader understand the broader social context of poverty and its effects on the whole person and communities.

Publisher's Website: http://www.springer.com


Description: Written for general mental health practitioners, this text provides a comprehensive introduction to working with diverse and poor clients. The book begins with a discussion of factors to consider in cross-cultural counseling, an examination of minority mental health research, and an overview of technological issues. It also addresses evolutionary psychology theories, global mental health issues, and special populations, including sexual orientation, disabilities, children, women, and the elderly.

Publisher’s Website: www.routledge.com


Description: Written for a popular audience, this controversial book provides a historical overview of how race and wealth have intersected in the U.S. The authors examine how federal policies have shaped the asset-building histories of Native Americans, Latinos, African Americans, Asian Americans, and European Americans.

Publisher’s Website: www.thenewpress.com

In this substantially revised and updated edition, Minuchin et al. detail a family systems approach to conceptualizing and facilitating change with poor and diverse families. The first half of the book provides a clear theoretical description for family-centered work, including family supportive-skills and procedures for promoting change. In the second half of the book, specific models for working with services systems are presented, including substance abuse and foster care. Finally, a description of family-oriented service systems is presented.

Publisher's Webpage: www.guilford.com


ARTICLES


*Description:* This article discusses the impact of poverty on children using the Family Stress Model. Barnett focuses on how poverty impacts children’s socioemotional development and reviews the literature on poverty’s effect on parenting, psychological distress, and family functioning. In addition, the article examines the effects of various family configurations and poverty.

*Journal’s Website:* http://www.springer.com/psychology/child+&+school+psychology/journal/10567


*Description:* A comprehensive and highly practical article on the topic of MFTs and poverty, this article discusses the numerous barriers to effectively serving low-income clients, including limited access to resources, client beliefs, working relationship, and therapist-client discrepancies. In addition, Grimes and McElwain include suggestions for improving services to low-income families and identifying effective and less effective approaches to treatment.

*Journal’s Website:* http://www.springer.com/psychology/psychology+general/journal/10591

Description: Based on the analysis of a qualitative study of couples with children, this article identifies three types of couples: postgender, gender legacy, and traditional. For these couples, movement toward equality was facilitated by a stimulus for change and patterns that promote change. The authors include implications for practice based on these couples’ experiences.

Journal’s Website: www.jmft.org


Description: Designed to raise consciousness of social class, this article outlines the issues of privilege and the need to promote therapist awareness of poverty in order to increase overall multicultural competency. The article includes a case study with analysis as well as recommendations for practice and training.

Journal’s Website: http://www.counseling.org/Publications/Journals.aspx


Description: In this article, Lott examines classism in the United States, arguing that distancing—institutionally, cognitively, and interpersonally—is the dominant response to the poor. Lott discusses the detrimental impact of distancing in the context of therapy and points to future directions for therapists to increase their awareness in this area.

Journal’s Website: http://www.apa.org/journals/amp/


Description: Based on a review of the literature, this article details a three-phase critical conversational model for helping clients identify and articulate their experiences of multiracial identities. Two case examples are included to illustrate this model.

Journal’s Website: www.jmft.org


Description: This article discusses issues of stigma, poverty, and victimization and how they affect the recovery process for persons with severe mental illness. Specific treatment and case management issues are provided.

*Description:* In this provocative article, Smith argues that therapist classism is still a significant barrier to effective treatment with clients who live in poverty. The article reviews the history of mental health practitioners’ awareness of the issue of class, including an overview of the specific discipline of family therapy. In addition, she discusses four key barriers to treatment using case examples.


*Description:* Written with educators in mind and citing a social justice framework, this article describes the importance of including poverty and social class as part of diversity training for mental health professionals. Smith recommends that educators include supplemental curricula on social class; encourage the exploration of privilege and personal reactions to poverty; apply social justice models in supervision; and teach flexible approaches to interventions.


*Description:* Grounded in a social justice model, Waldegrave argues that the social and therapeutic problems presented in therapy stem from contextual issues related to culture, gender, and socioeconomic status. The article discusses the impact of public policy and service delivery systems, and encourages mental health practitioners to be agents of change to promote equality and inclusion.


*Description:* This article describes the development and evaluation of a family-focused, culturally informed therapy for schizophrenia. It also includes a practical review of the literature related to key issues in the treatment of schizophrenia and describes how these are affected by culture.
Diversity and Family Development


*Description:* This classic family therapy text has been substantially revised over the years to integrate diversity and socioeconomic issues. The book introduces the family life cycle and discusses its relation to individual developmental models and its applications with a wide variety diversity issues, such as culture, social class, gender, migration, loss, divorce, remarriage, sexual orientation, substance abuse, violence, and chronic illness.

*Publisher’s Website:* [http://vig.pearsoned.com/](http://vig.pearsoned.com/)

*Book’s Website:* [http://vig.pearsoned.com/store/product/1,1207,store-7061_isbn-0205488293,00.html](http://vig.pearsoned.com/store/product/1,1207,store-7061_isbn-0205488293,00.html)


*Description:* A classic in the field, this edited volume has been recently revised to include diversity and other current issues. Divided into six major sections, this book provides a) an overview of the meaning of family normality in a rapidly changing society, b) a discussion of the varying family forms, including remarriage, LGBT families, adoption, divorce, and single-parent families, c) cultural dimensions of family functioning, d) developmental perspectives on family functioning, including resiliency theories, e) models of healthy couple and family processes, and f) social policy issues.

*Publisher’s Website:* [www.guilford.com](http://www.guilford.com)


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**Video/DVD Series**

*Examination copies were unavailable for videos or DVDs marked with an asterisk (*) due to company policies; thus, the evaluation is based on published description of the resources.*

**Alexander Street Videos.**

*Description:* This online database of videos (described above) includes 13 videos on multicultural counseling, both of counseling sessions and lectures on specific
populations and topics, such as Asian Americans, Native Americans, gender differences, Jewish-Americans, multicultural personality, etc.

Website: http://www.alexanderstreet.com


Description: Hosted by Dr. Jon Carlson, this series of nine videos covers a wide range of issues in working with multicultural clients. Each video includes an introductory discussion, an actual therapy session, and a follow-up question-and-answer session.

The series includes:
- Counseling Latina/Latino Clients
- Culturally Oriented Career Counseling
- Inclusive Cultural Empathy in Practice
- Mixed-Race Identities
- Working with African-American Clients
- Working with Arab Americans
- Working with Asian-American Clients
- Working with Immigrants
- Working with Native Americans

Publisher’s Website: www.apa.org/videos

Video Website: http://www.apa.org/videos/series5.html


Description: Designed to accompany the textbook with the same name, this series of DVDs includes:
- Working with African-American Clients
- Working with Asian Clients
- Working with Conservative Religious Clients
- Working with Latino/Latina Clients
- Working with Gay/Lesbian Clients
- Culturally Alert Counseling: A Demonstration of Skills

Publisher’s Webpage: www.sagepub.com

Video Webpage:
http://www.sagepub.com/booksProdDesc.nav?prodId=Book232992&

Description: This comprehensive series of videos covers the multitude of issues that arise in therapy with gay, lesbian, and bisexual individuals, couples, and families. The series includes interviews with 27 scholars and practitioners and numerous individuals who share their experiences. The series includes:

- Program 1: Historical Perspectives
- Program 2: Individual Assessment and Psychotherapy
- Program 3: Relationships, Families, and Couples Counseling
- Program 4: The Coming Out Process
- Program 5: The Bisexual Experience
- Program 6: Diversity and Multiple Identities
- Program 7: Sexual Minority Adolescents

Publisher's Website: http://psychotherapy.net

Video Website: http://psychotherapy.net/video/Gay_Lesbian_Bisexual
Introduction to Law and Ethics

The revised curriculum adds two new elements to law and ethics training:

1) difference in legal and ethical standards based on work setting, and
2) training in licensing law and processes.

Differences in Ethical and Legal Standards

There are limited specific resources on the differences in legal and ethical standards for various marriage and family work settings. Much of the literature on recovery-oriented treatment and community mental health care has imbedded within it discussions of alternative ethical standards and expectations. Instructors should review the above listed resources on Recovery for resources on ethics in recovery-oriented contexts in addition to considering those in this section.

Additionally, as MFTs work in more diverse practice environments, it is critical that educators increasingly emphasize the process of ethical decision making rather than mechanical adherence to ethical codes designed for traditional private practice settings serving middle and upper class clients. Thus, the area of teaching ethics is likely to be more challenging and nuanced in the years ahead.

Licensing Law

Thankfully, the BBS has recently published a user-friendly guide to the licensing process for MFTs in California that will be an excellent resource for educators in meeting this new requirement.

New curriculum description:

*Differences in legal and ethical standards for different types of work settings.* (BPC § 4980.36(d)(2)(f)(vi))

*Licensing law and licensing process.* (BPC § 4980.36(d)(2)(f)(vii))

BOOKS


*Description:* This edited volume covers a wide range of ethical concerns in community mental health settings, including boundaries and dual relationships, diversity issues, safety of family members and practitioners, involuntary interventions, psychiatric anticipatory planning, and the influence of the psychopharmaceutical industry.

*Publisher’s Website:* [http://www.springer.com/?SGWID=5-102-0-0-0](http://www.springer.com/?SGWID=5-102-0-0-0)


*Description:* Authored by lawyers, this text is written in a question-answer format covering a wide range of issues, including the legal system, involuntary hospitalization, criminal law, subpoenas, court orders, guardianship, consultation, confidentiality, privilege, mandatory reporting, record keeping, professional liability, and children and families.

*Publisher’s Website:* www.wwnorton.com

*Book’s Website:* http://www.wwnorton.com/NPB/npsych/702502.html


*Description:* This user-friendly handbook for students clearly describes a) how to obtain a degree in marriage and family therapy that qualifies for licensure, b) how to apply and become a Marriage and Family Therapy Intern, c) how to gain hours of work experience towards the license, and d) how to apply to take the licensing exams. The book includes numerous useful “tips” and suggestions for making the process run smoothly each step of the way.

*Publisher’s Website:* www.bbs.ca.gov

*Book’s Website:* http://www.bbs.ca.gov/forms.shtml


*Description:* This text focuses on the process of ethical reasoning and decision making in mental health practice and reviews several different ethical decision-making models. The text includes one specific chapter on the impact of organizational context on ethics; other chapters address specific issues in assessment, testing, and training.

*Publisher’s Website:* www.sagepub.com

*Book’s Website:* http://www.sagepub.com/booksProdDesc.nav?prodId=Book226466&


*Description:* One of the few law and ethics texts written exclusively for California MFTs, this book provides a comprehensive overview of standard issues, including informed consent, confidentiality, privilege, dual relationships, and crisis.
management. The book includes numerous examples of actual forms, such as subpoenas, court orders, child abuse reports, and clinical forms, making it a practical addition to the curriculum.

Publisher’s Website: www.fgrosso.com

Book’s Website:  

ARTICLES


Description: A twist on the typical ethical discussion, Evans proposes that patients also have duties and responsibilities in the treatment process. In this article, he identifies ten duties, ranging from participating in health schemes to promoting one’s own recovery. These are discussed in the context of a range of objections—principled, societal, epistemological, and practical. Evans argues that these duties can be used to promote a collaborative, problem-solving partnership between consumers and clinicians.

Journal’s Website: http://jme.bmj.com/


Description: In this thought-provoking piece, Fardella argues that the recovery model represents an approach to the self as a self-determining agent that is found in contemporary philosophy, specifically the works of Michel Foucault and Jurgen Habermas, philosophers who are also cited in narrative, collaborative, and solution-based therapies. The article provides a model based on Habermas’ discourse ethics that can be used to dialogically resolve differences between client and therapist.

Journal’s Website: http://www.springer.com/humanities/journal/10912


Description: Focusing on the ethical guideline of promoting consumer autonomy, this article details three case studies of the dilemmas surrounding patient self-governance in an acute psychiatric unit. The authors suggest small changes in staff behavior and institutional procedures that can enhance consumer autonomy in in-patient facilities.

Journal’s Website: http://jme.bmj.com/

*Description:* This article describes the results of a qualitative study in the European Union that investigated ethical issues in community mental health services. The following ethical dilemmas were identified in the study: community vs. hospital care; a life with care vs. a life without care; stimulation of the client toward greater responsibility vs. protection against such responsibility; budgetary control vs. financial incentives; and respect for the client vs. the needs of others (e.g., neighborhood residents).

*Journal’s Website:* [http://jme.bmj.com/](http://jme.bmj.com/)


*Description:* In this short article, Storey and colleagues discuss the impact of labels and prejudice on persons in recovery, arguing that systematic discrimination significantly impacts a person’s ability to successfully pursue recovery. They briefly discuss a recovery education strategy to reduce disempowering practices to help clinicians create safer and more supportive treatment environments.

*Journal’s Website:* [http://www.jemh.ca/](http://www.jemh.ca/)
Pedagogical Resources for Educators

Introduction to Pedagogical Resources

Implicit in the new curriculum is a move towards a more learning-centered, outcome-based teaching pedagogy that focuses on providing instruction on the competencies and practical skills that trainees and interns will need in the field. This move toward competency-based education is consistent with trends in MFT and mental health more broadly. More specifically, the list of 128 MFT Core Competencies developed by a task force commissioned by the American Association for Marriage and Family Therapy is an unparalleled and invaluable resource for implementing the new curriculum as most of the content in the new curriculum is also identified in the Core Competencies.

The following list of resources is designed to provide MFT educators with readings in how to implement the new curriculum.

BOOKS


*Description:* Containing numerous worksheets and self-assessments to assist faculty, this book provides instructors with a step-by-step guide for transforming any course using a learner/learning-centered model. The text is based on Weimer’s five key principles (see text below) and includes an overview of rubrics.

*Publisher’s Website:* www.josseybass.com


*Description:* Written in an accessible and down-to-earth style, this text introduces instructors to outcome-based assessment as part of learner-centered education. The authors guide readers in the often messy process of defining learning outcomes, developing measures, and then aligning these with course content. The text includes discussion of the practicalities as well as implications for faculty development and university culture.

*Publisher’s Website:* http://styluspub.com


*Description:* An ebook with scoring rubrics, this assessment system is the only complete assessment system for measuring the 128 MFT Core Competencies and has been adopted by nearly a third of COAMFTE accredited master’s degree programs. The system includes eight assessment instruments with scoring rubrics and a faculty manual that describes learning-centered, outcome pedagogy. The manual details a seven-step process for conceptualizing, implementing, and refining a custom assessment system. The system is already correlated to the MFT Core Competencies, greatly simplifying the accreditation process for COAMFTE and CACREP programs. Additionally, these learning outcomes can also be used to meet WASC accreditation requirements. A California edition of the system is available that includes recovery-oriented assessment.

*Publisher's Website:* [www.mftcompetencies.org](http://www.mftcompetencies.org)


*Description:* This workbook style text provides detailed instructions and numerous examples on how to create syllabi that support learning-centered course design. The author integrates a thoughtful discussion of learning-centered teaching philosophy and its practical implementations throughout.

*Publisher's Website:* http://www.josseybass.com/WileyCDA/


*Description:* This highly practical text provides a comprehensive introduction to scoring rubrics, which are a hallmark of learning-centered, outcome-based instruction. The text is divided into two parts, the first introducing rubrics and providing an overview of how to construct one. The second half describes the use of rubrics in different contexts, including four different models for using rubrics and discussing how to construct rubrics in collaboration with other faculty.

*Publisher’s Website:* [http://styluspub.com](http://styluspub.com)


*Description:* Written by one of the most highly regarded authorities on the subject, this text provides a comprehensive overview of learner-centered teaching. The book is organized around five key principles: the balance of power, function of content, role of the teacher, responsibility for learning, and purpose and process of evaluation. The book also includes a thoughtful discussion on practical concerns, such as responding to resistance, developmental issues, and tips for making it work. Sample syllabi and learning assignments are also included.

*Publisher’s Website:* [www.josseybass.com](http://www.josseybass.com)


**ARTICLES**


*Description:* In this pragmatic article, Chenail provides an overview of competency-based and learning-focused education in family therapy. To illustrate the approach, he describes how he has implemented these ideas to teach research competencies in a research in marriage and family therapy course using an “Evidence-Based Practice Assignment.”

*Journal’s Website:* [www.jmft.net](http://www.jmft.net)


*Description:* This article discusses the practical implications of designing a learning-centered, outcome-based pedagogy based on the MFT Core Competencies. It includes a discussion of the history of the competency movement, a comparison with other mental health disciplines, and a seven-step model for implementing a comprehensive assessment system.

*Journal’s Website:* Until published, contact author at dgehart@csun.edu for a draft copy.

Description: This article describes how four MFT programs have successfully integrated research and clinical training in their programs. Hodgson et al. discuss the usefulness and limitations of the Boulder scientist-practitioner model and its implications for MFT training. Specific recommendations and strategies are also included.

Journal's Website: www.jmft.net


Description: A publication of the Annapolis Coalition, which was developed to address workforce issues in mental health, this article outlines 16 best practices in behavioral workforce education and training based on the extensive research conducted by the organization.

Journal's Website: http://www.annapoliscoalition.org


Description: This article provides a comprehensive overview of competency development in the field of behavioral health, including addiction counseling, interdisciplinary health professions, marriage and family therapy, psychology, psychiatric nursing, psychiatric rehabilitation, psychiatry, and social work. In addition, competency work with special populations is also addressed, including children’s mental health, severe and persistent mental health, recovery-based treatment, diverse populations, and peer specialists.

Journal's Website: http://www.springer.com/public+health/journal/10488


Description: This article details the use of the OSCE, a common tool for assessing competencies in the field of medicine, in marriage and family therapy. Miller details how it has been used in a master’s level marriage and family therapy program to assess student learning.

Journal’s Website: www.jmft.net

Description: Attending to a unique area of specialty, this article details how Miller and colleagues have developed a measure for assessing student competencies in forensic MFT, focusing on how to prepare students to be expert witnesses in family law cases.

Journal’s Website: www.jmft.net


Description: Miller and colleagues explore the Core Competency movement in marriage and family therapy by considering it within the broader competency discourse. Specifically, they discuss competency efforts in education, law, and medicine and identify common dilemmas and promising practices.

Journal’s Website: www.jmft.net


Description: Written by members of the steering committee for the AAMFT Core Competencies Task Force, this article documents the development of the MFT Core Competencies, including their purpose, design, and pedagogical foundations. Nelson and colleagues discuss applications and future directions. The entire set of 128 competencies is included in the appendix.

Journal’s Website: www.jmft.net


Description: Already in use at numerous MFT programs around the country, the Basic Skills Evaluation Device is an early example of a rubric for assessing students in practicum settings. The article includes a copy of the measure as well as describing how it was developed.

Journal’s Website: www.jmft.net


Description: In this article, Nelson and Smock provide a useful introduction to outcome-based education and competency assessment in marriage and family
therapy. The article outlines key issues and concerns as well as future directions for MFT education.

Journal’s Website: www.familyprocess.org

ONLINE RESOURCES


*Description:* AAMFT has published the Core Competencies in pdf format for easy downloading. AAMFT Members also have access to articles in the *Family Therapy Magazine* on the competencies.

*Website:* www.aamft.org/institutes/2008si/refresher/mft%20core%20competencies_december%202004.pdf

MFT Competencies.org

*Description:* This website provides numerous resources on the MFT Core Competencies, including a list of the MFT Core Competencies, workshop handouts, summaries of pedagogical issues, links to related sites, and information about the *Complete MFT Core Competency Assessment System*. A webpage for California educators is also included.

*Website:* www.mftcompetencies.org

OpenEd Practices: Scoring Rubrics and Learning Tools

*Description:* A unique website where faculty from all disciplines can share rubrics and related learning tools, OpenEd Practices has numerous educational resources for free download that can be used as templates and examples. Instructors can search by university and learning tool type.

*Website:* http://openedpractices.org/resources
Community Resources

National Level Resources

2-1-1 United Way Human Service Information and Referral Service

Website: http://211us.org
Phone: 2-1-1

National Suicide Prevention Lifeline
1-800-273-TALK (1-800-273-8255) or 1-800-799-4889 (TTY)

National Online Drug Treatment Locator

National Center for Victims of Crime
www.ncvc.org

State Agencies and Departments

Board of Behavioral Sciences
www.bbs.ca.gov

California Institute of Mental Health (CIMH)
www.cimh.org

Description: A private agency that works closely with public mental health, CIMH has been a leader in training related to recovery-oriented treatment in California public mental health systems. The website provides resources on training opportunities, evidence-based practices, and the Mental Health Services Act.

California Department of Mental Health
www.dmh.cahwnet.gov

Phone List of County Departments of Mental Health
http://www.dmh.cahwnet.gov/docs/CMHDA.pdf

List of State and National Resources for Mental Health
http://www.dmh.cahwnet.gov/MH_Resources.asp

Description: Includes:
- California Mental Health Organizations
- National Mental Health Disorders/Disabilities Resources and Organizations

California Code of Regulations: Title 9: Rehabilitative and Developmental Services
Description: Title 9 is the “bible” for California Medi-Cal mental health services, outlining the requirements of mental health and rehabilitative services covered by the state. This legislation is used to guide audits of county agencies and their practices.

### Listings of State Level Community Resources

**Listing of 24-Hour County Crisis Lines**

[www.dmh.ca.gov](http://www.dmh.ca.gov)

**Child Abuse Reporting**

[http://ag.ca.gov/childabuse/forms.htm](http://ag.ca.gov/childabuse/forms.htm)

- Child Abuse Prevention
  [http://www.safestate.org/](http://www.safestate.org/)

- Child Protection Program

- Child Safety Rules
  [http://ag.ca.gov/missing/content/chldsfty.php](http://ag.ca.gov/missing/content/chldsfty.php)

**Elder and Dependent Adult Abuse**


- Elder and Dependent Adult Abuse Reporting

- Elder and Dependent Adult Abuse Civil Protection Act
  [http://www.harp.org/wc15600.htm](http://www.harp.org/wc15600.htm)

**Domestic Violence Shelters: Listing by County**

[www.bcdonline.com/sucasa/Hotline_List.pdf](http://www.bcdonline.com/sucasa/Hotline_List.pdf)

**List of State Psychiatric Hospitals**


**California Department of Alcohol and Drug Programs**

[www.adp.state.ca.us/default.asp](http://www.adp.state.ca.us/default.asp)
Client resource numbers:

(800) 879-2772 (toll-free); Available 24-hours a day. Answered by ADP staff 8:00 a.m. – 4:30 p.m. and answered by voice mail after-hours.

(800) 662-4357 (toll-free); Available 24-hours a day from telephone numbers within California. Answered by ADP staff 8:00 a.m. – 4:30 p.m. and answered by the U.S. Department of Health and Human Services staff after-hours.

(916) 327-3728. Available 24-hours a day. Answered by ADP staff 8:00 a.m. – 4:30 p.m. and answered by voice mail after-hours.

Cal Works Program
www.ladpss.org/dpss/calworks/default.cfm

Medi-Cal and the California Department of Health Care Services

Home Page
http://www.dhcs.ca.gov/Pages/default.aspx

Listing of Medical and Dental Services
http://www.dhcs.ca.gov/services/Pages/default.aspx

Medi-Cal Qualifications
http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalEligibility.aspx

Medi-Cal Application
http://www.dhcs.ca.gov/services/medi-cal/Pages/MediCalApplications.aspx

Health Families (Low cost insurance for children and teens)
http://www.dhcs.ca.gov/services/medi-cal/Pages/HealthyFamilies.aspx

Supplemental Security Income (SSI) in California
http://www.ssa.gov/pubs/11125.html

Housing Authorities Listings
http://www.hcd.ca.gov/hpd/hrc/tech/contacts.htm

Food Stamps: California Application
http://www.dss.ca能够让.gov/foodstamps/default.htm

Legal Assistance: Free and Lost Cost Service Listings
http://www.courtinfo.ca.gov/selfhelp/lowcost/

Department of Developmental Services
http://www.dds.ca能够让.gov/DDSHomePage.cfm

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List of Regional Centers
http://www.dds.ca.gov/RC/RCList.cfm

Department of Social Services: Child and Family Division (Adoptions & Foster Care)
http://www.childsworld.ca.gov

Family-Centered Services Wraparound Program
http://www.childsworld.ca.gov/PG1320.htm

Foster Care Programs
http://www.dss.cahwnet.gov/efsweb/PG1335.htm

California Early Prevention Programs (0-5)
http://www.dds.ca.gov/EarlyStart/Home.cfm

California Department of Education: Individualized Educational Plans (IEP)
http://www.cde.ca.gov/sp/se/sr/iepresources.asp

California Compensation Board for National Victims of Crime Program
http://www.boc.ca.gov

United Way Listings of California
http://www.unitedwaysca.org/Find-a-United-Way-in-Your-area

List of County Departments of Mental Health (Alphabetical Order)

ALAMEDA COUNTY

Websites: http://www.acbhcs.org
          http://alameda.networkofcare.org/mh/home/index.cfm

Address:
Alameda Co. Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

Phone:
510-567-8100; Fax: 510-567-8130

24-Hour Crisis Number: 800-491-9099

ALPINE COUNTY

Website: http://www.co.alpine.ca.us/departments/health_and_human_services/
behavioral_health/behavioral_health

Address:
Alpine County Behavioral Health Services
75C Diamond Valley Road
Markleeville, CA 96120-9512

Phone: 530-694-1816, 800-318-8212; Fax: 530-694-2387

24-Hour Crisis Number: **800-486-2163**

AMADOR COUNTY

*Websites*: [http://www.co.amador.ca.us/depts/mental/index.htm](http://www.co.amador.ca.us/depts/mental/index.htm)
[http://amador.networkofcare.org/mh/home/index.cfm](http://amador.networkofcare.org/mh/home/index.cfm)

Address:
Amador County Mental Health
10877 Conductor Blvd, Suite 300
Sutter Creek, CA 95685

Phone:
209-223-6412, 888-310-6555; Fax: 209-223-0920

24-Hour Crisis Number: **209-223-2600**

BERKELEY CITY

*Website*: [http://www.ci.berkeley.ca.us/mentalhealth](http://www.ci.berkeley.ca.us/mentalhealth)

Address:
Berkeley City Mental Health Administration
1947 Center Street, 3rd Floor
Berkeley, CA 94704

Phone:
510-981-5270; Fax 510-981-5235

24-Hour Crisis Number: **510-849-2212**

BUTTE COUNTY

[http://butte.networkofcare.org/mh/home/index.cfm](http://butte.networkofcare.org/mh/home/index.cfm)
**Butte County Department of Behavioral Health**

Address: Butte County Department of Behavioral Health
107 Parmac Road, Suite 4
Chico, CA 95926-2218

Phone: 530-891-2850; Fax: 530-895-6549

**24-Hour Crisis Numbers:** **530-891-2810, 800-334-6622**

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**CALAVERAS COUNTY**

*Websites:* [http://www.co.calaveras.ca.us/departments/mhealth.asp](http://www.co.calaveras.ca.us/departments/mhealth.asp)
[http://calaveras.networkofcare.org/mh/home/index.cfm](http://calaveras.networkofcare.org/mh/home/index.cfm)

Address: Calaveras County Behavioral Health Services
Mental Health Programs
Government Center, Dept. 127
891 Mountain Ranch Road
San Andreas, CA 95249

Phone: 209-754-6525; Fax: 209-754-6559

*County Crisis Intervention 24-Hour Numbers:* **209-754-3239, 800-499-3030**

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**COLUSA COUNTY**

*Website:* [http://colusa.networkofcare.org/mh/home/index.cfm](http://colusa.networkofcare.org/mh/home/index.cfm)

Address: Colusa County Department of Behavioral Health
217 9th Street, Suite
Colusa, CA 95932

Phone: 530-458-0520, Fax: 530-458-7751

*County Crisis Intervention 24-Hour Numbers:* **530-458-0520, 888-793-6580**

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**CONTRA COSTA COUNTY**

*Websites:*[http://www.cchealth.org/services/mental_health/](http://www.cchealth.org/services/mental_health/)
[http://contacosta.networkofcare.org/mh/home/index.cfm](http://contacosta.networkofcare.org/mh/home/index.cfm)
Address:
Contra Costa County Mental Health
1340 Arnold Drive, Suite 200
Martinez, CA 94553

Phone:
925-957-5150; Fax 925-957-5156

County Crisis Intervention 24-Hour Number: 925-646-2800

DELR NORTE COUNTY

Websites:  http://www.co.del-norte.ca.us/
            http://delnorte.networkofcare.org/mh/home/index.cfm

Address:
Del Norte County Mental Health
206 Williams Drive
Crescent City, CA 95531

Phone:
707-464-7224; Fax: 707-465-4272

County Crisis Intervention 24-Hour Numbers: 888-446-4408, 707-464-7224

EL DORADO COUNTY

Websites:  http://www.co.el-dorado.ca.us/mentalhealth/index.html
            http://eldorado.networkofcare.org/mh/home/index.cfm

Address:
Health Services Department
Mental Health Division
670 Placerville Drive, Suite 1B
Placerville, CA 95667-3920

Phone:
530-621-6200; Fax: 530-626-4713

WE Crisis Intervention 24-Hour Number: 530-622-3345

SLT Crisis Intervention 24-Hour Number: 530-544-2219

FRESNO COUNTY
Websites: http://www.fresnohumanservices.org/AdultServices
         http://fresno.networkofcare.org/mh/home/index.cfm

Address:
Department of Behavioral Health
5108 E. Clinton Way, #108
Fresno, CA 93727

Phone:
559-452-3463; Fax: 559-452-3470

County Crisis Intervention 24-Hour Numbers: 559-453-6304, 800-654-3937

GLENN COUNTY

Websites: http://www.countyofglenn.net/Mental_Health/home_page.asp
         http://glenn.networkofcare.org/mh/home/index.cfm

Address:
Glenn County Behavioral Health
242 N. Villa
Willows, CA

Phone:
530-934-6582; Fax: 530-934-6592

County Crisis Intervention 24-Hour Numbers: 530-934-6582, 800-507-3530

HUMBOLDT COUNTY

Websites: http://www.co.humboldt.ca.us/hhs/mh/
         http://humboldt.networkofcare.org/mh/home/index.cfm

Humboldt County Health and Human Services
507 F Street
Eureka, CA 95501

Phone:
707-441-5400; Fax: 707-441-5412

County Crisis Intervention 24-Hour Numbers: 707-445-7715, 888-849-5728

IMPERIAL COUNTY

Website: http://imperial.networkofcare.org/mh/home/index.cfm
Address:
Imperial County Behavioral Health Services
202 N. 8th Street
El Centro, CA 92243

Phone:
760-482-4000; Fax: 760-352-0798

County Crisis Intervention 24-Hour Numbers: 760-339-4504, 800-817-5292

INYO COUNTY

Website: http://inyo.networkofcare.org/mh/home/index.cfm

Address:
Inyo County Mental Health
162 J Grove Street
Bishop, CA 93514

Phone:
760-873-6533; Fax: 760-873-3277

County Crisis Intervention 24-Hour Numbers: 760-873-6533, 800-841-5011

KERN COUNTY

Website: http://www.co.kern.ca.us/KCMH/
http://kern.networkofcare.org/mh/home/index.cfm

Address:
Kern County Mental Health Services
P.O. Box 1000
Bakersfield, CA 93302
3300 Truxtun Avenue, Suite 290
Bakersfield, CA 93301

Phone:
661-868-6600; Fax: 661-868-6847

County Crisis Intervention 24-Hour Number: 800-991-5272

KINGS COUNTY

Website: http://www.countyofkings.com/mhsa/index.htm
Kings County Behavioral Health Administration
Kings County Government Center
450 Kings County Drive, Suite 104
Hanford, CA 93230

Phone: 559-582-3211; Fax: 559-589-6916

County Crisis Intervention 24-Hour Numbers: 559-582-4484, 800-655-2553

LAKE COUNTY

Websites: http://www.co.lake.ca.us/countygovernment/health/mh/index.asp
          http://lake.networkofcare.org/mh/home/index.cfm

Address:
Lake County Mental Health Department
991 Parallel Drive
Lakeport, CA 95453

Phone: 707-263-4338; Fax: 707-263-1507

County Crisis Intervention 24-Hour Number: 707-263-4338

LASSEN COUNTY

Websites: http://www.co.lassen.ca.us/mental_mission.htm
          http://lassen.networkofcare.org/mh/home/index.cfm

Address:
Lassen County Health and Social Services
1445 Paul Bunyan Road
Susanville, CA 96130
Mental Health Division
555 Hospital Lane
Susanville, CA 96130

Phone: 530-251-8174

County Crisis Intervention 24-Hour Number: 888-530-8688
LOS ANGELES COUNTY

Websites:  http://www.lacdmh.org/
          http://losangeles.networkofcare.org/mh/home/index.cfm

Address:
Los Angeles County Mental Health
550 South Vermont, 12th Floor
Los Angeles, CA  90020

Phone  
213-738-4601

County Crisis Intervention 24-Hour Number: 800-854-7771

MADERA COUNTY

          http://madera.networkofcare.org/mh/home/index.cfm

Address:
Madera County Behavioral Health Services
P.O. Box 1288
Madera, CA  93639-1288

Phone
559-675-7926; Fax: 559-675-4999

County Crisis Intervention 24-Hour Numbers: 559-673-3508, 888-275-9779

MARIN COUNTY

Websites:  http://www.co.marin.ca.us/depts/HH/main/mh/index.cfm
          http://marin.networkofcare.org/mh/home/index.cfm

Address:
Marin County Community
Mental Health Services)
20 N. San Pedro, Suite 2028
San Rafael, CA  94903

Phone:
415-499-6769; Fax: 415-507-1512

County Crisis Intervention 24-Hour Number: 415-499-6666
MARIPOSA COUNTY

Website: http://www.mariposacounty.org/

Address:
Mariposa County Mental Health
P.O. Box 99
Mariposa, CA 95338

Phone:
209-966-2000; Fax: 209-966-8251

County Crisis Intervention 24-Hour Numbers: 209-966-2000, 800-549-6741

MENDOCINO COUNTY

Website: http://www.co.mendocino.ca.us/mh/
http://mendocino.networkofcare.org/mh/home/index.cfm

Address:
Mendocino County Mental Health
860 N. Bush Street
Ukiah, CA 95482

Phone:
707-463-4303; Fax: 707-463-4043

County Crisis Intervention 24-Hour Numbers: 800-555-5906, 707-463-4396

MERCED COUNTY

Website: http://www.co.merced.ca.us/mentalhealth/index.html
http://merced.networkofcare.org/mh/home/index.cfm

Address:
Merced County Mental Health
3090 M Street
Merced, CA 95348
Mail to: P.O. Box 2087, Merced (95344)

Phone:
209-381-6813; Fax: 209-725-3676

County Crisis Intervention 24-Hour Numbers: 209-381-6800, 888-334-0163
MODOC COUNTY
Website: http://modoc.networkofcare.org/mh/home/index.cfm

Address:
Modoc County Mental Health Services
441 N. Main Street
Alturas, CA  96101

Phone.
530-233-6312; Fax 530-233-6339

County Crisis Intervention 24-Hour Number: 800-699-4880

MONO COUNTY

Websites: http://www.monocounty.ca.gov/departments/mental_health/mental_health.htm
http://mono.networkofcare.org/mh/home/index.cfm

Address:
Mono County Mental Health Services
P.O. Box 2619
Mammoth Lakes, CA  93546

Phone.
760-924-1740; Fax: 760-924-1741

County Crisis Intervention 24-Hour Number: 800-687-1101 or 911

MONTEREY COUNTY

Websites: http://www.co.monterey.ca.us/health/BehavioralHealth/
http://monterey.networkofcare.org/mh/home/index.cfm

Address:
Monterey County Mental Health
1270 Natividad Road, Room 200
Salinas, CA  93906-3198

Phone.
831-755-4510; Fax: 831-424-9808

County Crisis Intervention 24-Hour Number: 831-755-4111

NAPA COUNTY
NAPA COUNTY

Website: http://napa.networkofcare.org/mh/home/index.cfm

Address:
Napa County Health & Human Services
2261 Elm Street
Napa, CA 94559-3721

Phone:
707-253-4279; Fax: 707-253-6095

County Crisis Intervention 24-Hour Numbers: 707-253-4711, 800-648-8650

NEVADA COUNTY

Website: http://nevada.networkofcare.org/mh/home/index.cfm

Address:
Nevada County Behavioral Health
500 Crown Point Circle, Ste 120
Grass Valley, CA 95945

Phone:
530-265-1437; Fax: 530-271-0257

County Crisis Intervention 24-Hour Number: 530-265-5811

ORANGE COUNTY

Website: http://www.ochealthinfo.com/behavioral/index.htm

Website: http://orange.networkofcare.org/mh/home/index.cfm

Address:
Orange County Behavioral Health Services
405 West 5th Street, 7th Floor
Santa Ana, CA 92701

Phone:
714-834-6023; Fax: 714-834-5506

County Crisis Intervention 24-Hour Number: 714-834-6900

PLACER COUNTY

Website: http://www.placer.ca.gov/adult/mental.htm
Address:
Placer County Adult Systems of Care
11512 B Avenue
Auburn, CA  95603

Phone:
530-889-7240

County Crisis Intervention 24-Hour Numbers: 916-787-8860, 888-886-5401

PLUMAS COUNTY

Websites: http://www.countyofplumas.com/mentalhealth/
http://plumas.networkofcare.org/mh/home/index.cfm

Address:
Plumas County Mental Health Services
270 County Hospital Road, Suite 109
Quincy, CA  95971

Phone:
530-283-6307 or 800-757-7898; Fax: 530-283-6045

County Crisis Intervention 24-Hour Numbers: 530-283-6307, 800-757-7898

RIVERSIDE COUNTY

Websites: http://mentalhealth.co.riverside.ca.us/
http://riverside.networkofcare.org/mh/home/index.cfm

Address:
Riverside County Mental Health
P.O. Box 7549
Riverside, CA  92513-7549
4095 County Circle Drive
Riverside, CA  92503

Phone:
951-358-4500; Fax: 951-358-4513

County Crisis Intervention 24-Hour Number: 800-706-7500

SACRAMENTO COUNTY
          http://sacramento.networkofcare.org/mh/home/index.cfm

Address:
Department of Health & Human Services
7001 – A East Parkway, Suite 1000
Sacramento, CA  95823

Phone.
916-875-6091; Fax: 916-875-1283

County Crisis Intervention 24-Hour Numbers: 916-732-3637, 888-881-4881

SAN BENITO COUNTY

Websites: http://www.sbcmh.org/
          http://sanbenito.networkofcare.org/mh/home/index.cfm

Address:
San Benito County Behavioral Health
1131 San Felipe Road
Hollister, CA  95023

Phone.
831-636-4020; Fax: 831-636-4025

County Crisis Intervention 24-Hour Numbers: 831-636-4020, 888-636-4020

SAN BERNARDINO COUNTY

Websites: http://www.co.san-bernardino.ca.us/dbh/
          http://sanbernardino.networkofcare.org/mh/home/index.cfm

Address:
San Bernardino County Behavioral Health
268 West Hospitality Lane, Suite 400
San Bernardino, CA  92415-0026

Phone.
909-382-3133; Fax: 909-382-3105

County Crisis Intervention 24-Hour Number: 888-743-1478

SAN DIEGO COUNTY
Websites: http://www2.sdcounty.ca.gov/hhsa/programdetails.asp?ProgramID=3
http://sandiego.networkofcare.org/mh/home/index.cfm

Address:
San Diego Co. Behavioral Health Division
3255 Camino Del Rio South
San Diego, CA  92108

Phone.
619-563-2700; Fax: 619-563-2775

County Crisis Intervention 24-Hour Number: 800-479-3339

SAN FRANCISCO COUNTY

Websites: http://www.dph.sf.ca.us/PHP/MHP.htm
http://sanfrancisco.networkofcare.org/mh/home/index.cfm

Address:
San Francisco Community Behavioral Health Services
1380 Howard Street, 5th Floor
San Francisco, CA  94103

Phone.
415-255-3400; Fax: 415-255-3567

County Crisis Intervention 24-Hour Number: 415-781-0500

SAN JOAQUIN COUNTY

Website: http://www.co.san-joaquin.ca.us/mhs/

Address:
San Joaquin County Behavioral Health Services
1212 North California Street
Stockton, CA 95202

Phone.
209-468-8700; Fax: 209-468-2399

County Crisis Intervention 24-Hour Number: 209-468-8686

SAN LUIS OBISPO
Websites: http://www.slocounty.ca.gov/health/mentalhealthservices.htm
http://sanluisobispo.networkofcare.org/mh/home/index.cfm

Address:
San Luis Obispo County Behavioral Health Department
2178 Johnson Avenue
San Luis Obispo, CA 93401-4535

Phone:
805-781-4719; Fax: 805-781-1273

County Crisis Intervention 24-Hour Number: 805-781-4700

SAN MATEO COUNTY

Websites: http://www.smhealth.org/mental.html
http://sanmateo.networkofcare.org/mh/home/index.cfm

Address:
San Mateo County Behavioral Health & Recovery
225 37th Avenue, Suite 320
San Mateo, CA 94403-4324

Phone:
650-573-2541; Fax: 650-573-2841

Psychiatric Emergency Services (PES): 650-573-2662
ACCESS Team: 800-686-0101

SANTA BARBARA COUNTY

Websites: http://www.admhs.org/apps/admhs_main/Main/index.asp
http://santabarbara.networkofcare.org/mh/home/index.cfm

Address:
Santa Barbara County Alcohol, Drug & Mental Health Services
300 North San Antonio Rd., Bldg. 3
Santa Barbara, CA 93110

Phone:
805-681-5220; Fax: 805-681-5413

County Crisis Intervention 24-Hour Number: 888-868-1649

SANTA CLARA COUNTY
Websites: http://www.sccmhd.org
http://santaclara.networkofcare.org/mh/home/index.cfm

Address:
Santa Clara County Valley Health and Hospital System
Mental Health Department
828 South Bascom Avenue, Ste. 200
San Jose, CA 95128

Phone:
408-885-5770; Fax: 408-885-5788

24-Hour Numbers Suicide and Crisis Services: 408-279-3312 (San Jose Area) (Main 24-hour number); 650-494-8420 (North Santa Clara County); 408-683-2482 (South Santa Clara County)

SANTA CRUZ COUNTY

Websites: http://www.santacruzhealth.org/cmhs/2cmhs.htm
http://santacruz.networkofcare.org/mh/home/index.cfm

Address:
Santa Cruz County Mental Health and Substance Abuse Services
1400 Emeline Avenue, Bldg. K
Santa Cruz, CA 95060

Phone:
831-454-4170 or 831-454-4767

24-Hour Access Number: 800-952-2335

SHASTA COUNTY

Websites: http://www.co.shasta.ca.us/departments/mentalhealth/index.shtml
http://shasta.networkofcare.org/mh/home/index.cfm

Address:
Shasta County Mental Health, Alcohol & Drug Dept.
Mental Health Department
P.O. Box 496048
Redding, CA 96049

Phone:
530-225-5200; Fax: 530-225-5977

County Crisis Intervention 24-Hour Numbers: 530-225-5200, 888-385-5201
SIERRA COUNTY

Websites: http://www.sierracounty.ws/
          http://sierra.networkofcare.org/mh/home/index.cfm

Address:
Sierra County Mental Health
704 Mill Street/P.O. Box 265
Loyalton, CA 96118

Phone:
530-993-6748; Fax: 530-993-6741

County Crisis Intervention 24-Hour Number: 877-435-7137

SISKIYOU COUNTY

Websites: http://www.co.siskiyou.ca.us/bhs/index.htm
          http://siskiyou.networkofcare.org/mh/home/index.cfm

Address:
County of Siskiyou Behavioral Health Services
2060 Campus Drive
Yreka, CA 96097

Phone:
530-841-4800; Fax: 530-841-4712

County Crisis Intervention 24-Hour Number: 800-842-8979

SOLANO COUNTY

Websites: http://www.co.solano.ca.us/Department/Department.asp?NavID=87
          http://solano.networkofcare.org/mh/home/index.cfm

Address:
Solano County Health and Social Services
275 Beck Avenue, MS 5-250
Fairfield, CA 94533-6804

Phone:
707-784-8320; Fax: 707-421-6619

County Crisis Intervention 24-Hour Number: 707-428-1131
SONOMA COUNTY

Website: http://www.sonoma-county.org/health/mh/index.htm

Address:
Sonoma County Mental Health
3322 Chanate Road
Santa Rosa, CA 95404-1708

Phone:
707-565-4850; Fax: 707-565-4892

24-Hour Number MHSA Liaison and Programs: 707-576-8181, 800-746-8181

STANISLAUS COUNTY

Websites: http://www.co.stanislaus.ca.us/BHRS/index.htm
http://stanislaus.networkofcare.org/mh/home/index.cfm

Address:
Stanislaus County Behavioral Health and Recovery Services
800 Scenic
Modesto, CA 95350

Phone:
209-525-6225; Fax: 209-525-6291

County Crisis Intervention 24-Hour Number: 209-558-4600

SUTTER/YUBA COUNTY

Websites: http://www.co.sutter.ca.us/doc/government/depts/hs/mh/hs_mental_health
http://sutter.networkofcare.org/mh/home/index.cfm

Address:
Sutter/Yuba Mental Health Services
1965 Live Oak Blvd.
P.O. Box 1520
Yuba City, CA 95991

Phone:
530-822-7200 or 530-822-7108; Fax: 530-822-7627

County Crisis Intervention 24-Hour Numbers: 530-673-8255, 888-923-3800
TEHAMA COUNTY

Website: http://www.tehamacohealthservices.net/

Address:
Tehama County Health Services Agency
Mental Health Division
P.O. Box 400
Red Bluff, CA  96080

Phone:
530-527-5631; Fax: 530-527-0232

County Crisis Intervention 24-Hour Numbers: 530-527-5637, 800-240-3208

TRI-CITY MENTAL HEALTH CENTER

Website: http://www.tricitymhs.org/

Address:
Tri-City Mental Health Center
2008 N. Garey Avenue
Pomona, CA  91767-2722

Phone:
909-623-6131; Fax: 909-623-4073

County Crisis Intervention 24-Hour Number: 866-623-9500

TRINITY COUNTY

Websites: http://www.trinitycounty.org/Departments/Behave-AODS-Prevent/behavioralhealth.htm
http://trinity.networkofcare.org/mh/home/index.cfm

Address:
Trinity County Behavioral Health Services
1450 Main Street/P.O. Box 1640
Weaverville, CA  96093

Phone:
530-623-1362; Fax: 530-623-1447

County Crisis Intervention 24-Hour Number: 530-623-5708, 888-624-5820
TULARE COUNTY

*Websites:* http://www.tularehhsa.org/health_serv/index.cfm
   http://tulare.networkofcare.org/mh/home/index.cfm

*Address:*
Tulare County Health and Human Services Agency
Department of Mental Health
5957 South Mooney Boulevard
Visalia, CA 93277

*Phone.*
559-737-4660; Fax: 559-737-4572

*County Crisis Intervention 24-Hour Numbers:* **559-733-6877, 800-320-1616**

TUOLUMNE COUNTY

*Websites:* http://portal.co.tuolumne.ca.us/psp/ps/TUP_BEHAV_HEALTH/ENTP/
   h/?tab=DEFAULT
   http://tuolumne.networkofcare.org/mh/home/index.cfm

*Address:*
Tuolumne County Behavioral Health Department
2 South Green Street
Sonora, CA 95370

*Phone.*
209-533-6245; Fax: 209-588-9563

*County Crisis Intervention 24-Hour Numbers:* **209-588-9528 – Crisis Line; 800-273-TALK (8255) – Suicide Hotline; 800-630-1130 – Managed care line**

VENTURA COUNTY

*Websites:* http://www.vchca.org/bh/index.htm
   http://ventura.networkofcare.org/mh/home/index.cfm

*Address:*
Ventura County Behavioral Health Department
1911 Williams Drive, Suite 200
Oxnard, CA 93036

*Phone.*
805-981-6830; Fax: 805-981-6838

County Crisis Intervention 24-Hour Number: 877-327-4747

YOLO COUNTY

Websites: http://www.yolocounty.org/org/Mental%20Health/default.htm
http://yolo.networkofcare.org/mh/home/index.cfm

Address:
Yolo County Dept. of Alcohol, Drug & Mental Health
137 North Cottonwood Street, Suite 2500
Woodland, CA 95695

Phone:
530-666-8516; Fax: 530-666-8294

County Crisis Intervention 24-Hour Number: 888-965-6647

Domestic Violence Centers by County

ALAMEDA
- SAVE - Shelter Against Violent Environment Fremont 510-794-6055
- DeafHope Hayward hotline@deaf-hope.org;
- TTY 510-733-3133
- Emergency Shelter Program, Inc. Hayward 510-786-1246; 888-339-SAFE
- Tri Valley Haven Livermore 925-449-5842; 800-884-8119
- A Safe Place Oakland 510-536-7233
- Building Futures with Women/Children San Leandro 866-AWAYOUT

AMADOR
- Operation Care Jackson 209-223-2600; 209-223-2897

BUTTE
- Catalyst Domestic Violence Services Chico 800-895-8476

CALAVERAS
- Calaveras Women’s Crisis Center San Andreas 209-736-4011

CONTRA COSTA
- STAND! Against Domestic Violence Concord 888-215-5555; 925-676-2845

DEL NORTE
- Rural Human Services Crescent City 707-465-3013
EL DORADO
- El Dorado Women's Center Placerville 530-626-1131
- South Lake Tahoe Women's Center South Lake Tahoe 530-544-4444; 888-750-6444

FRESNO
- Marjaree Mason Center Fresno 559-233-HELP

HUMBOLDT
- Humboldt Women for Shelter Eureka 707-443-6042

IMPERIAL
- Center for Family Solutions/Women Haven El Centro 760-353-8530

KERN
- Alliance Against Family Violence/Sexual Assault Bakersfield 800-273-7713; 661-327-1091
- Women's Center High Desert, Inc. Ridgecrest 760-375-7525

KINGS
- Kings County Community Action Organization Handford 877-727-3225

LAKE
- Sutter Lakeside Community Services Lakeport 888-485-7733

LASSEN
- Lassen Family Services, Inc. Susanville 530-257-5004; 888-289-5004

LOS ANGELES
- Su Casa Family Crisis & Support Center Artesia 562-402-4888
- Peace & Joy Care Center Carson 310-898-3117
- House of Ruth Claremont 909-988-5559
- Angel Step Inn Downey 800-655-2226; 323-780-HELP
- YWCA of Glendale, DV Project Glendale 818-242-1106
- Antelope Valley DV Council Lancaster 800-282-4808; 661-945-6736
- 1736 Family Crisis Center Long Beach 562-388-7652; 877-367-7752
- Interval House Long Beach 562-594-4555
- WomenShelter of Long Beach Long Beach 562-437-4663
- 1736 Family Crisis Center Los Angeles 213-745-6434
- Center for the Pacific-Asian Family Los Angeles 800-339-3940; 323-653-4042
- CSAC Chicana Service Action Center Los Angeles 800-548-2722; 800-843-9675
- Good Shepard Shelter Los Angeles 323-737-6111
- Jenesse Center, Inc. Los Angeles 323-731-6500; 800-479-7328
- Domestic Violence Center/Santa Clarita Valley Newhall 661-259-4357; 800-339-6993
- Haven House Pasadena 323-681-2626
- 1736 Family Crisis Center Redondo Beach 310-370-5902
- Haven Hills San Fernando Valley 818-887-6589; 800-978-3600
- Rainbow Services, Ltd. San Pedro 310-547-9343
- Sojourn Services Santa Monica 310-264-6644
- Family Violence Project / Jewish Family Services Sherman Oaks 818-505-0900
- YWCA Wings West Covina 626-967-0658
- Women's & Children's Crisis Center Whittier 562-945-3939

**MADERA**
- Madera County Action Committee Madera 800-355-8989; 559-661-1000

**MARIN**
- Marin Abused Women's Services San Rafael 415-924-6616; 415-924-3456

**MARIPOSA**
- Mountain Crisis Services Mariposa 888-966-2350; 209-966-2350

**MENDOCINO**
- Project Sanctuary, Inc. Ukiah 707-462-9196; 707-463-HELP

**MERCED**
- A Woman's Place of Merced County Merced 800-799-SAFE; 209-722-4357

**MODOC**
- Modoc Crisis Center (T.E.A.C.H.) Alturas 800-291-2156; 530-233-4575

**MONO**
- Wild Iris Mammoth Lakes 877-873-7384

**MONTEREY**
- Shelter Outreach Plus Marina 831-422-2201; 800-339-8228
- YWCA of Monterey County Seaside 800-YWCA-151; 831-372-6300

**NAPA**
- Napa Emergency Women's Services (NEWS) Napa 707-255-6397

**NEVADA**
- Domestic Violence/Sexual Assault Coalition Grass Valley 530-272-3467; 530-272-2046

**ORANGE**
- Human Options, Inc Irvine 949-854-3554
- Women's Transitional Living Center (WTLC) Orange 714-992-1931
- Laura's House San Clemente 949-498-1511
- Interval House Seal Beach 714-891-8121

**PLACER**
- P.E.A.C.E. for Families Auburn 800-575-5352
- Tahoe Women's Services Kings Beach 800-736-1060

**PLUMAS**
- Plumas Rural Services, Inc. Quincy 800-485-8099

**RIVERSIDE**
- Shelter From the Storm, Inc. Palm Desert 800-775-6055; 760-328-7233
- Alternatives to Domestic Violence Riverside 951-672-6175; 800-339-7233

**SACRAMENTO**
- WEAVE Sacramento 916-920-2952; 866-920-2952

**SAN BERNARDINO**
- Desert Sanctuary, Inc. Barstow 760-256-3441; 800-982-2221
- DOVES of Big Bear Valley, Inc. Big Bear Lake 909-866-5723; 800-851-7601
- DOVES of Big Bear Valley, Inc. Crestline 909-867-7700
- Morongo Basin Unity Home Joshua Tree 760-366-9663
- Option House San Bernardino 909-381-3471
- High Desert Domestic Violence Program Victorville 760-949-4357; 866-770-7867
- Victor Valley Domestic Violence Center Victorville 760-955-8723

**SAN DIEGO**
- South Bay Community Services Chula Vista 800-640-2933
- Community Resource Center Encinitas 877-633-1112
- Women's Resource Center Oceanside 760-757-3500
- Center for Community Solutions San Diego 888-385-4657; 888-272-1767
- YWCA of San Diego County San Diego 619-234-3164

**SAN FRANCISCO**
- Asian Women's Shelter San Francisco 415-751-0880; 877-751-0880
- La Casa de las Madres San Francisco 877-503-1850; 877-923-0700
- Riley Center/St. Vincent de Paul San Francisco 415-255-0165
- Community United Against Violence San Francisco 415-333-HELP

**SAN JOAQUIN**
- Women's Center of San Joaquin County Stockton 209-465-4878

**SAN LUIS OBISPO**
- North Co. Women's Resource Center/Shelter Atascadero 800-549-8989; 805-461-1338
- Women's Shelter Program/San Luis Obispo Co. San Luis Obispo 800-549-8989; 805-781-6400

**SAN MATEO**
- Communities Overcoming Relationship Abuse San Mateo 650-312-8515; 800-300-1080

**SANTA BARBARA**
- Domestic Violence Solutions Lompoc 805-736-0965
- Domestic Violence Solutions Santa Barbara 805-964-5245
- Domestic Violence Solutions Santa María 805-925-2160
- Domestic Violence Solutions Santa Ynez 805-686-4390

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SANTA CLARA
- Community Solutions Morgan Hill 408-683-4118
- Support Network for Battered Women Mountain View 800-572-2782; 650-940-7850
- Asian Women's Home (AACI) San Jose 408-975-2739
- Next Door Solutions to Domestic Violence San Jose 408-279-2962

SANTA CRUZ
- Walnut Avenue Women's Center Santa Cruz 866-2MYALLY
- Women's Crisis Support Santa Cruz 831-685-3737
- Defensa de Mujeres Watsonville 831-MUJERES

SHASTA
- Shasta County Women's Refuge, Inc. Redding 530-244-0117

SISKIYOU
- Siskiyou Domestic Violence & Crisis Center Yreka 877-842-4068

SOLANO
- SafeQuest Solano Fairfield 707-425-7342

SONOMA
- YWCA of Sonoma County Santa Rosa 707-546-1234

STANISLAUS
- Haven Women's Center of Stanislaus Modesto 209-577-5980; 800-834-1990

SUTTER
- Casa de Esperanza, Inc. Yuba City 530-674-2040

TEHAMA
- Alternatives to Violence Red Bluff 530-528-0226; 800-324-6473

TRINITY
- Human Response Network Weaverville 530-623-4357

TULARE
- Central California Family Crisis Center, Inc. Porterville 559-784-0192
- Family Services of Tulare County Visalia 800-448-2044

TUOLUMNE
- Kene Me-Wu Family Healing Center, Inc. Sonora 800-792-7776
- Mountain Women's Resource Center Sonora 209-533-3401

VENTURA
- Interface Children Family Services Camarillo 800-339-9597
- Coalition to End Domestic & Sexual Violence Oxnard 805-656-1111; 800-300-2181
YOLO
- Sexual Assault & Domestic Violence Center Woodland 530-662-1133; 916-371-1907

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<td>800-491-9099</td>
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<td>Madera</td>
<td>559-675-7762 (adults); 559-675-7920 (adolescents)</td>
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<td>707-565-7450</td>
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<td>Marin</td>
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<td>Mariposa</td>
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<td>Sutter</td>
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<td>Mendocino</td>
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<td>Merced</td>
<td>209-381-6880</td>
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<td>Modoc</td>
<td>530-233-6319</td>
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<td>Monterey</td>
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<td><strong>Alameda City</strong></td>
<td>701 Atlantic Avenue</td>
<td>(510) 747-4300</td>
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<td><strong>Anaheim Housing Authority</strong></td>
<td>201 South Anaheim Boulevard #200</td>
<td>(714) 765-4320</td>
<td>(714) 765-4654</td>
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<td><strong>Auburn: Placer County Housing Authority</strong></td>
<td>11519 B Avenue, CA 95603</td>
<td>(530) 889-7962</td>
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<td>Auburn, CA</td>
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<td><strong>Bakersfield: Kern County</strong></td>
<td>601 - 24th Street</td>
<td>(661) 631-8500</td>
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<td><strong>Baldwin Park</strong></td>
<td>14403 Pacific Avenue</td>
<td>(626) 960-4011</td>
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<td>Baldwin Park, CA 91706</td>
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<td><strong>Belmont</strong></td>
<td>San Mateo County</td>
<td>(650) 802-3361</td>
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<td>264 Harbor Boulevard, Building A</td>
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<td><strong>Berkeley</strong></td>
<td>1901 Fairview Street</td>
<td>(510) 981-5470</td>
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<td><strong>Brawley</strong></td>
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<td>1401 D Street</td>
<td>(760) 344-9712</td>
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<td><strong>Burbank</strong></td>
<td>141 N. Glenoaks Blvd</td>
<td>(818) 238-5160</td>
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<td><strong>Calexico City</strong></td>
<td>1006 E 5th Street</td>
<td>(760) 357-3013</td>
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<td><strong>Carlsbad Housing Agency</strong></td>
<td>2965 Roosevelt Street, Suite B</td>
<td>(760) 434-2810</td>
<td>(760) 720-2037</td>
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<td><strong>Chico</strong></td>
<td>Butte</td>
<td>(530) 895-4474</td>
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<td><strong>Compton</strong></td>
<td>600 North Alameda, Room 163</td>
<td>(310) 605-3080</td>
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Crescent City
235 H Street
Crescent City, CA 95531
Phone: (707) 464-9216
Fax: (707) 464-2692

Culver City
9770 Culver Boulevard
Culver City, CA 90232
Phone: (310) 202-5764
Fax: (310) 253-5785

Dublin
6700 Dougherty Road, Apartment 151
Dublin, CA 94568
Phone: (925) 828-3132
Fax: (925) 828-5450

El Dorado County PHA
937 Spring Street
Placerville, CA 95667
Phone: (530) 642-7150
Fax: (530) 295-2598

Encinitas
505 South Vulcan Avenue
Encinitas, CA 92024
Phone: (760) 633-2723
Fax: (760) 633-2818

Eureka - Humboldt
735 West Everding Street
Eureka, CA 95503
Phone: (707) 443-4583
Fax: (707) 443-2150

Eureka
735 West Everding Street
Eureka, CA 95503
Phone: (707) 443-4583
Fax: (707) 443-2150

Fairfield
823b Jefferson Street
Fairfield, CA 94533
Phone: (707) 428-7392
Fax: (707) 425-0512

Fresno City Housing Authority
1331 Fulton Mall
Fresno, CA 93721
Phone: (559) 443-8475
Fax: (559) 443-8495

Fresno County Housing Authority
1331 Fulton Mall
Fresno, CA 93721
Phone: (559) 443-8475
Fax: (559) 445-8981

Garden Grove
11277 Garden Grove Blvd, Suite 101-C
Garden Grove, CA 92843
Phone: (714) 741-5150
Fax: (714) 741-5197

Glendale
141 North Glendale Avenue #202
Glendale, CA 91206
Phone: (818) 548-3936
Fax: (818) 548-3724

Hanford
Kings County Housing Authority
680 N Douty Street
Hanford, CA 93230
Phone: (559) 582-2806
Fax: (559) 583-6964

Hawaiian Gardens
21815 Pioneer Boulevard
Hawaiian Gardens, CA 90716
Phone: (562) 420-2641
Fax: (562) 496-3708

Hawthorne Housing
4455 West 126th Street
Hawthorne, CA 90250
Phone: (310) 349-1603
Fax: (310) 978-9864
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<th>Alameda County Housing Authority</th>
<th>Hayward, CA 94541</th>
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<td>Hollister</td>
<td>2931 Mission Street</td>
<td>Santa Cruz County Housing Authority</td>
<td>Santa Cruz, CA 95060</td>
<td>Phone: (831) 454-9455</td>
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<td>Inglewood</td>
<td>One Manchester Boulevard, Suite 750</td>
<td>Inglewood County Housing Authority</td>
<td>Inglewood, CA 90301</td>
<td>Phone: (310) 412-5221</td>
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<td>Lakewood</td>
<td>5050 North Clark Avenue</td>
<td>Lakewood County Housing Authority</td>
<td>Lakewood, CA 90712</td>
<td>Phone: (562) 866-9771</td>
<td>Fax: (562) 866-0505</td>
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<tr>
<td>Lassen County</td>
<td>2545 Main Street</td>
<td>Lassen County Housing Authority</td>
<td>Susanville, CA 96130</td>
<td>Phone: (530) 251-8346</td>
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<tr>
<td>Lawndale</td>
<td>14717 Burin Avenue</td>
<td>Monterey County Housing Authority</td>
<td>Monterey, CA 91755</td>
<td>Phone: (707) 995-7120</td>
<td>Fax: (707) 995-7129</td>
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<tr>
<td>Livermore</td>
<td>3203 Leahy Way</td>
<td>Mariposa County Housing Authority</td>
<td>Mariposa, CA 95338</td>
<td>Phone: (209) 966-3609</td>
<td>Fax: (209) 966-3519</td>
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<tr>
<td>Lomita</td>
<td>24925 Walnut Street</td>
<td>Santa Barbara County Housing Authority</td>
<td>Santa Barbara, CA 93436</td>
<td>Phone: (805) 736-3423</td>
<td>Fax: (805) 735-7672</td>
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<tr>
<td>Lomita</td>
<td>1390 Main Street</td>
<td>Monterey County Housing Authority</td>
<td>Monterey, CA 91755</td>
<td>Phone: (707) 995-7120</td>
<td>Fax: (707) 995-7129</td>
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<tr>
<td>Lower Lake</td>
<td>205 N. G Street</td>
<td>Mariposa County Housing Authority</td>
<td>Mariposa, CA 95338</td>
<td>Phone: (209) 966-3609</td>
<td>Fax: (209) 966-3519</td>
</tr>
</tbody>
</table>
Marin Housing  
4020 Civic Center Drive  
San Rafael, CA 94903  
Phone: (415) 491-2525  
Fax: (415) 479-3305

Martinez  
Contra Costa County  
3133 Estudillo Street  
Martinez, CA 94553  
Phone: (925) 957-8019  
Fax: (925) 372-0236

Marysville  
Yuba County Housing Authority  
915 8th Street, Suite 130  
Marysville, CA 95901  
Phone: (530) 749-5460  
Fax: (530) 749-5464

Mendocino County  
1076 N State Street  
Ukiah, CA 95482  
Phone: (707) 463-5462  
Fax: (707) 463-4188

Merced  
405 U Street  
Merced, CA 95341  
Phone: (209) 722-3501  
Fax: (209) 722-0106

Monterey  
123 Rico Street  
Salinas, CA 93907  
Phone: (831) 775-5000  
Fax: (831) 424-9153

Napa Housing Authority  
1115 Seminary Street  
Napa, CA 94559  
Phone: (707) 257-9543  
Fax: (707) 257-9239

National City  
140 E 12th Street, Suite B  
National City, CA 91950  
Phone: (619) 336-4254  
Fax: (619) 477-3747

Needles  
908 Sycamore Drive  
Needles, CA 92363  
Phone: (760) 326-3222  
Fax: (760) 326-2741  
Both  
CA146 Nevada County Housing Authority  
950 Maidu Ave, PO Box 1210  
Nevada City, CA 95959  
Phone: (530) 265-1340  
Fax: (530) 265-9860

Norwalk  
12035 Firestone Blvd  
Norwalk, CA 90650  
Phone: (562) 929-5588  
Fax: (562) 929-5537

Oakland HA  
1619 Harrison Street  
Oakland, CA 94612  
Phone: (510) 874-1512  
Fax: (510) 874-1674

Oceanside  
321 North Nevada Street  
Oceanside, CA 92054  
Phone: (760) 435-3360  
Fax: (760) 757-9076
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<th>Location</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
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<tbody>
<tr>
<td>Orange County</td>
<td>1770 North Broadway, Santa Ana, CA 92706</td>
<td>(714) 480-2700</td>
<td>(714) 480-2803</td>
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<tr>
<td>Pomona Housing Authority</td>
<td>505 S. Garey Ave., Box 660, Pomona, CA 91769</td>
<td>(909) 620-2368</td>
<td>(909) 620-4567</td>
</tr>
<tr>
<td>Oxnard Housing Authority</td>
<td>435 South D Street, Oxnard, CA 93030</td>
<td>(805) 385-8096</td>
<td>(805) 385-7969</td>
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<tr>
<td>Port Hueneme Housing Authority</td>
<td>250 N Ventura Road, Port Hueneme, CA 93041</td>
<td>(805) 986-6522</td>
<td>(805) 986-6562</td>
</tr>
<tr>
<td>Paramount</td>
<td>16400 Colorado Avenue, Paramount, CA 90723</td>
<td>(562) 220-2207</td>
<td>(562) 529-8497</td>
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<tr>
<td>Plumas</td>
<td>183 West Main Street, Quincy, CA 95971</td>
<td>(530) 283-2466</td>
<td>(530) 283-2478</td>
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<tr>
<td>Redding Housing Authority</td>
<td>777 Cypress Avenue, Redding, CA 96001</td>
<td>(530) 225-4048</td>
<td>(530) 225-4126</td>
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<tr>
<td>Paso Robles</td>
<td>3201 Pine Street, Paso Robles, CA 93446</td>
<td>(805) 238-4015</td>
<td>(805) 238-4036</td>
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<tr>
<td>Redondo Beach</td>
<td>320 Knob Hill, Room 2, Redondo Beach, CA 90277</td>
<td>(310) 372-1171</td>
<td>(310) 374-4828</td>
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<tr>
<td>Pico Rivera</td>
<td>6615 Passons Boulevard, Pico Rivera, CA 90660</td>
<td>(562) 801-4347</td>
<td>(562) 949-7506</td>
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<tr>
<td>Pittsburg</td>
<td>916 Cumberland Street, Pittsburg, CA 94565</td>
<td>(925) 252-4109</td>
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<tr>
<td>Pleasanton</td>
<td>123 Main Street, Pleasanton, CA 94566</td>
<td>(925) 484-8008</td>
<td>(925) 484-8234</td>
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<td>Pleasanton</td>
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<td>(925) 484-8008</td>
<td>(925) 484-8234</td>
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141
Roseville Housing Authority  
311 Vernon Street  
Roseville, CA 95678  
Phone: (916) 774-5270  
Fax: (916) 774-5286

Sacramento City  
701 12th Street  
Sacramento, CA 95814  
Phone: (916) 440-1390  
Fax: (916) 264-1643

Sacramento County  
701 12th Street  
Sacramento, CA 95814  
Phone: (916) 440-1390  
Fax: (916) 264-1643

San Bernardino County  
715 East Brier Dr  
San Bernardino, CA 92408  
Phone: (909) 890-0644  
Fax: (909) 890-4618

San Buenaventura City  
995 Riverside Street  
Ventura, CA 93001  
Phone: (805) 648-5008  
Fax: (805) 643-7984

San Diego County  
3989 Ruffin Road  
San Diego, CA 92123  
Phone: (858) 694-4801  
Fax: (858) 694-4871

San Diego Housing Commission  
1122 Broadway Suite 300  
San Diego, CA 92101  
Phone: (619) 231-9400  
Fax: (619) 578-7375

San Francisco HA  
440 Turk Street  
San Francisco, CA 94102  
Phone: (415) 554-1200  
Fax: (415) 241-1024

Santa Clara  
505 West Julian Street  
San Jose, CA 95110  
Phone: (408) 275-8770  
Fax: (408) 280-0358

San Jose City Housing Authority  
505 West Julian Street  
San Jose, CA 95110  
Phone: (408) 275-8770  
Fax: (408) 280-0358

San Luis Obispo  
487 Leff Street  
San Luis Obispo, CA 93401  
Phone: (805) 543-4478  
Fax: (805) 543-4992

Shasta County Housing Authority  
1450 Court Street, Suite 108  
Redding, CA 96001  
Phone: (530) 225-5160  
Fax: (530) 225-5178

Santa Ana Housing Authority  
20 Civic Center Plaza 2nd Floor, M-27  
Santa Ana, CA 92701  
Phone: (714) 667-2200  
Fax: (714) 547-5411

Santa Barbara City  
808 Laguna Street  
Santa Barbara, CA 93101  
Phone: (805) 965-1071  
Fax: (805) 564-7041

San Juan Bautista  
2931 Mission Street  
Santa Cruz, CA 95060  
Phone: (831) 454-9455  
Fax: (831) 469-3712

San Joaquin  
448 S Center Street  
Stockton, CA 95203  
Phone: (209) 460-5000  
Fax: (209) 460-5165
Upland Housing Authority
1200 North Campus Avenue
Upland, CA 91786
Phone: (909) 982-2649
Fax: (909) 982-0237

Wasco Apts.
750 H Street
Wasco, CA 93280
Phone: (661) 758-6406
Fax: (661) 758-0765

Vacaville
40 Eldridge Avenue #2
Vacaville, CA 95688
Phone: (707) 449-5675
Fax: (707) 449-6242

West Hollywood
8300 West Santa Monica Boulevard
West Hollywood, CA 90069
Phone: (323) 848-6418
Fax: (323) 848-6567

Vallejo
200 Georgia Street
Vallejo, CA 94590
Phone: (707) 648-4507
Fax: (707) 648-5249

Yolo County Housing
147 West Main Street
Woodland, CA 95695
Phone: (530) 662-5428
Fax: (530) 662-5429

Ventura County
1400 West Hillcrest Drive
Phone: (805) 480-9991
Fax: (805) 480-1021

Newbury Park, CA 91320

List of Regional Centers

Alta California Regional Center
2135 Butano Drive
Sacramento, CA 95825
(916) 978-6400

Serves Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba counties

Central Valley Regional Center
4615 North Marty Avenue
Fresno, CA 93722-4186
(559) 276-4300

Serves Fresno, Kings, Madera, Mariposa, Merced, and Tulare counties

Eastern Los Angeles Regional Center
1000 South Fremont
Alhambra, CA 91802-7916
Mailing Address: P.O. Box 7916
Alhambra, CA 91802-7916
(626) 299-4700
Serves Eastern Los Angeles County including the communities of Alhambra and Whittier

**Far Northern Regional Center**
1900 Churn Creek Road, #319
Redding, CA 96002
Mailing Address: P. O. Box 492418
Redding, CA 96049-2418 Laura Larson
(530) 222-4791

Serves Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama, and Trinity counties

**Frank D. Lanterman Regional Center**
3303 Wilshire Boulevard, Suite 700
Los Angeles, CA 90010
(213) 383-1300

Serves Central Los Angeles county including Burbank, Glendale, and Pasadena

**Golden Gate Regional Center**
875 Stevenson Street, 6th Floor
San Francisco, CA 94103
(415) 546-9222

Serves Marin, San Francisco, and San Mateo counties

**Harbor Regional Center**
21231 Hawthorne Boulevard
Torrance, CA 90503
(310) 540-1711

Serves Southern Los Angeles county including Bellflower, Harbor, Long Beach, and Torrance

**Inland Regional Center**
674 Brier Drive
San Bernardino, CA 92408
Mailing Address: P. O. Box 6127
San Bernardino, CA 92412-6127
(909) 890-3000

Serves Riverside and San Bernardino counties

**Kern Regional Center**
3200 North Sillect Avenue
Bakersfield, CA 93308
(661) 327-8531

Serves Inyo, Kern, and Mono counties
North Bay Regional Center
10 Executive Court, Suite A
Napa, CA 94558
(707) 256-1100
Serves Napa, Solano, and Sonoma counties

North Los Angeles County Regional Center
15400 Sherman Way, Suite 170
Van Nuys, CA 91406-4211
(818) 778-1900
Serves Northern Los Angeles county including San Fernando and Antelope Valleys

Redwood Coast Regional Center
525 Second Street, Suite 300
Eureka, CA 95501
(707) 445-0893
Serves Del Norte, Humboldt, Mendocino, and Lake counties

Regional Center of the East Bay
7677 Oakport Street, Suite 300
Oakland, CA 94621
(510) 383-1200
Serves Alameda and Contra Costa counties

Regional Center of Orange County
801 Civic Center Drive West, Suite 100
Santa Ana, CA 92701
(714) 796-5100
Serves Orange county

San Andreas Regional Center
300 Orchard City Drive, Suite 170
Campbell, CA 95008
(408) 374-9960
Serves Monterey, San Benito, Santa Clara, and Santa Cruz counties

San Diego Regional Center
4355 Ruffin Road, Suite 200
San Diego, CA 92123-1648
(858) 576-2996
Serves Imperial and San Diego counties

San Gabriel/Pomona Regional Center
761 Corporate Center Drive
Pomona, CA 91768
(909) 620-7722

Serves Eastern Los Angeles County including El Monte, Monrovia, Pomona, and Glendora

South Central Los Angeles Regional Center
650 West Adams Boulevard, Suite 200
Los Angeles, CA 90007-2545
(213) 744-7000

Serves Southern Los Angeles County including the communities of Compton and Gardena

Tri-Counties Regional Center
520 East Montecito Street
Santa Barbara, CA 93103-3274
(805) 962-7881

Serves San Luis Obispo, Santa Barbara, and Ventura counties

Valley Mountain Regional Center
702 North Aurora Street
Stockton, CA 95202
(209) 473-0951

Serves Amador, Calaveras, San Joaquin, Stanislaus, and Tuolumne counties

Westside Regional Center
5901 Green Valley Circle, Suite 320
Culver City, CA 90230-6953
(310) 258-4000

Serves Western Los Angeles county including the communities of Culver City, Inglewood, and Santa Monica

United Way Local Listings

Butte & Glenn Counties
United Way of Butte & Glenn Counties
P.O. Box 3829
Chico, CA 95927-3829
(530) 342-7898
http://www.localunitedway.org/
**Fresno County**
United Way of Fresno County  
4949 East Kings Canyon Road  
Fresno, CA 93727-3812  
(559) 244-5710  
http://www.unitedwayfresno.org/

**Humboldt County**
United Way of Humboldt County  
1809 Albee Street  
Eureka, CA 95501-2844  
(707) 443-8637  
http://www.unitedwayhumboldt.org/

**Imperial County**
United Way of Imperial County  
P.O. Box 1924  
El Centro, CA 92244-1924  
(760) 355-4900  
http://www.ivpressonline.com/united/

**Kern County**
United Way of Kern County, Inc.  
5405 Stockdale Highway, Suite 200  
Bakersfield, CA 93309 (661) 834-1820  
http://www.uwkern.org/

**Kings County**
Kings United Way  
P.O. Box 878  
Armona, CA 93202-0878  
(559) 584-1536  
http://kingsunitedway.org/

**Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama & Trinity counties - Redding**
United Way of Northern California  
P.O. Box 990248  
Redding, CA 96099-0248  
(530) 241-7521  
http://www.norcalunitedway.org/

**Los Angeles**
United Way of Greater Los Angeles  
523 West 6th Street  
Los Angeles, CA 90014-1217  
(213) 808-6220  
http://www.unitedwayla.org/
Los Angeles County
United Way of Greater Los Angeles, Antelope & Santa Clarita Valleys
42442 10th Street West, Suite A
Lancaster, CA 93534
(661) 729-8910
http://www.unitedwayla.org/

Los Angeles County
United Way of Greater Los Angeles, Harbor Area Office
3515 Linden Avenue
Long Beach, CA 90807-4519
(562) 988-2500
http://www.unitedwayla.org/

Los Angeles County
United Way of Greater Los Angeles, San Fernando & San Gabriel Valleys
5121 Van Nuys Boulevard, Suite #206
Sherman Oaks CA 91403
(818) 380-2560
http://www.unitedwayla.org/

Madera County
United Way of Madera County
P.O. Box 505
Madera, CA 93639
(559) 674-9780
No Website

Merced County
United Way of Merced County
P.O. Box 2026
Merced, CA 95344-0026
(209) 383-4242
http://www.unitedwaymerced.org/

Monterey County
United Way of Monterey County
2511 Garden Road, Suite C-100
Monterey, CA 93940-5333
(831) 372-8026
http://www.unitedwaymcca.org/
Nevada County
United Way of Nevada County
P.O. Box 2733
Grass Valley, CA 95945-2733
(530) 274-8111
http://www.uwnc.org/

Orange County
Orange County United Way
18012 Mitchell Avenue South
Irvine, CA 92614-6008
(949) 660-7600
http://www.unitedwayoc.org/

Riverside County - Corona
Corona-Norco United Way
P.O. Box 1809
Corona, CA 92878-1809
(951) 736-0620
http://www.cnunitedway.org/

Riverside County - Hemet
Central County United Way
418 East Florida Avenue
Hemet, CA 92543
(951) 929-9691
http://www.ccuw.org/

Riverside County – Palm Springs
United Way of the Desert
P.O. Box 1990
Palm Springs, CA 92263-1990
(760) 323-2731
http://www.unitedwayofthedesert.org/

Riverside County – Riverside
United Way of the Inland Valleys
6215 River Crest Drive, Suite B
Riverside, CA 92507-0703
(951) 697-4700
http://www.uwiv.org/

Sacramento, Amador, El Dorado, Placer, & part of Yolo
United Way California Capital Region
10389 Old Placerville Road
Sacramento, CA 95827
(916) 368-3000
http://www.yourlocalunitedway.org/
San Bernardino County - Apple Valley
Desert Communities United Way
16192 Siskiyou Road, #4
Apple Valley, CA 92307-1316
(760) 242-5370
http://www.dcuw.org/

San Bernardino County - Barstow
United Way of Mojave Valley
P.O. Box 362
Barstow, CA 92312-0362
(760) 256-8789
No Website

San Bernardino County – Ridgecrest
United Way of Indian Wells Valley
206 Balsam Street
Ridgecrest, CA 93555
(760) 375-1920
http://www.iwvunitedway.org/

San Bernardino County – San Bernardino
Arrowhead United Way
P.O. Box 796
San Bernardino, CA 92402-0796
(909) 884-9441
http://www.arrowheadunitedway.org/

San Bernardino County (west)
Inland Empire United Way
9644 Hermosa Avenue
Rancho Cucamonga, CA 91730
(909) 980-2857
http://www.ieuw.org/

San Diego County
United Way of San Diego County
4699 Murphy Canyon Road
San Diego, CA 92123-5371
(858) 492-2000
http://www.uwsd.org/

San Francisco, San Mateo, Marin, Solano, Alameda, Contra Costa counties
United Way of the Bay Area
221 Main Street, Suite 300
San Francisco, CA 94105
(415) 808-4300
http://www.uwba.org/
San Joaquin County
United Way of San Joaquin County, Inc.
P.O. Box 1585
Stockton, CA 95201-3085
(209) 469-6980
http://www.unitedwaysjc.org/

San Luis Obispo County
United Way of San Luis Obispo County
P.O. Box 14309
San Luis Obispo, CA 93406-4309
(805) 541-1234
http://www.unitedwayslo.org/

Santa Barbara County (north)
Northern Santa Barbara County United Way
P.O. Box 947
Santa Maria, CA 93456-0947
(805) 922-0329
http://uwcentralcoast.org/

Santa Barbara County (south)
United Way of Santa Barbara County
320 E Gutierrez Street
Santa Barbara, CA 93101-1707
(805) 965-8591
http://www.unitedwaysb.org/

Santa Clara and San Benito counties
United Way Silicon Valley
1400 Parkmoor Avenue, Suite 250
San Jose, CA 95126-3429
(408) 345-4300
http://www.uwsv.org/

Santa Cruz County
United Way of Santa Cruz County
P.O. Box 1458
Capitola, CA 95010-1458
(831) 479-5466
http://www.unitedwaysc.org/

Sonoma, Mendocino, Lake counties
United Way of the Wine Country
P.O. Box A
Santa Rosa, CA 95402-0009
(707) 528-4485
http://www.unitedwaywinecountry.org/
Stanislaus, Tuolumne, Calaveras counties
United Way of Stanislaus County, Inc.
P.O. Box 3066
Modesto, CA 95355-3066  (209) 523-4562
http://www.uwaystan.org/

Tulare County
United Way of Tulare County
1601 East Prosperity
Tulare, CA 93274
(559) 685-1766
http://www.unitedwaytc.org/

Ventura County
United Way of Ventura County
1317 Del Norte Road, Suite 100
Camarillo, CA 93010-8483
(805) 485-6288 ext. 230
http://www.vcunitedway.org/

Yolo County - Woodland
Woodland United Way
1017 Main Street
Woodland, CA 95695-3530
(530) 662-3633
http://www.woodlandunitedway.org/

Yuba & Sutter Counties
Yuba-Sutter United Way
P.O. Box 2450
Marysville, CA 95901-2450
(530) 743-1847
http://www.yuba-sutterunitedway.org/
BBS Enforcement Review
October 10, 2009
Los Angeles, California

Complaint Examples
- An event that triggers review of individual conduct by the BBS enforcement staff.
- Arrest reports
- Conviction reports
- Consumer complaints
- CE Audit failure
- Agency Reports
- 801 Reports

Enforcement Terminology
Field Investigation

The collection of information and evidence related to a complaint by board staff or the Division of Investigation.

Examples

- Interviewing witnesses
- Collecting documents
- Collecting physical evidence

Enforcement Terminology
Field Investigations

Average Complaint Processing Time
In February 2009, BBS began using two Investigative Analysts to perform field investigations. Through the end of August 2009, those analysts have completed 24 investigations. Those investigations were completed in an average of 120 days.

As of August 30, 2009 another 24 investigations were pending with the Investigative Analysts. We expect to see approximately 48 investigations closed in the 2009 calendar year.

As a point of reference the board completed 30 field investigations in the 2007-08 Fiscal Year. The average completion time for those investigations was 396 days.

**Investigative Analysts**

**Case**
Legal action taken by the Attorney General on behalf of the board.

**Examples**
- Accusation
- Statement of Issues
- Petition to Revoke Probation

**Enforcement Terminology**
Disciplinary Activity

- Consumer Complaint Filings (47% Increase)
- Conviction Related Filings (38% Increase)
- Referred to AG (183% Increase)

Disciplinary Actions

- Consumer Complaint Cases (46% Decrease)
- Conviction Related Cases (128% Increase)
BBS Enforcement Budget

Board Enforcement Expenditures

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<td>% of Total Expenditures</td>
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To: Board Members  
From: Kim Madsen  
Assistant Executive Officer  
Subject: Substance Abuse Coordination Committee

Background

Senate Bill 1441, signed by the Governor on September 28, 2008, established the Substance Abuse Coordination Committee (SACC) within the Department of Consumer Affairs (DCA). This committee is comprised of the Executive Officers of the healing arts boards within DCA, and a designee of the State Department of Alcohol Drug Programs. The bill required the committee to develop, by January 1, 2010, uniform and specific standards in specific areas that each healing arts board would be required to follow when addressing the issue of a substance abusing licensee and ensuring public protection. Further, the SACC is subject to the Bagley-Keene Open Meeting Act.

Development Process

The SACC held its first meeting in March 2009 to initiate the process of developing the standards for sixteen (16) areas. The SACC determined that the most efficient way to meet the time lines established in Senate Bill 1441 was to create a smaller working group to develop the standards.

The working group is comprised of individuals within DCA who have the expertise in the areas of diversion, probation, and enforcement. The working group is charged with developing draft standards that can be applied to both licensees in diversion programs and licensees on probation. The proposed standards are drafted and presented at a public meeting to solicit public comment. Following this meeting, the working group reviews the public comments and prepares the proposed standards to present to the SACC.

To date, the working group has completed 15 of the 16 standards. The SACC will meet on September 30, 2009, to review and approve the 15 draft standards. It is anticipated that the working group and the SACC will complete their work in November 2009.

Board Review

Once the standards are approved by the SACC, each healing arts board will be required to follow the standards and the standards will impact each board’s enforcement program. In terms of the impact to the BBS enforcement program, at a minimum, we anticipate that another revision of our current disciplinary guidelines will be required.

Attached for your review and comment are the draft standards.
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UNIFORM STANDARDS REQUIRED BY SB 1441

Substance Abuse Coordination Committee:
Comprised of the executive officers of the department’s healing arts boards established pursuant to Division 2 (commencing with Section 500), the State Board of Chiropractic Examiners, the Osteopathic Medical Board of California, and a designee of the State Department of Alcohol and Drug Programs. The Director of Consumer Affairs shall chair the committee and may invite individuals or stakeholders who have particular expertise in the area of substance abuse to advise the committee. The committee shall be subject to the Bagley-Keene Open Meeting Act.

The Committee shall:
(c) By January 1, 2010, the committee shall formulate uniform and specific standards in each of the following areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program:

1. Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.
2. Specific requirements for the temporary removal of the licensee from practice to enable the licensee to undergo the clinical diagnostic evaluation any treatment recommended by the evaluator and approved by the board and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.
3. Specific requirements that govern the ability of the licensing board to communicate with the licensee’s employer about the licensee’s status and condition.
4. Standards governing all aspects of required testing, including, but not limited to:
   - frequency of testing
   - randomnicity
   - method of notice to the licensee
   - number of hours between the provision of notice and the test, standards for specimen collectors
   - procedures used by specimen collectors
   - the permissible locations of testing
   - whether the collection process must be observed by the collector
   - backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing
   - requirements for the laboratory that analyzes the specimens
   - required maximum timeframe from the test to the receipt of the result of the test.

5. Standards governing all aspects of group meeting attendance requirements, including, but not limited to:
   - required qualifications for group meeting facilitators
   - frequency of required meeting attendance
• methods of documenting and reporting attendance or nonattendance by licensees.

(6) Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

(7) Worksite monitoring requirements and standards, including, but not limited to:
  • required qualifications of worksite monitors
  • required methods of monitoring by worksite monitors
  • required reporting by worksite monitors.

(8) Procedures to be followed when a licensee tests positive for a banned substance.

(9) Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

(10) Specific consequences for major violations and minor violations. In particular, the committee shall consider the use of a “deferred prosecution” stipulation similar to the stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency unless or until the licensee commits a major violation, in which case it is revived and the license is surrendered.

(11) Criteria that a licensee must meet in order to petition for return to practice on a full-time basis.

(12) Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

(13) If a board uses a private-sector vendor that provides diversion services:
  • standards for immediate reporting by the vendor to the board of any and all noncompliance with any term of the diversion contract or probation
  • standards for the vendor’s approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors
  • standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services
  • standards for a licensee’s termination from the program and referral to enforcement.

(14) If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

(15) If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor’s performance in adhering to the standards adopted by the committee.

(16) Measurable criteria and standards to determine whether each board’s method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.
Senate Bill No. 1441

CHAPTER 548

An act to amend Sections 1695.1, 1695.5, 1695.6, 1697, 1698, 2361, 2365, 2366, 2367, 2369, 2663, 2665, 2666, 2770.1, 2770.7, 2770.8, 2770.11, 2770.12, 3501, 3534.1, 3534.3, 3534.4, 3534.9, and 4371 of, and to add Article 3.6 (commencing with Section 315) to Chapter 4 of Division 1 of, the Business and Professions Code, relating to health care.

[Approved by Governor September 28, 2008. Filed with Secretary of State September 28, 2008.]

LEGISLATIVE COUNSEL’S DIGEST


Existing law requires various healing arts licensing boards, including the Dental Board of California, the Board of Registered Nursing, the Physical Therapy Board of California, the Physician Assistant Committee, the Osteopathic Medical Board of California, and the California State Board of Pharmacy to establish and administer diversion or recovery programs or diversion evaluation committees for the rehabilitation of healing arts practitioners whose competency is impaired due to the abuse of drugs or alcohol, and gives the diversion evaluation committees certain duties related to termination of a licensee from the diversion program and reporting termination, designing treatment programs, denying participation in the program, reviewing activities and performance of contractors, determining completion of the program, and purging and destroying records, as specified.

Existing law requires the California State Board of Pharmacy to contract with one or more qualified contractors to administer the pharmacists recovery program and requires the board to review the pharmacists recovery program on a quarterly basis, as specified.

This bill would establish in the Department of Consumer Affairs the Substance Abuse Coordination Committee, which would be comprised of the executive officers of the department’s healing arts licensing boards, as specified, and a designee of the State Department of Alcohol Drug Programs. The bill would require the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board would be required to use in dealing with substance-abusing licensees. The bill would specify that the program managers of the diversion programs for the Dental Board of California, the Board of Registered Nursing, the Physical Therapy Board of California, the Physician Assistant Committee, and the Osteopathic Medical Board of California, as designated by the executive officers of those entities, are responsible for certain duties, including, as specified, duties related to termination of a licensee from the diversion program, the review and evaluation of recommendations of the committee,
approving the designs of treatment programs, denying participation in the program, reviewing activities and performance of contractors, and determining completion of the program. The bill would also provide that diversion evaluation committees created by any of the specified boards or committees operate under the direction of the program manager of the diversion program, and would require those diversion evaluation committees to make certain recommendations. The bill would require the executive officer of the California State Board of Pharmacy to designate a program manager of the pharmacists recovery program, and would require the program manager to review the pharmacists recovery program quarterly and to work with the contractors, as specified. The bill would set forth provisions regarding entry of a registered nurse into the diversion program and the investigation and discipline of registered nurses who are in, or have been in, the diversion program, and would require registered nurses in the diversion program to sign an agreement of understanding regarding withdrawal or termination from the program, as specified.

The bill would specify that the diversion program responsibilities imposed on licensing boards under these provisions shall be considered current operating expenses of those boards.

The people of the State of California do enact as follows:

SECTION 1. The Legislature hereby finds and declares all of the following:

(a) Substance abuse is an increasing problem in the health care professions, where the impairment of a health care practitioner for even one moment can mean irreparable harm to a patient.

(b) Several health care licensing boards have “diversion programs” designed to identify substance-abusing licensees, direct them to treatment and monitoring, and return them to practice in a manner that will not endanger the public health and safety.

(c) Substance abuse monitoring programs, particularly for health care professionals, must operate with the highest level of integrity and consistency. Patient protection is paramount.

(d) The diversion program of the Medical Board of California, created in 1981, has been subject to five external performance audits in its 27-year history and has failed all five audits, which uniformly concluded that the program has inadequately monitored substance-abusing physicians and has failed to promptly terminate from the program, and appropriately refer for discipline, physicians who do not comply with the terms and conditions of the program, thus placing patients at risk of harm.

(e) The medical board’s diversion program has failed to protect patients from substance-abusing physicians, and the medical board has properly decided to cease administering the program effective June 30, 2008.

(f) The administration of diversion programs created at other health care boards has been contracted to a series of private vendors, and none of those
vendors has ever been subject to a performance audit, such that it is not possible to determine whether those programs are effective in monitoring substance-abusing licensees and assisting them to recover from their addiction in the long term.

(g) Various health care licensing boards have inconsistent or nonexistent standards that guide the way they deal with substance-abusing licensees.

(h) Patients would be better protected from substance-abusing licensees if their regulatory boards agreed to and enforced consistent and uniform standards and best practices in dealing with substance-abusing licensees.

SEC. 2. It is the intent of the Legislature that:

(a) Pursuant to Section 156.1 of the Business and Professions Code and Section 8546.7 of the Government Code, that the Department of Consumer Affairs conduct a thorough audit of the effectiveness, efficiency, and overall performance of the vendor chosen by the department to manage diversion programs for substance-abusing licensees of health care licensing boards created in the Business and Professions Code, and make recommendations regarding the continuation of the programs and any changes or reforms required to ensure that individuals participating in the programs are appropriately monitored, and the public is protected from health care practitioners who are impaired due to alcohol or drug abuse or mental or physical illness.

(b) The audit shall identify, by type of board licensee, the percentage of self-referred participants, board-referred participants, and board-ordered participants. The audit shall describe in detail the diversion services provided by the vendor, including all aspects of bodily fluids testing, including, but not limited to, frequency of testing, randomicity, method of notice to participants, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, such as whether the collection process is observed by the collector, location of testing, and average timeframe from the date of the test to the date the result of the test becomes available; group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by program participants; standards used in determining whether inpatient or outpatient treatment is necessary; and, if applicable, worksite monitoring requirements and standards. The audit shall review the timeliness of diversion services provided by the vendor; the thoroughness of documentation of treatment, aftercare, and monitoring services received by participants; and the thoroughness of documentation of the effectiveness of the treatment and aftercare services received by participants. In determining the effectiveness and efficiency of the vendor, the audit shall evaluate the vendor’s approval process for providers or contractors that provide diversion services, including specimen collectors, group meeting facilitators, and worksite monitors; the vendor’s disapproval of providers or contractors that fail to provide effective or timely diversion services; and the vendor’s promptness in notifying the boards when a participant fails to comply with the terms of his or her
diversion contract or the rules of the board’s program. The audit shall also recommend whether the vendor should be more closely monitored by the department, including whether the vendor should provide the department with periodic reports demonstrating the timeliness and thoroughness of documentation of noncompliance with diversion program contracts and regarding its approval and disapproval of providers and contractors that provide diversion services.

(c) The vendor and its staff shall cooperate with the department and shall provide data, information, and case files as requested by the department to perform all of his or her duties. The provision of confidential data, information, and case files from health care-related boards and the vendor to the department shall not constitute a waiver of any exemption from disclosure or discovery or of any confidentiality protection or privilege otherwise provided by law that is applicable to the data, information, or case files. It is the Legislature’s intent that the audit be completed by June 30, 2010, and on subsequent years thereafter as determined by the department.

SEC. 3. Article 3.6 (commencing with Section 315) is added to Chapter 4 of Division 1 of the Business and Professions Code, to read:

Article 3.6. Uniform Standards Regarding Substance-Abusing Healing Arts Licensees

315. (a) For the purpose of determining uniform standards that will be used by healing arts boards in dealing with substance-abusing licensees, there is established in the Department of Consumer Affairs the Substance Abuse Coordination Committee. The committee shall be comprised of the executive officers of the department’s healing arts boards established pursuant to Division 2 (commencing with Section 500), the State Board of Chiropractic Examiners, the Osteopathic Medical Board of California, and a designee of the State Department of Alcohol and Drug Programs. The Director of Consumer Affairs shall chair the committee and may invite individuals or stakeholders who have particular expertise in the area of substance abuse to advise the committee.

(b) The committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Division 3 of Title 2 of the Government Code).

(c) By January 1, 2010, the committee shall formulate uniform and specific standards in each of the following areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program:

(1) Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

(2) Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic
evaluation described in subdivision (a) and any treatment recommended by the evaluator described in subdivision (a) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

(3) Specific requirements that govern the ability of the licensing board to communicate with the licensee’s employer about the licensee’s status and condition.

(4) Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomnicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

(5) Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

(6) Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

(7) Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

(8) Procedures to be followed when a licensee tests positive for a banned substance.

(9) Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

(10) Specific consequences for major violations and minor violations. In particular, the committee shall consider the use of a “deferred prosecution” stipulation similar to the stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency unless or until the licensee commits a major violation, in which case it is revived and the license is surrendered.

(11) Criteria that a licensee must meet in order to petition for return to practice on a full-time basis.

(12) Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

(13) If a board uses a private-sector vendor that provides diversion services, standards for immediate reporting by the vendor to the board of any and all noncompliance with any term of the diversion contract or probation; standards for the vendor’s approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors;
standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and standards for a licensee’s termination from the program and referral to enforcement.

(14) If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

(15) If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor’s performance in adhering to the standards adopted by the committee.

(16) Measurable criteria and standards to determine whether each board’s method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

SEC. 4. Section 1695.1 of the Business and Professions Code is amended to read:

1695.1. (a) “Board” means the Board of Dental Examiners of California.

(b) “Committee” means a diversion evaluation committee created by this article.

(c) “Program manager” means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 5. Section 1695.5 of the Business and Professions Code is amended to read:

1695.5. (a) The board shall establish criteria for the acceptance, denial, or termination of licentiates in a diversion program. Unless ordered by the board as a condition of licentiate disciplinary probation, only those licentiates who have voluntarily requested diversion treatment and supervision by a committee shall participate in a diversion program.

(b) A licentiate who is not the subject of a current investigation may self-refer to the diversion program on a confidential basis, except as provided in subdivision (f).

(c) A licentiate under current investigation by the board may also request entry into the diversion program by contacting the board’s Diversion Program Manager. The Diversion Program Manager may refer the licentiate requesting participation in the program to a diversion evaluation committee for evaluation of eligibility. Prior to authorizing a licentiate to enter into the diversion program, the Diversion Program Manager may require the licentiate, while under current investigation for any violations of the Dental Practice Act or other violations, to execute a statement of understanding that states that the licentiate understands that his or her violations of the Dental Practice Act or other statutes that would otherwise be the basis for discipline, may still be investigated and the subject of disciplinary action.

(d) If the reasons for a current investigation of a licentiate are based primarily on the self-administration of any controlled substance or dangerous drugs or alcohol under Section 1681 of the Business and Professions Code,
or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drugs for self-administration that does not involve actual, direct harm to the public, the board shall close the investigation without further action if the licentiate is accepted into the board’s diversion program and successfully completes the requirements of the program. If the licentiate withdraws or is terminated from the program by a diversion evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the board.

(e) Neither acceptance nor participation in the diversion program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any licentiate for any unprofessional conduct committed before, during, or after participation in the diversion program.

(f) All licentiates shall sign an agreement of understanding that the withdrawal or termination from the diversion program at a time when a diversion evaluation committee determines the licentiate presents a threat to the public’s health and safety shall result in the utilization by the board of diversion treatment records in disciplinary or criminal proceedings.

(g) Any licentiate terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the diversion program. A licentiate who has been under investigation by the board and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the board.

SEC. 6. Section 1695.6 of the Business and Professions Code is amended to read:

1695.6. A committee created under this article operates under the direction of the program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those licentiates who request to participate in the diversion program according to the guidelines prescribed by the board and to make recommendations. In making the recommendations, a committee shall consider the recommendations of any licentiates designated by the board to serve as consultants on the admission of the licentiate to the diversion program.

(b) To review and designate those treatment facilities to which licentiates in a diversion program may be referred.

(c) To receive and review information concerning a licentiate participating in the program.

(d) To consider in the case of each licentiate participating in a program whether he or she may with safety continue or resume the practice of dentistry.

(e) To perform such other related duties, under the direction of the board or program manager, as the board may by regulation require.
SEC. 7. Section 1697 of the Business and Professions Code is amended to read:

1697. Each licentiate who requests participation in a diversion program shall agree to cooperate with the treatment program designed by the committee and approved by the program manager and to bear all costs related to the program, unless the cost is waived by the board. Any failure to comply with the provisions of a treatment program may result in termination of the licentiate’s participation in a program.

SEC. 8. Section 1698 of the Business and Professions Code is amended to read:

1698. (a) After the committee and the program manager in their discretion have determined that a licentiate has been rehabilitated and the diversion program is completed, the committee shall purge and destroy all records pertaining to the licentiate’s participation in a diversion program.

(b) Except as authorized by subdivision (f) of Section 1695.5, all board and committee records and records of proceedings pertaining to the treatment of a licentiate in a program shall be kept confidential and are not subject to discovery or subpoena.

SEC. 9. Section 2361 of the Business and Professions Code is amended to read:

2361. As used in this article:
(a) “Board” means the Osteopathic Medical Board of California.
(b) “Diversion program” means a treatment program created by this article for osteopathic physicians and surgeons whose competency may be threatened or diminished due to abuse of drugs or alcohol.
(c) “Committee” means a diversion evaluation committee created by this article.
(d) “Participant” means a California licensed osteopathic physician and surgeon.
(e) “Program manager” means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 10. Section 2365 of the Business and Professions Code is amended to read:

2365. (a) The board shall establish criteria for the acceptance, denial, or termination of participants in the diversion program. Unless ordered by the board as a condition of disciplinary probation, only those participants who have voluntarily requested diversion treatment and supervision by a committee shall participate in the diversion program.

(b) A participant who is not the subject of a current investigation may self-refer to the diversion program on a confidential basis, except as provided in subdivision (f).

(c) A participant under current investigation by the board may also request entry into the diversion program by contacting the board’s Diversion Program Manager. The Diversion Program Manager may refer the participant requesting participation in the program to a diversion evaluation committee for evaluation of eligibility. Prior to authorizing a licentiate to enter into the
A committee created under this article operates under the direction of the diversion program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those licensees who request participation in the program according to the guidelines prescribed by the board, and to make recommendations.

(b) To review and designate those treatment facilities and services to which a participant in the program may be referred.

(c) To receive and review information concerning participants in the program.
(d) To consider whether each participant in the treatment program may safely continue or resume the practice of medicine.

(e) To prepare quarterly reports to be submitted to the board, which include, but are not limited to, information concerning the number of cases accepted, denied, or terminated with compliance or noncompliance and a cost analysis of the program.

(f) To promote the program to the public and within the profession, including providing all current licentiates with written information concerning the program.

(g) To perform such other related duties, under the direction of the board or the program manager, as the board may by regulation require.

SEC. 12. Section 2367 of the Business and Professions Code is amended to read:

2367. (a) Each licensee who requests participation in a treatment program shall agree to cooperate with the treatment program designed by the committee and approved by the program manager. The committee shall inform each participant in the program of the procedures followed, the rights and responsibilities of the participant, and the possible results of noncompliance with the program. Any failure to comply with the treatment program may result in termination of participation.

(b) Participation in a program under this article shall not be a defense to any disciplinary action which may be taken by the board. Further, no provision of this article shall preclude the board from commencing disciplinary action against a licensee who is terminated from a program established pursuant to this article.

SEC. 13. Section 2369 of the Business and Professions Code is amended to read:

2369. (a) After the committee and the program manager, in their discretion, have determined that a participant has been rehabilitated and the program is completed, the committee shall purge and destroy all records pertaining to the participation in a treatment program.

(b) Except as authorized by subdivision (f) of Section 2365, all board and committee records and records of proceedings pertaining to the treatment of a participant in a program shall be confidential and are not subject to discovery or subpoena except in the case of discovery or subpoena in any criminal proceeding.

SEC. 14. Section 2663 of the Business and Professions Code is amended to read:

2663. The board shall establish and administer a diversion program for the rehabilitation of physical therapists and physical therapist assistants whose competency is impaired due to the abuse of drugs or alcohol. The board may contract with any other state agency or a private organization to perform its duties under this article. The board may establish one or more diversion evaluation committees to assist it in carrying out its duties under this article. Any diversion evaluation committee established by the board shall operate under the direction of the diversion program manager, as designated by the executive officer of the board. The program manager has
the primary responsibility to review and evaluate recommendations of the committee.

SEC. 15. Section 2665 of the Business and Professions Code is amended to read:

2665. Each diversion evaluation committee has the following duties and responsibilities:

(a) To evaluate physical therapists and physical therapist assistants who request participation in the program and to make recommendations. In making recommendations, the committee shall consider any recommendations from professional consultants on the admission of applicants to the diversion program.

(b) To review and designation of treatment facilities to which physical therapists and physical therapist assistants in the diversion program may be referred.

(c) To receive and review information concerning physical therapists and physical therapist assistants participating in the program.

(d) To set forth in writing the terms and conditions of the diversion agreement that is approved by the program manager for each physical therapist and physical therapist assistant participating in the program, including treatment, supervision, and monitoring requirements.

(e) To consider whether each participant in the diversion program may with safety continue or resume the practice of physical therapy.

(f) To hold a general meeting at least twice a year, which shall be open and public, to evaluate the diversion program’s progress, to prepare reports to be submitted to the board, and to suggest proposals for changes in the diversion program.

SEC. 16. Section 2666 of the Business and Professions Code is amended to read:

2666. (a) Criteria for acceptance into the diversion program shall include all of the following:

(1) The applicant shall be licensed as a physical therapist or approved as a physical therapist assistant by the board and shall be a resident of California.

(2) The applicant shall be found to abuse dangerous drugs or alcoholic beverages in a manner which may affect his or her ability to practice physical therapy safely or competently.
(3) The applicant shall have voluntarily requested admission to the program or shall be accepted into the program in accordance with terms and conditions resulting from a disciplinary action.

(4) The applicant shall agree to undertake any medical or psychiatric examination ordered to evaluate the applicant for participation in the program.

(5) The applicant shall cooperate with the program by providing medical information, disclosure authorizations, and releases of liability as may be necessary for participation in the program.

(6) The applicant shall agree in writing to cooperate with all elements of the treatment program designed for him or her.

Any applicant may be denied participation in the program if the board, the program manager, or a diversion evaluation committee determines that the applicant will not substantially benefit from participation in the program or that the applicant’s participation in the program creates too great a risk to the public health, safety, or welfare.

(b) A participant may be terminated from the program for any of the following reasons:

(1) The participant has successfully completed the treatment program.

(2) The participant has failed to comply with the treatment program designated for him or her.

(3) The participant fails to meet any of the criteria set forth in subdivision (a) or (c).

(4) It is determined that the participant has not substantially benefited from participation in the program or that his or her continued participation in the program creates too great a risk to the public health, safety, or welfare. Whenever an applicant is denied participation in the program or a participant is terminated from the program for any reason other than the successful completion of the program, and it is determined that the continued practice of physical therapy by that individual creates too great a risk to the public health, safety, and welfare, that fact shall be reported to the executive officer of the board and all documents and information pertaining to and supporting that conclusion shall be provided to the executive officer. The matter may be referred for investigation and disciplinary action by the board. Each physical therapist or physical therapy assistant who requests participation in a diversion program shall agree to cooperate with the recovery program designed for him or her. Any failure to comply with that program may result in termination of participation in the program.

The diversion evaluation committee shall inform each participant in the program of the procedures followed in the program, of the rights and responsibilities of a physical therapist or physical therapist assistant in the program, and the possible results of noncompliance with the program.

(c) In addition to the criteria and causes set forth in subdivision (a), the board may set forth in its regulations additional criteria for admission to the program or causes for termination from the program.

SEC. 17. Section 2770.1 of the Business and Professions Code is amended to read:
2770.1. As used in this article:
   (a) “Board” means the Board of Registered Nursing.
   (b) “Committee” means a diversion evaluation committee created by this article.
   (c) “Program manager” means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 18. Section 2770.7 of the Business and Professions Code is amended to read:

2770.7. (a) The board shall establish criteria for the acceptance, denial, or termination of registered nurses in the diversion program. Only those registered nurses who have voluntarily requested to participate in the diversion program shall participate in the program.

(b) A registered nurse under current investigation by the board may request entry into the diversion program by contacting the board. Prior to authorizing a registered nurse to enter into the diversion program, the board may require the registered nurse under current investigation for any violations of this chapter or any other provision of this code to execute a statement of understanding that states that the registered nurse understands that his or her violations that would otherwise be the basis for discipline may still be investigated and may be the subject of disciplinary action.

(c) If the reasons for a current investigation of a registered nurse are based primarily on the self-administration of any controlled substance or dangerous drug or alcohol under Section 2762, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drug for self-administration that does not involve actual, direct harm to the public, the board shall close the investigation without further action if the registered nurse is accepted into the board’s diversion program and successfully completes the requirements of the program. If the registered nurse withdraws or is terminated from the program by a diversion evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the board.

(d) Neither acceptance nor participation in the diversion program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any registered nurse for any unprofessional conduct committed before, during, or after participation in the diversion program.

(e) All registered nurses shall sign an agreement of understanding that the withdrawal or termination from the diversion program at a time when the licentiate presents a threat to the public’s health and safety shall result in the utilization by the board of diversion treatment records in disciplinary or criminal proceedings.

(f) Any registered nurse terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the
diversion program. A registered nurse who has been under investigation by the board and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the board.

SEC. 19. Section 2770.8 of the Business and Professions Code is amended to read:

2770.8. A committee created under this article operates under the direction of the diversion program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those registered nurses who request participation in the program according to the guidelines prescribed by the board, and to make recommendations.

(b) To review and designate those treatment services to which registered nurses in a diversion program may be referred.

(c) To receive and review information concerning a registered nurse participating in the program.

(d) To consider in the case of each registered nurse participating in a program whether he or she may with safety continue or resume the practice of nursing.

(e) To call meetings as necessary to consider the requests of registered nurses to participate in a diversion program, and to consider reports regarding registered nurses participating in a program.

(f) To make recommendations to the program manager regarding the terms and conditions of the diversion agreement for each registered nurse participating in the program, including treatment, supervision, and monitoring requirements.

SEC. 20. Section 2770.11 of the Business and Professions Code is amended to read:

2770.11. (a) Each registered nurse who requests participation in a diversion program shall agree to cooperate with the rehabilitation program designed by the committee and approved by the program manager. Any failure to comply with the provisions of a rehabilitation program may result in termination of the registered nurse’s participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board’s enforcement program.

(b) If the program manager determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the program manager shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board’s enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

SEC. 21. Section 2770.12 of the Business and Professions Code is amended to read:
2770.12. (a) After the committee and the program manager in their discretion have determined that a registered nurse has successfully completed the diversion program, all records pertaining to the registered nurse’s participation in the diversion program shall be purged.

(b) All board and committee records and records of a proceeding pertaining to the participation of a registered nurse in the diversion program shall be kept confidential and are not subject to discovery or subpoena, except as specified in subdivision (b) of Section 2770.11 and subdivision (c).

(c) A registered nurse shall be deemed to have waived any rights granted by any laws and regulations relating to confidentiality of the diversion program, if he or she does any of the following:

1. Presents information relating to any aspect of the diversion program during any stage of the disciplinary process subsequent to the filing of an accusation, statement of issues, or petition to compel an examination pursuant to Article 12.5 (commencing with Section 820) of Chapter 1. The waiver shall be limited to information necessary to verify or refute any information disclosed by the registered nurse.

2. Files a lawsuit against the board relating to any aspect of the diversion program.

3. Claims in defense to a disciplinary action, based on a complaint that led to the registered nurse’s participation in the diversion program, that he or she was prejudiced by the length of time that passed between the alleged violation and the filing of the accusation. The waiver shall be limited to information necessary to document the length of time the registered nurse participated in the diversion program.

SEC. 22. Section 3501 of the Business and Professions Code is amended to read:

3501. As used in this chapter:

(a) “Board” means the Medical Board of California.

(b) “Approved program” means a program for the education of physician assistants that has been formally approved by the committee.

(c) “Trainee” means a person who is currently enrolled in an approved program.

(d) “Physician assistant” means a person who meets the requirements of this chapter and is licensed by the committee.

(e) “Supervising physician” means a physician and surgeon licensed by the board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.

(f) “Supervision” means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.

(g) “Committee” or “examining committee” means the Physician Assistant Committee.
(h) “Regulations” means the rules and regulations as contained in Chapter 13.8 (commencing with Section 1399.500) of Title 16 of the California Code of Regulations.

(i) “Routine visual screening” means uninvasive nonpharmacological simple testing for visual acuity, visual field defects, color blindness, and depth perception.

(j) “Program manager” means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 23. Section 3534.1 of the Business and Professions Code is amended to read:

3534.1. The examining committee shall establish and administer a diversion program for the rehabilitation of physician assistants whose competency is impaired due to the abuse of drugs or alcohol. The examining committee may contract with any other state agency or a private organization to perform its duties under this article. The examining committee may establish one or more diversion evaluation committees to assist it in carrying out its duties under this article. As used in this article, “committee” means a diversion evaluation committee. A committee created under this article operates under the direction of the diversion program manager, as designated by the executive officer of the examining committee. The program manager has the primary responsibility to review and evaluate recommendations of the committee.

SEC. 23. Section 3534.3 of the Business and Professions Code is amended to read:

3534.3. Each committee has the following duties and responsibilities:

(a) To evaluate physician assistants who request participation in the program and to make recommendations to the program manager. In making recommendations, a committee shall consider any recommendations from professional consultants on the admission of applicants to the diversion program.

(b) To review and designate treatment facilities to which physician assistants in the diversion program may be referred, and to make recommendations to the program manager.

(c) The receipt and review of information concerning physician assistants participating in the program.

(d) To call meetings as necessary to consider the requests of physician assistants to participate in the diversion program, to consider reports regarding participants in the program, and to consider any other matters referred to it by the examining committee.

(e) To consider whether each participant in the diversion program may with safety continue or resume the practice of medicine.

(f) To set forth in writing the terms and conditions of the diversion agreement that is approved by the program manager for each physician assistant participating in the program, including treatment, supervision, and monitoring requirements.
(g) To hold a general meeting at least twice a year, which shall be open and public, to evaluate the diversion program’s progress, to prepare reports to be submitted to the examining committee, and to suggest proposals for changes in the diversion program.

(h) For the purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, any member of a committee shall be considered a public employee. No examining committee or committee member, contractor, or agent thereof, shall be liable for any civil damage because of acts or omissions which may occur while acting in good faith in a program established pursuant to this article.

SEC. 24. Section 3534.4 of the Business and Professions Code is amended to read:

3534.4. Criteria for acceptance into the diversion program shall include all of the following: (a) the applicant shall be licensed as a physician assistant by the examining committee and shall be a resident of California; (b) the applicant shall be found to abuse dangerous drugs or alcoholic beverages in a manner which may affect his or her ability to practice medicine safely or competently; (c) the applicant shall have voluntarily requested admission to the program or shall be accepted into the program in accordance with terms and conditions resulting from a disciplinary action; (d) the applicant shall agree to undertake any medical or psychiatric examination ordered to evaluate the applicant for participation in the program; (e) the applicant shall cooperate with the program by providing medical information, disclosure authorizations, and releases of liability as may be necessary for participation in the program; and (f) the applicant shall agree in writing to cooperate with all elements of the treatment program designed for him or her.

An applicant may be denied participation in the program if the examining committee, the program manager, or a committee determines that the applicant will not substantially benefit from participation in the program or that the applicant’s participation in the program creates too great a risk to the public health, safety, or welfare.

SEC. 25. Section 3534.9 of the Business and Professions Code is amended to read:

3534.9. If the examining committee contracts with any other entity to carry out this section, the executive officer of the examining committee or the program manager shall review the activities and performance of the contractor on a biennial basis. As part of this review, the examining committee shall review files of participants in the program. However, the names of participants who entered the program voluntarily shall remain confidential, except when the review reveals misdiagnosis, case mismanagement, or noncompliance by the participant.

SEC. 26. Section 4371 of the Business and Professions Code is amended to read:

4371. (a) The executive officer of the board shall designate a program manager of the pharmacists recovery program. The program manager shall have background experience in dealing with substance abuse issues.
(b) The program manager shall review the pharmacists recovery program on a quarterly basis. As part of this evaluation, the program manager shall review files of all participants in the pharmacists recovery program.

(c) The program manager shall work with the contractor administering the pharmacists recovery program to evaluate participants in the program according to established guidelines and to develop treatment contracts and evaluate participant progress in the program.

SEC. 27. The responsibilities imposed on a licensing board by this act shall be considered a current operating expense of that board, and shall be paid from the fund generally designated to provide operating expenses for that board, subject to the appropriation provisions applicable to that fund.
SB 1441 REQUIREMENT
(1) Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

Draft Uniform Standard #1

If a board has determined that a clinical diagnostic evaluation is necessary in order to evaluate whether practice restrictions or other actions are warranted, the following minimum standards shall apply.

1. The clinical diagnostic evaluation shall be conducted by a licensed practitioner who:
   • holds a valid, unrestricted license to do so;
   • has three (3) years experience in providing evaluations of health professionals with substance abuse disorders;
   • is approved by the board;

2. The clinical diagnostic evaluation shall be conducted in accordance with acceptable professional standards for conducting substance abuse clinical diagnostic evaluations.

3. The clinical diagnostic evaluation report shall:
   • set forth, in the evaluator’s opinion, whether the licensee has a substance abuse problem;
   • set forth, in the evaluator’s opinion, whether the licensee is a threat to himself/herself or others; and,
   • set forth, in the evaluator’s opinion, recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee’s rehabilitation and safe practice.

The evaluator may not have a financial relationship, personal relationship, or business relationship with the licensee. The evaluator shall provide an objective, unbiased, and independent evaluation.

If the evaluator determines during the evaluation process that a licensee is a threat to himself/herself or others, the evaluator shall notify the board within 24 hours of such a determination.

For all evaluations, a final written report shall be provided to the board no later than 30 days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation, not to exceed ninety (90) days.
(2) Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in subdivision (a) and any treatment recommended by the evaluator described in subdivision (a) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

Draft Uniform Standard #2

1. The board shall determine on a case-by-case basis whether a licensee shall be temporarily removed from practice to undergo the clinical diagnostic evaluation and any treatment recommended by the evaluator. The board may utilize any statutory provisions or other authority for temporary removal of the licensee.

2. Specific requirements for the temporary removal of the licensee from practice shall be determined on a case-by-case basis by the board using the following criteria:
   • license type;
   • licensee’s history;
   • documented length of sobriety/time that has elapsed since substance use;
   • scope and pattern of use;
   • treatment history;
   • licensee’s medical history and current medical condition;
   • nature, duration and severity of substance abuse, and
   • threat to himself/herself or the public.

3. These same criteria shall be used by the board to determine whether to permit a licensee to return to practice on a part- or full-time basis.
SB 1441 REQUIREMENT

(3) Specific requirements that govern the ability of the licensing board to communicate with the licensee’s employer about the licensee’s status or condition.

Draft Uniform Standard #3

If the licensee has an employer, he/she shall provide the name, physical address, and telephone number of all employers and shall give specific, written consent that the licensee authorizes the board and the employers to communicate regarding the licensee’s work status, performance, and monitoring.
SB 1441 REQUIREMENT

(4) Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

DRAFT UNIFORM STANDARD #4

If the board determines a licensee shall be subject to drug testing, the following minimum standards apply:

1. Licensees shall be tested at least 18 times per year for the first three years of continual abstinence. After the first three years, licensees shall be tested at least 12 times per year.
2. The scheduling of tests shall be done on a random basis, preferably by a computer program.
3. Licensees shall be required to make daily contact to determine if testing is required.
4. Licensees shall be required to test on the date of notification as directed by the board.
5. Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation.
6. Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.
7. Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.
8. Collection of specimens shall be observed.
9. Prior to vacation or absence, alternative testing location(s) must be approved by the board.
10. Laboratories shall be certified by the U.S. Department of Health and Human Services.
11. A collection site must submit a specimen to the laboratory within one business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within 7 days of receipt of the specimen. The appropriate board will be notified of non-negative test results within one business day and will be notified of negative test results within seven business days.
(5) Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

Draft Uniform Standard # 5

If the board determines a licensee must attend group meetings or support groups, the following standards shall apply:

1. When determining the frequency of required group meeting attendance, consideration shall be given to the following:
   - the licensee's history;
   - the documented length of sobriety/time that has elapsed since substance use;
   - the recommendation of the clinical evaluator;
   - the scope and pattern of use;
   - the licensee's treatment history; and,
   - the nature, duration, and severity of substance abuse.

2. The licensee shall be required to submit to the board, at least once a month, documentation of attendance at the group meeting signed or initialed by a representative of the meeting’s organizer.

If the board determines a licensee must attend a group meeting facilitated by an individual who reports directly or indirectly to the board, in addition to the requirements above, the following standards shall also apply:

3. The meeting facilitator must have a minimum of three years experience in the treatment and rehabilitation of substance abuse.

4. The meeting facilitator must not have a financial relationship, personal relationship, or business relationship with the licensee.

5. The document showing attendance must be signed by the group meeting facilitator and must include the licensee’s name, the group name, the date and location of the meeting, and the licensee’s level of participation and progress in treatment.

6. The facilitator shall report any unexcused absence within two (2) business days.
**SB 1441 REQUIREMENT**

(6) Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

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<tr>
<th>Draft Uniform Standard #6</th>
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<tr>
<td>In determining whether inpatient, outpatient, or other type of treatment is necessary, the Board shall consider the following criteria:</td>
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<tr>
<td>• recommendation of the clinical diagnostic evaluation pursuant to Uniform Standard #1;</td>
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<tr>
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<td>• threat to himself/herself or the public.</td>
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SB 1441 REQUIREMENT

(7) Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

DRAFT UNIFORM STANDARD #7

If the Board determines a worksite monitor is necessary, the worksite monitor shall meet the following requirements to be considered for approval by the Board.

1. Shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board. This provision may be waived by the Board on a case-by-case basis.

2. The monitor’s licensure scope of practice shall include the scope of practice of the licensee that is being monitored or be another health care professional approved by the board.

3. Shall have an active unrestricted license, with no disciplinary action within the last five years.

4. Shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee’s disciplinary order and/or contract and agrees to monitor the licensee as set forth by the Board.

5. The worksite monitor must adhere to the required methods of monitoring the licensee:

   a) Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the Board.

   b) Interview other staff in the office regarding the licensee’s behavior, if applicable.

   c) Review the licensee’s work attendance.
6. Reporting by the worksite monitor to the Board shall be as follows:

a) Any suspected substance abuse must be verbally reported to the Board and the licensee’s employer within one hour of occurrence. If occurrence is not during the Board’s normal business hours the report must be within one hour of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.

b) Any suspected substance abuse must be verbally reported to the Board one hour of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.

c) The worksite monitor shall complete and submit a written report monthly or as directed by the Board. The report shall include:

- the licensee’s name;
- license number;
- worksite monitor’s name and signature;
- worksite monitor’s license number;
- worksite location(s);
- dates licensee had face-to-face contact with monitor;
- staff interviewed, if applicable;
- attendance report;
- any change in behavior and/or personal habits;
- any indicators that can lead to suspected substance abuse.

7. The licensee shall complete the required consent forms and sign an agreement with the worksite monitor and the Board to allow the Board to communicate with the worksite monitor.
SB 1441 REQUIREMENT

(8) Procedures to be followed when a licensee tests positive for a banned substance.

DRAFT UNIFORM STANDARD #8

1. When a licensee tests positive for a banned substance based on an established national drug testing standard, the licensee shall be removed from practice.

2. The Board shall then do the following:
   - Communicate with the board probation coordinator or recovery program, if applicable;
   - Confront the licensee;
   - Communicate with the employer and worksite monitor, if applicable;
   - Communicate with any treatment provider including support group facilitator.

3. Based on information gathered, at least one of the following actions shall be followed in response to a positive test for a banned substance:
   - Revocation or suspension;
   - Require participation in inpatient and/or outpatient treatment;
   - Increase frequency of testing;
   - Impose practice restrictions, e.g. increased level of supervised practice, limit the scope of duties.
SB 1441 REQUIREMENT

(9) Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

DRAFT UNIFORM STANDARD #9

1. When a licensee is confirmed to have used a banned substance based on an established national drug testing standard, the licensee shall be removed from practice.

2. The Board shall then do the following:
   - Communicate with the board probation coordinator or recovery program, if applicable;
   - Confront the licensee;
   - Communicate with the employer and worksite monitor, if applicable;
   - Communicate with any treatment provider including support group facilitator.

3. Based on information gathered, at least one of the following actions shall be followed in response to confirmation of a licensee who has used a banned substance:
   - Revocation or suspension;
   - Require participation in inpatient and/or outpatient treatment;
   - Increase frequency of testing;
   - Impose practice restriction e.g. increased level of supervised practice; limit the scope of duties.
SB 1441 REQUIREMENT

(10) Specific consequences for major and minor violations. In particular, the committee shall consider the use of a “deferred prosecution” stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency until or unless licensee commits a major violation, in which case it is revived and license is surrendered.

DRAFT UNIFORM STANDARD #10

The Board shall review each violation of a contract, disciplinary order or probationary order on a case-by-case basis and determine the consequences based upon the following guidelines:

Major Violations include, but are not limited to:

1. Failure to complete a board-ordered program;
2. Failure to undergo a required clinical diagnostic evaluation;
3. Multiple minor violations;
4. Treating patients while under the influence of drugs/alcohol;
5. Any drug/alcohol related act which would constitute a violation of the practice act or state/federal laws;
6. Failure to obtain biological testing for substance abuse.

Consequences:

At least one of the following consequences shall be taken for a major violation:

- Suspension
- Revocation
- Other action as determined by the Board.
**Minor Violations** include, but are not limited to:

1. Untimely receipt of required documentation;
2. Non-attendance at group meetings;
3. Failure to contact a monitor when required;
4. Any other violations that do not present an immediate threat to the violator or to the public.

**Consequences:**

At least one of the following consequences shall be taken for a minor violation:

- Removal from practice;
- Practice limitations;
- Required supervision;
- Increased documentation
- Issuance of citation and fine or a warning notice;
- Required revaluation/testing;
- Other action as determined by the Board.
SB 1441 REQUIREMENT

(11) Criteria that a licensee must meet in order to petition for return to practice on a full time basis.

DRAFT UNIFORM STANDARD #11

“Petition” as used in this standard is an informal request as opposed to a “Petition for Modification” under the Administrative Procedure Act.

The licensee shall meet the following criteria before submitting a request (petition) to return to full time practice:

1. Demonstrated sustained compliance with current recovery program.

2. Demonstrated the ability to practice safely as evidenced by current work site reports, evaluations, and any other information relating to the licensee’s substance abuse.
SB 1441 REQUIREMENT
(12) Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

DRAFT UNIFORM STANDARD #12

“Petition for Reinstatement” as used in this standard is an informal request (petition) as opposed to a “Petition for Reinstatement” under the Administrative Procedure Act.

The licensee must meet the following criteria to request (petition) a full and unrestricted license.

1. Demonstrated sustained compliance with the terms of the disciplinary order, if applicable.

2. Demonstrated successful completion of recovery program, if required.

3. Demonstrated a consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.

4. Demonstrated that he or she is able to practice safely.
(13) SB 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, (1) standards for immediate reporting by the vendor to the board of any and all noncompliance with any term of the diversion contract or probation; (2) standards for the vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; (3) standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and (4) standards for a licensee's termination from the program and referral to enforcement.

DRAFT UNIFORM STANDARD #13.

1. A vendor must report to the board, any noncompliance with any term of the diversion contract or probation as follows:

   A. Whenever a licensee commits a major violation, the contractor shall notify the Board within one (1) business day. Major violations include, but are not limited to:

      1. Failure to complete a board-ordered program;
      2. Failure to complete a required treatment program;
      3. Failure to undergo a required clinical diagnostic evaluation;
      4. Multiple minor violations;
      5. Treating patients while under the influence of drugs or alcohol;
      6. Any drug/alcohol related act which would constitute a violation of the practice act or state or federal laws;
      7. Failure to obtain biological testing for substance abuse.

   B. Whenever a licensee commits a minor violation, the contractor shall notify the Board within five (5) business days. Minor violations include, but are not limited to:

      1. Untimely receipt of required documentation;
      2. Non-attendance at group meetings;
      3. Failure to contact a monitor when required;
      4. Any other violations that do not present an immediate threat to the violator or to the public.

   C. The vendor shall contact the Board within one business day if a licensee fails to daily check-in for biological testing or as otherwise required by the Board.

   D. The vendor shall notify the Board, on the same business day they are notified, if a licensee tests positive or poses an immediate danger to himself/herself or the public.
2. A vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors is as follows:

**Specimen Collectors:**

1. The provider or subcontractor shall possess all the materials, equipment, and technical expertise necessary to provide all the services.
2. The provider or subcontractor shall be able to scientifically test for urine, blood, and hair specimens for the detection of alcohol, illegal, and controlled substances.
3. The provider or subcontractor must provide collection sites that are located in areas throughout California.
4. The provider or subcontractor must have an automated 24-hour toll-free telephone system and/or a secure on-line computer database that allows the participant to check in daily for testing.
5. The provider or subcontractor must have or be subcontracted with operating collection sites that are engaged in the business of collecting urine, blood, and hair follicle specimens for the testing of drugs and alcohol within the State of California.
6. The provider or subcontractor must have a secure, HIPAA compliant, website or computer system to allow staff access to drug test results and compliance reporting information that is available 24 hours a day.
7. The provider or subcontractor shall employ or contract with toxicologists that are licensed physicians and have knowledge of substance abuse disorders and the appropriate medical training to interpret and evaluate laboratory drug test results, medical histories, and any other information relevant to biomedical information.

**Group Meeting Facilitators:**

A group meeting facilitator for any facilitated group must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse.

**Work Site Monitors:**

1. The worksite monitor must meet the following qualifications:
   - Shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board. This provision may be waived by the Board on a case-by-case basis.
   - The monitor’s licensure scope of practice shall include the scope of practice of the licensee that is being monitored or be another health care professional approved by the board.
   - Shall have an active unrestricted license, with no disciplinary action within the last five years.
• Shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee’s disciplinary order and/or contract and agrees to monitor the licensee as set forth by the Board.

2. The worksite monitor must adhere to the required methods of monitoring the licensee:
   • Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the Board.
   • Interview other staff in the office regarding the licensee’s behavior, if applicable.
   • Review the licensee’s work attendance

3. The worksite monitor must report to the contractor and the Board:
   • Any suspected substance abuse must be verbally reported to the Board and the licensee’s employer within one hour of occurrence. If occurrence is not during the Board’s normal business hours the report must be within one hour of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.

4. The worksite monitor shall complete and submit a written report monthly or as directed by the Board. The report shall include:
   • the licensee’s name;
   • license number;
   • worksite monitor’s name and signature;
   • worksite monitor’s license number;
   • worksite location(s);
   • dates licensee had face-to-face contact with monitor;
   • staff interviewed, if applicable;
   • attendance report;
   • any change in behavior and/or personal habits;
   • any indicators that can lead to suspected substance abuse.

Treatment Providers

1. Treatment facility staff and services must have:
   • Licensure and/or accreditation by appropriate regulatory agencies;
   • Sufficient resources available to adequately evaluate the physical and mental needs of the client, provide for safe detoxification, and manage any medical emergency;
   • Professional staff who are competent and experienced members of the clinical staff;
   • Treatment planning involving a multidisciplinary approach and specific aftercare plans;
   • Means to provide treatment/progress documentation to the provider.
3. The vendor shall disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services as follows:

   The vendor is fully responsible for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by any of them. No subcontract shall relieve the vendor of its responsibilities and obligations. All state policies, guidelines, and requirements apply to all subcontractors.

   1. If a subcontractor fails to provide effective or timely services as listed above, but not limited to any other subcontracted services, the vendor will terminate services of said contractor within 30 business days of notification of failure to provide adequate services.

   2. The vendor shall notify the appropriate Board within 5 business days of termination of said subcontractor.

4. A licensee’s termination from the program and referral to enforcement shall be determined as follows:

   Whenever a licensee commits a major violation, the vendor shall notify the Board within one (1) business day. The violation will be reviewed by the Board on a case by case basis for termination from the program and referral to enforcement.

5. The vendors and all sub-contractors shall comply with the “uniform standards.”
SB 1441 REQUIREMENT

(14) If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

DRAFT UNIFORM STANDARD #14

The board may only provide to the public the following information for licensees who are participating in a board monitoring program regardless of whether the licensee is a self-referral or a board referral:

- Licensee’s name and the fact that they are in a monitoring program;
- Whether the licensee’s practice is restricted;
- A detailed description of any restriction imposed.
SB 1441 REQUIREMENT

(15) If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor’s performance in adhering to the standards adopted by the committee.

DRAFT UNIFORM STANDARD #15

If a board uses a private-sector vendor to provide monitoring services for its licensees, an external independent audit must be conducted at least once every three years by a qualified, independent reviewer or review team from outside the board with no real or apparent conflict of interest with the vendor providing the monitoring services. In addition, the reviewer shall not be a part of or under the control of the board. The independent reviewer or review team must consist of individuals who are competent in the professional practice of internal auditing and assessment processes and qualified to perform audits of monitoring programs.

The audit must assess the vendor’s performance in adhering to the uniform standards established by the board. The reviewer must provide a report of their findings to the board by June 30 of each three-year cycle. The report shall identify any material inadequacies, deficiencies, irregularities, or other non-compliance with the terms of the vendor’s monitoring services that would interfere with the board’s mandate of public protection.
To: Board Members  
Date: September 17, 2009

From: Christy Berger  
Telephone: (916) 574-7834
MHSA Coordinator

Subject: Review and Discussion of Licensing Requirements Related to Aging

The California Commission on Aging (CCOA) serves as "the principal advocate in the state on behalf of older individuals, including, but not limited to, advisory participation in the consideration of all legislation and regulations made by state and federal departments and agencies relating to programs and services that affect older individuals." It is the "principal advisory body to the Governor, State Legislature, and State, Federal and local departments and agencies on issues affecting older individuals in order to ensure a quality of life for older Californians so they may live with dignity in their chosen environment."¹

The CCOA contacted the Board regarding Senate Bill 33 (Marriage and Family Therapist education/experience, Statutes of 2009) and asked that the board amend it to include requirements for education related to providing therapy to elder adults and adult abuse assessment and reporting. The bill was amended on June 8, 2009 to include these changes.

Carol Sewell, CCOA Program Analyst, will address the Board at its October 2009 meeting to propose additional amendments to the laws relating to working with victims of elder abuse and their families.

Attachments
A. Current Requirements Pertaining to Aging
B. Excerpts from Senate Bill 33 (Statutes of 2009) Related to Elder Adults
C. CDC Brief on Mental Health and Aging
D. Surgeon General's Report Excerpt - Older Adults and Mental Health

¹ California Commission on Aging website, http://www.ccoa.ca.gov/, accessed September 17, 2009
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MFT-Related Requirements

§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.

(c) In order to satisfy the coursework requirement of this section, the applicant shall submit to the board a certification from the chief academic officer of the educational institution from which the applicant graduated stating that the coursework required by this section is included within the institution's required curriculum for graduation, or within the coursework, that was completed by the applicant.

(d) The board shall not issue a license to the applicant until the applicant has met the requirements of this section.

§4980.395 ADDITIONAL CONTINUING EDUCATION REQUIREMENT

(a) A licensee who began graduate study prior to January 1, 2004, shall complete a three-hour continuing education course in aging and long-term care during his or her first renewal period after the operative date of this section and shall submit to the board evidence, acceptable to the board, of the person's satisfactory completion of the course.

(b) The course shall include, but is not limited to, the biological, social, and psychological aspects of aging.

(c) A person seeking to meet the requirements of subdivision (a) of this section may submit to the board a certificate evidencing completion of equivalent courses in aging and long-term care taken prior to the operative date of this section, or proof of equivalent teaching or practice experience. The board, in its discretion, may accept that certification as meeting the requirements of this section.

(d) The board may not renew an applicant's license until the applicant has met the requirements of this section.

(e) Continuing education courses taken pursuant to this section shall be applied to the 36 hours of approved continuing education required in Section 4980.54.

(f) This section shall become operative on January 1, 2005.
LCSW-Related Requirements

§4996.25 ADDITIONAL COURSEWORK
(a) Any applicant for licensure as a licensed clinical social worker 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.

(c) In order to satisfy the coursework requirement of this section, the applicant shall submit to the board a certification from the chief academic officer of the educational institution from which the applicant graduated stating that the coursework required by this section is included within the institution's required curriculum for graduation, or within the coursework, that was completed by the applicant.

(d) The board shall not issue a license to the applicant until the applicant has met the requirements of this section.

§4996.26 ADDITIONAL CONTINUING EDUCATION REQUIREMENTS; AGING AND LONG-TERM CARE
(a) A licensee who began graduate study prior to January 1, 2004, shall complete a three-hour continuing education course in aging and long-term care during his or her first renewal period after the operative date of this section, and shall submit to the board evidence acceptable to the board of the person's satisfactory completion of the course.

(b) The course shall include, but is not limited to, the biological, social, and psychological aspects of aging.

(c) Any person seeking to meet the requirements of subdivision (a) of this section may submit to the board a certificate evidencing completion of equivalent courses in aging and long-term care taken prior to the operative date of this section, or proof of equivalent teaching or practice experience. The board, in its discretion, may accept that certification as meeting the requirements of this section.

(d) The board may not renew an applicant's license until the applicant has met the requirements of this section. (e) Continuing education courses taken pursuant to this section shall be applied to the 36 hours of approved continuing education required in Section 4996.22. (f) This section shall become operative on January 1, 2005.
Senate Bill 33 (Statutes of 2009) Amendments relating to Elder Adults:

Section 4980.36 (d)(1)(A)

No less than 12 semester or 18 quarter units of coursework in theories, principles, and methods of a variety of psychotherapeutic orientations directly related to marriage and family therapy and marital and family systems approaches to treatment and how these theories can be applied therapeutically with individuals, couples, families, adults, including elder adults, children, adolescents, and groups to improve, restore, or maintain healthy relationships.

Section 4980.36(d)(2)(C)(i)

(i) Child and adult abuse assessment and reporting.
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Issue Brief #1:
What Do the Data Tell Us?

In recognition of the essential role mental health plays in overall health, the Healthy Aging Program at the Centers for Disease Control and Prevention (CDC) and the National Association of Chronic Disease Directors (NACDD) are releasing two issue briefs focused on the mental health of older adults in the United States.

This first issue brief reviews existing data and lays the foundation for understanding key issues related to mental health in adults over 50. The second brief will focus on depression, an important and emerging public health issue. Recent public health efforts to develop, test, and disseminate programs that address depression in older adults have led to practical information on this topic; the second issue brief will examine interventions to address depression that communities can use to improve the mental health and quality of life of older Americans.

The State of Mental Health and Aging in America

The World Health Organization defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (1). Because mental health is essential to overall health and well-being, it must be recognized and treated in all Americans, including older adults, with the same urgency as physical health. For this reason, mental health is becoming an increasingly important part of the public health mission. In fact, the mental health of older Americans has been identified as a priority by the Healthy People 2010 objectives (2), the 2005 White House Conference on Aging (3), and the 1999 Surgeon General’s report on mental health (4).

The goals and traditions of public health and health promotion can be applied just as usefully in the field of mental health as they have been in the prevention of both infectious and chronic diseases. Public health agencies can incorporate mental health promotion into chronic disease prevention efforts, conduct surveillance and research to improve the mental health evidence base, and collaborate with partners to develop comprehensive mental health plans and to enhance coordination of care. The challenges for public health are to identify risk factors, increase awareness about mental disorders and the effectiveness of treatment, remove the stigma associated with mental disorders and receiving treatment for them, eliminate health disparities, and improve access to mental health services, particularly among populations that are disproportionately affected (5).
The presence of depressive disorders often adversely affects the course and complicates the treatment of other chronic diseases.

Mental Health Problems in Older Adults

It is estimated that 20% of people age 55 years or older experience some type of mental health concern (6). The most common conditions include anxiety, severe cognitive impairment, and mood disorders (such as depression or bipolar disorder) (6). Mental health issues are often implicated as a factor in cases of suicide. Older men have the highest suicide rate of any age group (7). Men aged 85 years or older have a suicide rate of 45.23 per 100,000, compared to an overall rate of 11.01 per 100,000 for all ages (7).

The Significance of Depression

Depression, a type of mood disorder, is the most prevalent mental health problem among older adults. It is associated with distress and suffering (4). It also can lead to impairments in physical, mental, and social functioning (4). The presence of depressive disorders often adversely affects the course and complicates the treatment of other chronic diseases (8). Older adults with depression visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer in the hospital (4).

Although the rate of older adults with depressive symptoms tends to increase with age (4), depression is not a normal part of growing older. Rather, in 80% of cases it is a treatable condition (8). Unfortunately, depressive disorders are a widely under-recognized condition and often are untreated or undertreated among older adults (4).

The Behavioral Risk Factor Surveillance System and Indicators

As described earlier, a core public health function related to mental health is the collection of surveillance data that can be used for priority setting and as the foundation for developing public health programs.

Through CDC’s Behavioral Risk Factor Surveillance System (BRFSS—see Technical Information), states collect data on the mental health of older adults. The BRFSS questionnaire consists of three parts: 1) core questions asked to all 50 states, the District of Columbia and three territories, 2) supplemental modules which are a series of questions on specific topics (e.g. mental health, adult asthma history, intimate partner violence), and 3) state-added questions that are selected by individual states.

There are BRFSS core questions related to mental health that collect information on the prevalence of social and emotional support, life satisfaction, and the number of mentally unhealthy days.

An Anxiety and Depression module was developed for the BRFSS to collect additional information on mental health conditions. In 2006, 38 states and three territories used this module to determine the prevalence of current depression, lifetime diagnosis of depression, and lifetime diagnosis of anxiety.

This issue brief reports on six indicators related to mental health that were part of the 2006 BRFSS survey, both from core questions and the Anxiety and Depression module. Data are provided for the U.S. population age 50 years or older, with a focus on age, racial/ethnic differences, and sex.
- Social support serves major support functions, including emotional support (e.g., sharing problems or venting emotions), informational support (e.g., advice and guidance), and instrumental support (e.g., providing rides or assisting with housekeeping) (9).

- Adequate social and emotional support is associated with reduced risk of mental illness, physical illness, and mortality (9).

- The majority (nearly 90%) of adults age 50 or older indicated that they are receiving adequate amounts of support.

- Adults age 65 or older were more likely than adults age 50–64 to report that they “rarely” or “never” received the social and emotional support they needed (12.2% compared to 8.1%, respectively).

- Approximately one-fifth of Hispanic and other, non-Hispanic adults age 65 years or older reported that they were not receiving the support they need, compared to about one-tenth of older white adults.

- Among adults age 50 or older, men were more likely than women to report they “rarely” or “never” received the support they needed (11.39% compared to 8.49%).

**BRFSS Question**

“How often do you get the social and emotional support you need?”

The response options included: “always”, “usually”, “sometimes”, “rarely”, or “never.”
Life satisfaction is the self-evaluation of one’s life as a whole, and is influenced by socioeconomic, health, and environmental factors (10).

Life dissatisfaction is associated with obesity and risky health behaviors such as smoking, physical inactivity, and heavy drinking (10).

Nearly 95% of adults age 50 or older reported being “satisfied” or “very satisfied” with their lives, with approximately 5% indicating that they were “dissatisfied” or “very dissatisfied” with their lives.

Adults age 50–64 were more likely than adults age 65 or older to report that they were “dissatisfied” or “very dissatisfied” with their lives (5.8% compared to 3.5%, respectively).

Other, non-Hispanic adults age 50–64 were the group most likely to report that they were “dissatisfied” or “very dissatisfied” with their lives (9.7% compared to 7.0% of Hispanics, 7.2% of black, non-Hispanic adults, and 5.25% of white, non-Hispanic adults in the same age group).

Men and women age 50 or older reported similar rates of life satisfaction (4.7% to 5.0%, respectively).

BRFSS Question

“In general, how satisfied are you with your life?”

The response options included: “very satisfied”, “satisfied”, “dissatisfied”, or “very dissatisfied.”
Frequent mental distress (FMD) may interfere with major life activities, such as eating well, maintaining a household, working, or sustaining personal relationships.

FMD can also affect physical health. Older adults with FMD were more likely to engage in behaviors that can contribute to poor health, such as smoking, not getting recommend amounts of exercise, or eating a diet with few fruits and vegetables (11).

The overwhelming majority of older adults did not experience FMD—in fact, in 2006, the prevalence of FMD was only 9.2% among U.S. adults age 50 or older and 6.5% among those age 65 or older.

Hispanics had a higher prevalence of FMD (13.2%) compared to white, non-Hispanics (8.3%) or black, non-Hispanics (11.1%).

Women aged 50-64 and 65 or older reported more FMD than men in the same age groups (13.2% and 7.7% compared to 9.1% and 5.0%, respectively).
Current Depression

Percentage of adults aged 50 or older who had current depression.

- 0 - 5.41%
- 5.42 - 6.66%
- 6.67 - 8.57%
- 8.58 - 12.43%
- No data


**BRFSS Question**

**Current Depression**

A PHQ-8 score of 10 or greater (see technical information).

- Depression is more than just a passing mood. Rather, it is a condition in which one may experience persistent sadness, withdrawal from previously enjoyed activities, difficulty sleeping, physical discomforts, and feeling “slowed down” (12).

- Risk factors for late-onset depression included widowhood, physical illness, low educational attainment (less than high school), impaired functional status, and heavy alcohol consumption (4).

- Depression is one of the most successfully treated illnesses. There are highly effective treatments for depression in late life, and most depressed older adults can improve dramatically from treatment (12).

- Contrary to popular belief, most adults age 50 or older were not currently depressed — only 7.7% in this age group reported current depression, and 15.7% reported a lifetime diagnosis of depression.
In 2006, adults age 50–64 reported more current depression and lifetime diagnosis of depression than adults age 65 or older (9.4% compared with 5.0% for current depressive symptoms and 19.3% compared with 10.5% for lifetime diagnosis of depression, respectively).

Hispanic adults age 50 or older reported more current depression than white, non-Hispanic, black, non-Hispanic adults, or other, non-Hispanic adults (11.4% compared to 6.8%, 9.0%, and 11%, respectively).

Women age 50 or older reported more current and lifetime diagnosis of depression than men (8.9% compared to 6.2% for current depressive symptoms; 19.1% compared to 11.7% for lifetime diagnosis).

Lifetime Diagnosis of Depression

| Percentage of adults aged 50 or older with a lifetime diagnosis of depression. |
|-----------------|-----------------|-----------------|-----------------|-----------------|
|                  | 0 - 14.22%      | 14.23 - 15.86%  | 15.87 - 18.06%  | 18.07 - 23.19%  | No data         |

BRFSS Question

Lifetime Diagnosis of Depression “Has a doctor or other healthcare provider EVER told you that you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?”

Depression is one of the most successfully treated illnesses
• Anxiety, like depression, is among the most prevalent mental health problems among older adults (6). The two conditions often go hand in hand, with almost half of older adults who are diagnosed with a major depression also meeting the criteria for anxiety (13).

• Late-life anxiety is not well understood, but is believed to be as common in older adults as in younger age groups (although how and when it appears is distinctly different in older adults). Anxiety in this age group may be underestimated because older adults are less likely to report psychiatric symptoms and more likely to emphasize physical complaints (13).

• More than 90% of adults age 50 or older did not report a lifetime diagnosis of anxiety.

• Adults age 50–64 reported a lifetime diagnosis of an existing anxiety disorder more than adults age 65 or older (12.7% compared to 7.6%).

• Hispanic adults age 50 or older were slightly more likely to report a lifetime diagnosis of an anxiety disorder compared to white, non-Hispanic, black, non-Hispanic, or other, non-Hispanic adults (14.5% compared to 12.6%, 11% and 14.2%, respectively).

• Women age 50–64 years report a lifetime diagnosis of an anxiety disorder more often than men in this age group (16.1% compared to 9.2%, respectively.)
Next Steps

Most older adults are experiencing the life satisfaction, social and emotional support, and good mental health that are essential to healthy aging. For those who do need assistance, programs and services should be accessible and tailored to meet the unique needs of older adults. Public health professionals, while relative newcomers to the field, have an essential role to fulfill in assuring that the mental health status of the older adult population is monitored through surveillance systems such as the BRFSS. This information then can be used to support evidence-based programs and interventions.

This issue brief lays the foundation for examining a select group of mental health indicators among older adults. Future work will focus on connecting this information to programmatic efforts and other resources that public health, aging services, and mental health professionals can use to improve the health and quality of life of older Americans.

Technical Information

For the past two decades, CDC’s Behavioral Risk Factor Surveillance System (BRFSS) has helped states survey U.S. adults regarding a wide range of health issues and behaviors that affect their health. The crucial information gathered through this state-based telephone surveillance system is used by national, state, and local public health agencies to identify populations that might be at risk and to monitor the need for and the effectiveness of various public health interventions.

A subset of BRFSS survey questions assess how many people are experiencing mental health issues, including frequent mental distress, current depression, lifetime diagnoses of both depression or an anxiety disorder, as well as the availability of social and emotional support, which may reduce risk of emotional distress. BRFSS’s Anxiety and Depression Module used the PHQ-8, a well-validated, brief, self-reported measure for detecting current depression. The PHQ-8 asked 8 questions about depressive symptoms. This questionnaire is based on criteria from the Diagnostic and Statistical Manual of Mental Disorders (fourth edition) diagnosis of depressive disorders (14). The PHQ-8 has been shown to be effective for detecting current depression in various race/ethnicities (15) as well as in older adults (16). For the BRFSS, PHQ-8 questions were modified to be comparable to other BRFSS questions by assessing the number of days in the past 2 weeks the respondent experienced a particular depressive symptom (12, 17). Each question asked about number of days the symptom occurred in the past two weeks and a score was assigned based on the number of days (0 to 1 days=0 points, 2 to 6 days=1 point, 7 to 11 days=3 points, and 12 to 14 days=4 points). The scores for each item were summed to produce a total score between 0 and 24 points. A respondent with a total score of ≥10 was defined as having current depression.

While the BRFSS is a useful tool for assessing the mental health of the older adult population, it has some limitations: It excludes people who do not have telephones or are in institutions, such as nursing homes; it may under-represent people who are severely impaired because of the functional capacity required to participate in the survey; and responses to BRFSS are self-reported and therefore have not been confirmed by a healthcare provider. Despite these limitations, the BRFSS is a uniquely powerful tool to provide the prevalence of mental health issues among older community-dwelling U.S. adults, due to its large sample size and proven reliability and validity (18).

The BRFSS is administered and supported by the Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC. For more information, please visit http://www.cdc.gov/brfss.
References


Acknowledgments

Healthy Aging Program, CDC

Adults and Older Adults Goal Team, CDC

Behavioral Surveillance Branch, CDC

Healthy Aging Council, NACDD

Lisa Jeannotte, Consultant

For more information, please visit
www.cdc.gov/aging and www.chronicdisease.org

Suggested Citation:
# CHAPTER 5

## OLDER ADULTS AND MENTAL HEALTH

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The past century has witnessed a remarkable lengthening of the average life span in the United States, from 47 years in 1900 to more than 75 years in the mid-1990s (National Center for Health Statistics [NCHS], 1993). Equally noteworthy has been the increase in the number of persons ages 85 and older (Figure 5-1). These trends will continue well into the next century and be magnified as the numbers of older Americans increase with the aging of the post–World War II baby boom generation.

Millions of older Americans—indeed, the majority—cope constructively with the physical limitations, cognitive changes, and various losses, such as bereavement, that frequently are associated with late life. Research has contributed immensely to our understanding of developmental processes that continue to unfold as we age. Drawing on new scientific information and acting on clinical common sense, mental health and general health care providers are increasingly able to suggest mental health strategies and skills that older adults can hone to make this stage of the life span satisfying and rewarding.

The capacity for sound mental health among older adults notwithstanding, a substantial proportion of the population 55 and older—almost 20 percent of this age group—experience specific mental disorders that are not part of “normal” aging (see Table 5-1). Research that has helped differentiate mental disorders from “normal” aging has been one of the more important achievements of recent decades in the field of geriatric health. Unrecognized or untreated, however, depression, Alzheimer’s disease, alcohol and drug misuse and abuse, anxiety, late-life schizophrenia, and other conditions can be severely impairing, even fatal.

Figure 5-1. Increases in the percent of the U.S. population over age 85 years and over age 85 years (Malmgren, 1994).
in the United States, the rate of suicide, which is frequently a consequence of depression, is highest among older adults relative to all other age groups (Hoyert et al., 1999). The clinical challenges such conditions present may be exacerbated, moreover, by the manner in which they both affect and are affected by general medical conditions or by changes in cognitive capacities. Another complicating factor is that many older people, disabled by or at risk for mental disorders, find it difficult to afford and obtain needed medical and related health care services. Late-life mental disorders also can pose difficulties for the burgeoning numbers of family members who assist in caretaking tasks for their loved ones (Light & Lebowitz, 1991).

**Chapter Overview**

Fortunately, the past 15 to 20 years have been marked by rapid growth in the number of clinical, research, and training centers dedicated to the mental illness- and mental health-related needs of older people. As evident in this chapter, much has been learned. The chapter reviews, first, normal developmental milestones of aging, highlighting the adaptive capacities that enable many older people to change, cope with loss, and pursue productive and fulfilling activities. The chapter then considers mental disorders in older people—their diagnosis and treatment, and the various risk factors that may complicate the course or outcome of treatment. Risk factors include co-occurring, or comorbid, general medical conditions, the high numbers of medications many older individuals take, and psychosocial stressors such as bereavement or isolation. These are cause for concern, but, as the chapter notes, they also point the way to possible new preventive interventions. The goal of such prevention strategies may be to limit disability or to postpone or even eliminate the need to institutionalize an ill person (Lebowitz & Pearson, in press). The chapter reviews gains that have been realized in making appropriate mental health services available to older people and the challenges associated with the delivery of services to this population. The advantages of a decisive shift away from mental hospitals and nursing homes to treatment in community-based settings today are in jeopardy of being undermined by fragmentation and insufficient availability of such services (Gatz & Smyer, 1992; Cohen & Cairl, 1996). The chapter examines obstacles and opportunities in the service delivery sphere, in part through the lens of public and private sector financing policies and managed care.

Finally, the chapter reviews the supports for older persons that extend beyond traditional, formal treatment settings. Through support networks, self-help groups, and other means, consumers, families, and communities are assuming an increasingly important

### Table 5-1. Best Estimate 1-Year Prevalence Rates Based on Epidemiologic Catchment Area, Age 55+

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Anxiety Disorder</td>
<td>11.4</td>
</tr>
<tr>
<td>Simple Phobia</td>
<td>7.3</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>1.0</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>4.1</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>0.5</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>1.5</td>
</tr>
<tr>
<td>Any Mood Disorder</td>
<td>4.4</td>
</tr>
<tr>
<td>Major Depressive Episode</td>
<td>3.8</td>
</tr>
<tr>
<td>Unipolar Major Depression</td>
<td>3.7</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>1.6</td>
</tr>
<tr>
<td>Bipolar I</td>
<td>0.2</td>
</tr>
<tr>
<td>Bipolar II</td>
<td>0.1</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0.6</td>
</tr>
<tr>
<td>Somatization</td>
<td>0.3</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>0.0</td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td>0.0</td>
</tr>
<tr>
<td>Severe Cognitive Impairment</td>
<td>6.6</td>
</tr>
<tr>
<td>Any Disorder</td>
<td>19.8</td>
</tr>
</tbody>
</table>

role in treating and preventing mental health problems and disorders among older persons.

**Normal Life-Cycle Tasks**
With improved diet, physical fitness, public health, and health care, more adults are reaching age 65 in better physical and mental health than in the past. Trends show that the prevalence of chronic disability among older people is declining: from 1982 to 1994, the prevalence of chronic disability diminished significantly, from 24.9 to 21.3 percent of the older population (Manton et al., 1997). While some disability is the result of more general losses of physiological functions with aging (i.e., normal aging), extreme disability in older persons, including that which stems from mental disorders, is not an inevitable part of aging (Cohen, 1988; Rowe & Kahn, 1997).

Normal aging is a gradual process that ushers in some physical decline, such as decreased sensory abilities (e.g., vision and hearing) and decreased pulmonary and immune function (Miller, 1996; Carman, 1997). With aging come certain changes in mental functioning, but very few of these changes match commonly held negative stereotypes about aging (Cohen, 1988; Rowe & Kahn, 1997). In normal aging, important aspects of mental health include stable intellectual functioning, capacity for change, and productive engagement with life.

**Cognitive Capacity With Aging**
Cognition subsumes intelligence, language, learning, and memory. With advancing years, cognitive capacity with aging undergoes some loss, yet important functions are spared. Moreover, there is much variability between individuals, variability that is dependent upon lifestyle and psychosocial factors (Gottlieb, 1995). Most important, accumulating evidence from human and animal research finds that lifestyle modifies genetic risk in influencing the outcomes of aging (Finch & Tanzi, 1997). This line of research is beginning to dispel the pejorative stereotypes of older people as rigidly shaped by heredity and incapable of broadening their pursuits and acquiring new skills.

A large body of research, including both cross-sectional studies and longitudinal studies, has investigated changes in cognitive function with aging. Studies have found that working memory declines with aging, as does long-term memory (Siegler et al., 1996), with decrements more apparent in recall than in recognition capacities. Slowing or some loss of other cognitive functions takes place, most notably in information processing, selective attention, and problem-solving ability, yet findings are variable (Siegler et al., 1996). These cognitive changes translate into a slower pace of learning and greater need for repetition of new information. Vocabulary increases slightly until the mid-70s, after which it declines (Carman, 1997). In older people whose IQ declines, somatic illness is implicated in some cases (Cohen, 1988). Fluid intelligence, a form of intelligence defined as the ability to solve novel problems, declines over time, yet research finds that fluid intelligence can be enhanced through training in cognitive skills and problem-solving strategies (Baltes et al., 1989).

Memory complaints are exceedingly common in older people, with 50 to 80 percent reporting subjective memory complaints (cited in Levy-Cushman & Abeles, in press). However, subjective memory complaints do not correspond with actual performance. In fact, some who complain about memory display performance superior to those who do not complain (Collins & Abeles, 1996). Memory complaints in older people, according to several studies, are thought to be more a product of depression than of decline in memory performance (cited in Levy-Cushman & Abeles, in press). (The importance of proper diagnosis and treatment of depression is emphasized in subsequent sections of this chapter.) Studies attempting to treat memory complaints associated with normal aging—using either pharmacological or psychosocial means—have been, with few exceptions, unsuccessful (Crook, 1993). In one of these exceptions, a recent study demonstrated a significant reduction in memory complaints with training workshops for healthy older people. The workshops stressed not only memory promotion strategies, but also ways of dealing with
expectations and perceptions about memory loss (Levy-Cushman & Abeles, in press).

One large, ongoing longitudinal study found high cognitive performance to be dependent on four factors, ranked here in decreasing order of importance: education, strenuous activity in the home, peak pulmonary flow rate, and “self-efficacy,” which is a personality measure defined by the ability to organize and execute actions required to deal with situations likely to happen in the future (Albert et al., 1995). Education, as assessed by years of schooling, is the strongest predictor of high cognitive functioning. This finding suggests that education not only has salutary effects on brain function earlier in life, but also foreshadows sustained productive behavior in later life, such as reading and performing crossword puzzles (Rowe & Kahn, 1997).

The coexistence of mental and somatic disorders (i.e., comorbidity) is common (Kramer et al., 1992). Some disorders with primarily somatic symptoms can cause cognitive, emotional, and behavioral symptoms as well, some of which rise to the level of mental disorders. At that point, the mental disorder may result from an effect of the underlying disorder on the central nervous system (e.g., dementia due to a medical condition such as hypothyroidism) or an effect of treatment (e.g., delirium due to a prescribed medication). Likewise, mental problems or disorders can lead to or exacerbate other physical conditions by decreasing the ability of older adults to care for themselves, by impairing their capacity to rally social support, or by impairing physiological functions. For example, stress increases the risk of coronary heart disease and can suppress cellular immunity (McEwen, 1998). Depression can lead to increased mortality from heart disease and possibly cancer (Frasure-Smith et al., 1993, 1995; Penninx et al., 1998).

A new model postulates that successful aging is contingent upon three elements: avoiding disease and disability, sustaining high cognitive and physical function, and engaging with life (Rowe & Kahn, 1997). The latter encompasses the maintenance of interpersonal relationships and productive activities, as defined by paid or unpaid activities that generate goods or services of economic value. The three major elements are considered to act in concert, for none is deemed sufficient by itself for successful aging. This new model broadens the reach of health promotion in aging to entail more than just disease prevention.

Change, Human Potential, and Creativity

Descriptive research reveals evidence of the capacity for constructive change in later life (Cohen, 1988). The capacity to change can occur even in the face of mental illness, adversity, and chronic mental health problems. Older persons display flexibility in behavior and attitudes and the ability to grow intellectually and emotionally. Time plays a key role. Externally imposed demands upon one’s time may diminish, and the amount of time left at this stage in life can be significant. In the United States in the late 20th century, late-life expectancy approaches another 20 years at the age of 65. In other words, average longevity from age 65 today approaches what had been the average longevity from birth some 2,000 years ago. This leaves plenty of time to embark upon new social, psychological, educational, and recreational pathways, as long as the individual retains good health and material resources.

In his classic developmental model, Erik Erikson characterized the final stage of human development as a tension between “ego integrity and despair” (Erikson, 1950). Erikson saw the period beginning at age 65 years as highly variable. Ideally, individuals at this stage witness the flowering of seeds planted earlier in the prior seven stages of development. When they achieve a sense of integrity in life, they garner pride from their children, students and protégés, and past accomplishments. With contentment comes a greater tolerance and acceptance of the decline that naturally accompanies the aging process. Failure to achieve a satisfying degree of ego integrity can be accompanied by despair.

Cohen (in press) has proposed that with increased longevity and health, particularly for people with adequate resources, aging is characterized by two human potential phases. These phases, which emphasize the positive aspects of the final stages of the
life cycle, are termed Retirement/Liberation and Summing Up/Swan Song.

Retirement often is viewed as the most important life event prior to death. Retirement frequently is associated with negative myths and stereotypes (Sheldon et al., 1975; Bass, 1995). Cohen points out, however, that most people fare well in retirement. They have the opportunity to explore new interests, activities, and relationships due to retirement’s liberating qualities. In the Retirement/Liberation phase, new feelings of freedom, courage, and confidence are experienced. Those at risk for faring poorly are individuals who typically do not want to retire, who are compelled to retire because of poor health, or who experience a significant decline in their standard of living (Cohen, 1988). In short, the liberating experience of having more time and an increased sense of freedom can be the springboard for creativity in later life. Creative achievement by older people can change the course of an individual, family, community, or culture.

In the late-life Summing Up/Swan Song phase, there is a tendency to appraise one’s life work, ideas, and discoveries and to share them with family or society. The desire to sum up late in life is driven by varied feelings, such as the desire to complete one’s life work, the desire to give back after receiving much in life, or the fear of time evaporating. Important opportunities for creative sharing and expression ensue. There is a natural tendency with aging to reminisce and elaborate stories that has propelled the development of reminiscence therapy for health promotion and disease prevention. The swan song, the final part of this phase, connotes the last act or final creative work of a person before retirement or death.

There is much misunderstanding about thoughts of death in later life. Depression, serious loss, and terminal illness trigger the sense of mortality, regardless of age. Contrary to popular stereotypes, studies on aging reveal that most older people generally do not have a fear or dread of death in the absence of being depressed, encountering serious loss, or having been recently diagnosed with a terminal illness (Kastenbaum, 1985). Periodic thoughts of death—not in the form of dread or angst—do occur. But these are usually associated with the death of a friend or family member. When actual dread of death does occur, it should not be dismissed as accompanying aging, but rather as a signal of underlying distress (e.g., depression). This is particularly important in light of the high risk of suicide among depressed older adults, which is discussed later in this chapter.

Coping With Loss and Bereavement

Many older adults experience loss with aging—loss of social status and self-esteem, loss of physical capacities, and death of friends and loved ones. But in the face of loss, many older people have the capacity to develop new adaptive strategies, even creative expression (Cohen, 1988, 1990). Those experiencing loss may be able to move in a positive direction, either on their own, with the benefit of informal support from family and friends, or with formal support from mental health professionals.

The life and work of William Carlos Williams are illustrative. Williams was a great poet as well as a respected physician. In his 60s, he suffered a stroke that prevented him from practicing medicine. The stroke did not affect his intellectual abilities, but he became so severely depressed that he needed psychiatric hospitalization. Nonetheless, Williams, with the help of treatment for a year, surmounted the depression and for the next 10 years wrote luminous poetry, including the Pulitzer Prize-winning *Pictures From Bruegel*, which was published when he was 79. In his later life, Williams wrote about “old age that adds as it takes away.” What Williams and his poetry epitomize is that age can be the catalyst for tapping into creative potential (Cohen, 1998a).

Loss of a spouse is common in late life. About 800,000 older Americans are widowed each year. Bereavement is a natural response to death of a loved one. Its features, almost universally recognized, include crying and sorrow, anxiety and agitation, insomnia, and loss of appetite (Institute of Medicine [IOM], 1984). This constellation of symptoms, while overlapping somewhat with major depression, does not by itself constitute a mental disorder. Only when symptoms persist for 2 months and longer after the loss does the
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DSM-IV permit a diagnosis of either adjustment disorder or major depressive disorder. Even though bereavement of less than 2 months’ duration is not considered a mental disorder, it still warrants clinical attention (DSM-IV). The justification for clinical attention is that bereavement, as a highly stressful event, increases the probability of, and may cause or exacerbate, mental and somatic disorders.

Bereavement is an important and well-established risk factor for depression. At least 10 to 20 percent of widows and widowers develop clinically significant depression during the first year of bereavement. Without treatment, such depressions tend to persist, become chronic, and lead to further disability and impairments in general health, including alterations in endocrine and immune function (Zisook & Shuchter, 1993; Zisook et al., 1994). Several preventive interventions, including participation in self-help groups, have been shown to prevent depression among widows and widowers, although one study suggested that self-help groups can exacerbate depressive symptoms in certain individuals (Levy et al., 1993). These are described later in this chapter.

Bereavement-associated depression often coexists with another type of emotional distress, which has been termed traumatic grief (Prigerson et al., in press). The symptoms of traumatic grief, although not formalized as a mental disorder in DSM-IV, appear to be a mixture of symptoms of both pathological grief and post-traumatic stress disorder (Frank et al., 1997a). Such symptoms are extremely disabling, associated with functional and health impairment and with persistent suicidal thoughts, and may well respond to pharmacotherapy (Zygmont et al., 1998). Increased illness and mortality from suicide are the most serious consequences of late-life depression.

The dynamics around loss in later life need greater clarification. One pivotal question is why some, in confronting loss with aging, succumb to depression and suicide—which, as noted earlier, has its highest frequency after age 65—while others respond with new adaptive strategies. Research on health promotion also needs to identify ways to prevent adverse reactions and to promote positive responses to loss in later life. Meanwhile, despite cultural attitudes that older persons can handle bereavement by themselves or with support from family and friends, it is imperative that those who are unable to cope be encouraged to access mental health services. Bereavement is not a mental disorder but, if unattended to, has serious mental health and other health consequences.

Overview of Mental Disorders in Older Adults

Older adults are encumbered by many of the same mental disorders as are other adults; however, the prevalence, nature, and course of each disorder may be very different. This section provides a general overview of assessment, diagnosis, and treatment of mental disorders in older people. Its purpose is to describe issues common to many mental disorders. Subsequent sections of this chapter provide more detailed reviews of late-life depression and Alzheimer’s disease. Also, to shed light on the range and frequency of disorders that impair the mental well-being of older Americans, the chapter reviews the impact on older adults of anxiety, schizophrenia, and alcohol and substance abuse.

Assessment and Diagnosis

Assessment and diagnosis of late-life mental disorders are especially challenging by virtue of several distinctive characteristics of older adults. First, the clinical presentation of older adults with mental disorders may be different from that of other adults, making detection of treatable illness more difficult. For example, many older individuals present with somatic complaints and experience symptoms of depression and anxiety that do not meet the full criteria for depressive or anxiety disorders. The consequences of these subsyndromal conditions may be just as deleterious as the syndromes themselves. Failure to detect individuals who truly have treatable mental disorders represents a serious public health problem (National Institutes of Health [NIH] Consensus Development Panel on Depression in Late Life, 1992).

Detection of mental disorders in older adults is complicated further by high comorbidity with other
medical disorders. The symptoms of somatic disorders may mimic or mask psychopathology, making diagnosis more taxing. In addition, older individuals are more likely to report somatic symptoms than psychological ones, leading to further under-identification of mental disorders (Blazer, 1996b).

Primary care providers carry much of the burden for diagnosis of mental disorders in older adults, and, unfortunately, the rates at which they recognize and properly identify disorders often are low. With respect to depression, for example, a significant number of depressed older adults are neither diagnosed nor treated in primary care (NIH Consensus Development Panel on Depression in Late Life, 1992; Unutzer et al., 1997b). In one study of primary care physicians, only 55 percent of internists felt confident in diagnosing depression, and even fewer (35 percent of the total) felt confident in prescribing antidepressants to older persons (Callahan et al., 1992). Physicians were least likely to report that they felt “very confident” in evaluating depression in other late-life conditions (Gallo et al., in press). Researchers estimate that an unmet need for mental health services may be experienced by up to 63 percent of adults aged 65 years and older with a mental disorder, based on prevalence estimates from the Epidemiologic Catchment Area (ECA) study (Rabins, 1996).

The large unmet need for treatment of mental disorders reflects patient barriers (e.g., preference for primary care, tendency to emphasize somatic problems, reluctance to disclose psychological symptoms), provider barriers (e.g., lack of awareness of the manifestations of mental disorders, complexity of treatment, and reluctance to inform patients of a diagnosis), and mental health delivery system barriers (e.g., time pressures, reimbursement policies).

Stereotypes about normal aging also can make diagnosis and assessment of mental disorders in late life challenging. For example, many people believe that “senility” is normal and therefore may delay seeking care for relatives with dementing illnesses. Similarly, patients and their families may believe that depression and hopelessness are natural conditions of older age, especially with prolonged bereavement.

Cognitive decline, both normal and pathological, can be a barrier to effective identification and assessment of mental illness in late life. Obtaining an accurate history, which may need to be taken from family members, is important for diagnosis of most disorders and especially for distinguishing between somatic and mental disorders. Normal decline in short-term memory and especially the severe impairments in memory seen in dementing illnesses hamper attempts to obtain good patient histories. Similarly, cognitive deficits are prominent features of many disorders of late life that make diagnosis of psychiatric disorders more difficult.

Overview of Prevention

Prevention in mental health has been seen until recently as an area limited to childhood and adolescence. Now there is mounting awareness of the value of prevention in the older population. While the body of published literature is not as extensive as that for diagnosis or treatment, investigators are beginning to shape new approaches to prevention. Yet because prevention research is driven, in part, by refined understanding of disease etiology—and etiology research itself continues to be rife with uncertainty—prevention advances are expected to lag behind those in etiology.

There are many ways in which prevention models can be applied to older individuals, provided a broad view of prevention is used (Lebowitz & Pearson, in press). Such a broad view entails interventions for reducing the risk of developing, exacerbating, or experiencing the consequences of a mental disorder. Consequently, this section covers primary prevention (including the prevention of depression and suicide), treatment-related prevention, prevention of excess disability, and prevention of premature institutionalization. However, many of the research advances noted in this section have yet to be translated into practice. Given the frequency of memory complaints and depression, the time may soon arrive for older adults to be encouraged to have “mood and memory checkups” in the same manner that they are now encouraged to have physical checkups (N. Abeles, personal communication, 1998).
Primary Prevention

Primary prevention, the prevention of disease before it occurs, can be applied to late-onset disorders. Progress in our understanding of etiology, risk factors, pathogenesis, and the course of mental disorders—discussed later in this chapter for depression, Alzheimer’s disease, and other conditions—stimulates and channels the development of prevention interventions.

The largest body of primary prevention research focuses on late-life depression, where some progress has been documented. With other disorders, primary prevention research is in its infancy. Prevention in Alzheimer’s disease might target individuals at increased genetic risk with prophylactic nutritional (e.g., vitamin E), cholinergic, or amyloid-targeting interventions. Prevention research on late-onset schizophrenia might explore potential protective factors, such as estrogen.

Prevention of Depression and Suicide

Depression is strikingly prevalent among older people. As noted below, 8 to 20 percent of older adults in the community and up to 37 percent in primary care settings experience symptoms of depression.

One approach to preventing depression is through grief counseling for widows and widowers. For example, participation in self-help groups appears to ameliorate depression, improve social adjustment, and reduce the use of alcohol and other drugs of abuse in widows (Constantino, 1988; Lieberman & Videka-Sherman, 1986). The efficacy of self-help groups approximates that of brief psychodynamic psychotherapy in older bereaved individuals without significant prior psychopathology (Marmar et al., 1988). The battery of psychosocial and pharmacological treatments to prevent recurrences of depression (i.e., secondary prevention) is discussed later in this chapter under the section on depression.

Depression is a foremost risk factor for suicide in older adults (Conwell, 1996; Conwell et al., 1996). Older people have the highest rates of suicide in the U.S. population: suicide rates increase with age, with older white men having a rate of suicide up to six times that of the general population (Kachur et al., 1995; Hoyert et al., 1999). Despite the prevalence of depression and the risk it confers for suicide, depression is neither well recognized nor treated in primary care settings, where most older adults seek and receive health care (Unutzer et al., 1997a). Studies described in the depression section of this chapter have found that undiagnosed and untreated depression in the primary care setting plays a significant role in suicide (Caine et al., 1996). This awareness has prompted the development of suicide prevention strategies expressly for primary care. One of the first published suicide prevention studies, an uncontrolled experiment conducted in Sweden, suggested that a depression training program for general practitioners reduces suicide (Rihmer et al., 1995). Suicide interventions, especially in the primary care setting, have become a priority of the U.S. Public Health Service, with lead responsibility assumed by the Office of the Surgeon General and the National Institute of Mental Health.

Depression and suicide prevention strategies also are important for nursing home residents. About half of patients newly relocated to nursing homes are at heightened risk for depression (Parmelee et al., 1989).

Treatment-Related Prevention

Prevention of relapse or recurrence of the underlying mental disorder is important for improving the mental health of older patients with mental disorders. For example, treatments that are applied with adequate intensities for depression (Schneider, 1996) and for depression in Alzheimer’s disease (Small et al., 1997) may prevent relapse or recurrence. Substantial residual disability in chronically mentally ill individuals (Lebowitz et al., 1997) suggests that treatment must be approached from a longer term perspective (Reynolds et al., 1996).

Prevention of medication side effects and adverse reactions also is an important goal of treatment-related prevention efforts in older adults. Comorbidity and the associated polypharmacy for multiple conditions are characteristic of older patients. New information on the genetic basis of drug metabolism and on the action of drug-metabolizing enzymes can lead to a better
understanding of complex drug interactions (Nemeroff et al., 1996). For example, many of the selective serotonin reuptake inhibitors compete for the same metabolic pathway used by beta-blockers, type 1C antiarrhythmics, and benzodiazepines (Nemeroff et al., 1996). This knowledge can assist the clinician in choosing medications that can prevent the likelihood of side effects. In addition, many older patients require antipsychotic treatment for management of behavioral symptoms in Alzheimer’s disease, schizophrenia, and depression. Although doses tend to be quite low, age and length of treatment represent major risk factors for movement disorders (Saltz et al., 1991; Jeste et al., 1995a). Recent research on older people suggests that the newer antipsychotics present a much lower risk of movement disorders, highlighting their importance for prevention (Jeste et al., in press). Finally, body sway and postural stability are affected by many drugs, although there is wide variability within classes of drugs (Laghrissi-Thode et al., 1995). Minimizing the risk of falling, therefore, is another target for prevention research. Falls represent a leading cause of injury deaths among older persons (IOM, 1999).

**Prevention of Excess Disability**

Prevention efforts in older mentally ill populations also target avoidance of excessive disability. The concept of excess disability refers to the observation that many older patients, particularly those with Alzheimer’s disease and other severe and persistent mental disorders, are more functionally impaired than would be expected according to the stage or severity of their disorder. Medical, psychosocial, and environmental factors all contribute to excess disability. For example, depression contributes to excess disability by hastening functional impairment in patients with Alzheimer’s disease (Ritchie et al., 1998). The fast pace of modern life, with its emphasis on independence, also contributes to excess disability by making it more difficult for older adults with impairments to function autonomously. Attention to depression, anxiety, and other mental disorders may reduce the functional limitations associated with concomitant mental and somatic impairments. Many studies have demonstrated that attention to these factors and aggressive intervention, where appropriate, maximize function (Lebowitz & Pearson, in press).

**Prevention of Premature Institutionalization**

Another important goal of prevention efforts in older adults is prevention of premature institutionalization. While institutional care is needed for many older patients who suffer from severe and persistent mental disorders, delay of institutional placement until absolutely necessary generally is what patients and family caregivers prefer. It also has significant public health impact in terms of reducing costs. A randomized study of counseling and support versus usual care for family caregivers of patients with Alzheimer’s disease found the intervention to have delayed patients’ nursing home admission by over 300 days (Mittelman et al., 1996). The intervention also resulted in a significant reduction in depressive symptoms in the caregivers. The intervention consisted of three elements: individual and family counseling sessions, support group participation, and availability of counselors to assist with patient crises.

The growing importance of avoiding premature institutionalization is illustrated by its use as one measure of the effectiveness of pharmacotherapy in older individuals. For example, clinical trials of drugs for Alzheimer’s disease have begun using delay of institutionalization as a primary outcome (Sano et al., 1997) or as a longer-term outcome in a followup study after the double-blind portion of the clinical trial ended (Knopman et al., 1996).

**Overview of Treatment**

Treatment of mental disorders in older adults encompasses pharmacological interventions, electroconvulsive therapy, and psychosocial interventions. While the pharmacological and psychosocial interventions used to treat mental health problems and specific disorders may be identical for older and younger adults, characteristics unique to older adults may be important considerations in treatment selection.
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Pharmacological Treatment

The special considerations in selecting appropriate medications for older people include physiological changes due to aging; increased vulnerability to side effects, such as tardive dyskinesia; the impact of polypharmacy; interactions with other comorbid disorders; and barriers to compliance. All are discussed below.

The aging process leads to numerous changes in physiology, resulting in altered blood levels of certain medications, prolonged pharmacological effects, and greater risk for many side effects (Kendell et al., 1981). Changes may occur in the absorption, distribution, metabolism, and excretion of psychotropic medications (Pollock & Mulsant, 1995).

As people age, there is a gradual decrease in gastrointestinal motility, gastric blood flow, and gastric acid production (Greenblatt et al., 1982). This slows the rate of absorption, but the overall extent of gastric absorption is probably comparable to that in other adults. The aging process is also associated with a decrease in total body water, a decrease in muscle mass, and an increase in adipose tissue (Borkan et al., 1983). Drugs that are highly lipophilic, such as neuroleptics, are therefore more likely to be accumulated in fatty tissues in older patients than they are in younger patients.

The liver undergoes changes in blood flow and volume with age. Phase I metabolism (oxidation, reduction, hydrolysis) may diminish or remain unchanged, while phase II metabolism (conjugation with an endogenous substrate) does not change with aging. Renal blood flow, glomerular surface area, tubular function, and reabsorption mechanisms all have been shown to diminish with age. Diminished renal excretion may lead to a prolonged half-life and the necessity for a lower dose or longer dosing intervals.

Pharmacodynamics, which refers to the drug’s effect on its target organ, also can be altered in older individuals. An example of aging-associated pharmacodynamic change is diminished central cholinergic function contributing to increased sensitivity to the anticholinergic effects of many neuroleptics and antidepressants in older adults (Molchan et al., 1992).

Because of the pharmacokinetic and pharmacodynamic concerns presented above, it is often recommended that clinicians “start low and go slow” when prescribing new psychoactive medications for older adults. In other words, efficacy is greatest and side effects are minimized when initial doses are small and the rate of increase is slow. Nevertheless, the medication should generally be titrated to the regular adult dose in order to obtain the full benefit. The potential pitfall is that, because of slower titration and the concomitant need for more frequent medical visits, there is less likelihood of older adults receiving an adequate dose and course of medication.

Increased Risk of Side Effects

Older people encounter an increased risk of side effects, most likely the result of taking multiple drugs or having higher blood levels of a given drug. The increased risk of side effects is especially true for neuroleptic agents, which are widely prescribed as treatment for psychotic symptoms, agitation, and behavioral symptoms. Neuroleptic side effects include sedation, anticholinergic toxicity (which can result in urinary retention, constipation, dry mouth, glaucoma, and confusion), extrapyramidal symptoms (e.g., parkinsonism, akathisia, and dystonia), and tardive dyskinesia. Chapter 4 contains more detailed information about the side effects of neuroleptics.

Tardive dyskinesia is a frequent and persistent side effect that occurs months to years after initiation of neuroleptics. In older adults, tardive dyskinesia typically entails abnormal movements of the tongue, lips, and face. In a recent study of older outpatients treated with conventional neuroleptics the incidence of tardive dyskinesia after 12 months of neuroleptic treatment was 29 percent of the patients. At 24 and 36 months, the mean cumulative incidence was 50.1 percent and 63.1 percent, respectively (Jeste et al., 1995a). This study demonstrates the high risk of tardive dyskinesia in older patients even with low doses of conventional neuroleptics. Studies of younger adult patients reveal an annual cumulative incidence of tardive dyskinesia at 4 to 5 percent (Kane et al., 1993).
Unlike conventional neuroleptics, the newer atypical ones, such as clozapine, risperidone, olanzapine, and quetiapine, apparently confer several advantages with respect to both efficacy and safety. These drugs are associated with a lower incidence of extrapyramidal symptoms than conventional neuroleptics are. For clozapine, the low risk of tardive dyskinesia is well established (Kane et al., 1993). The incidence of tardive dyskinesia with other atypical antipsychotics is also likely to be lower than that with conventional neuroleptics because extrapyramidal symptoms have been found to be a risk factor for tardive dyskinesia in older adults (Saltz et al., 1991; Jeste et al., 1995a). The determination of exact risk of tardive dyskinesia with these newer drugs needs long-term studies.

Polypharmacy
In addition to the effects of aging on pharmacokinetics and pharmacodynamics and the increased risk of side effects, older individuals with mental disorders also are more likely than other adults to be medicated with multiple compounds, both prescription and nonprescription (i.e., polypharmacy). Older adults (over the age of 65) fill an average of 13 prescriptions a year (for original or refill prescriptions), which is approximately three times the number filled by younger individuals (Chrischilles et al., 1992). Polypharmacy greatly complicates effective treatment of mental disorders in older adults. Specifically, drug-drug interactions are of concern, both in terms of increasing side effects and decreasing efficacy of one or both compounds.

Treatment Compliance
Compliance with the treatment regimen also is a special concern in older adults, especially in those with moderate or severe cognitive deficits. Physical problems, such as impaired vision, make it likely that instructions may be misread or that one medicine may be mistaken for another. Cognitive impairment may also make it difficult for patients to remember whether or not they have taken their medication. Although in general, older patients are more compliant about taking psychoactive medications than other types of drugs (Cooper et al., 1982), when noncompliance does occur, it may be less easily detected, more serious, less easily resolved, mistaken for symptoms of a new disease, or even falsely labeled as “old-age” symptomatology. Accordingly, greater emphasis must be placed on strict compliance by patients in this age group (Lamy et al., 1992). Medication noncompliance takes different forms in older adults, that is, overuse and abuse, forgetting, and alteration of schedules and doses. The most common type of deliberate noncompliance among older adults may be the underuse of the prescribed drug, mainly because of side effects and cost considerations. Factors that contribute to medication noncompliance in older patients include inadequate information given to them regarding the necessity for drug treatment, unclear prescribing directions, suboptimal doctor-patient relationship, the large number of times per day drugs must be taken, and the large number of drugs that are taken at the same time (Lamy et al., 1992). Better compliance may be achieved by giving simple instructions and by asking specific questions to make sure that the patient understands directions.

Psychosocial Interventions
Several types of psychosocial interventions have proven effective in older patients with mental disorders, but the research is more limited than that on pharmacological interventions (see Klausner & Alexopoulos, in press). Both types are frequently used in combination. Most of the research has been restricted to psychosocial treatments for depression, although, as discussed below, there is mounting interest in dementia. For other mental disorders, psychosocial interventions found successful for younger adults are often tailored to older people in the practice setting without the benefit of efficacy research.

Despite the relative paucity of research, psychosocial interventions may be preferred for some older patients, especially those who are unable to tolerate, or prefer not to take, medication or who are confronting stressful situations or low degrees of social support (Lebowitz et al., 1997). The benefits of psychosocial interventions are likely to assume greater prominence.
as a result of population demographics: as the number of older people grows, progressively more older people in need of mental health treatment—especially the very old—are expected to be suffering from greater levels of comorbidity or dealing with the stresses associated with disability. Psychosocial interventions not only can help relieve the symptoms of a variety of mental disorders and related problems but also can play more diverse roles: they can help strengthen coping mechanisms, encourage (and monitor) patients’ compliance with medications, and promote healthy behavior (Klausner & Alexopoulos, in press).

New approaches to service delivery are being designed to realize the benefits of established psychosocial interventions. Many older people are not comfortable with traditional mental health settings, partially as a result of stigma (Waters, 1995). In fact, many older people prefer to receive treatment for mental disorders by their primary care physicians, and most older people do receive such care in the primary care setting (Brody et al., 1997; Unutzer et al., 1997a). Since older people show willingness to accept psychosocial interventions in the primary care setting, new models are striving to integrate into the primary care setting the delivery of specialty mental health services. The section of this chapter on service delivery discusses new models in greater detail.

**Gap Between Efficacy and Effectiveness**
A problem common to both pharmacological and psychosocial interventions is the disparity between treatment efficacy, as demonstrated in randomized controlled clinical trials, and effectiveness in real-world settings. While this problem is certainly not unique to older people (see Chapter 2 for a broader discussion of the problem), this problem is especially significant for older people with mental disorders. Older people are often undertreated for their mental disorders in primary care settings (Unutzer et al., 1997a). When they do receive appropriate treatment, older people are more likely than other people to have comorbid disorders and social problems that reduce treatment effectiveness (Unutzer et al., 1997a). An additional overlay of barriers, including financing and systems of care, is discussed later in this chapter.

**Depression in Older Adults**
Depression in older adults not only causes distress and suffering but also leads to impairments in physical, mental, and social functioning. Despite being associated with excess morbidity and mortality, depression often goes undiagnosed and untreated. The startling reality is that a substantial proportion of older patients receive no treatment or inadequate treatment for their depression in primary care settings, according to expert consensus (NIH Consensus Development Panel on Depression in Late Life, 1992; Lebowitz et al., 1997). Part of the problem is that depression in older people is hard to disentangle from the many other disorders that affect older people, and its symptom profile is somewhat different from that in other adults. Depressive symptoms are far more common than full-fledged major depression. However, several depressive symptoms together represent a condition—explained below as “minor depression”—that can be as disabling as major depression (Unutzer et al., 1997a). Minor depression, despite the implications of the term, is major in its prevalence and impact. Eight to 20 percent of older adults in the community and up to 37 percent in primary care settings suffer from depressive symptoms. Treatment is successful, with response rates between 60 and 80 percent, but the response generally takes longer than that for other adults. In addition to reviewing information on prevalence and treatment, this section also discusses depression’s course, barriers to diagnosis, interactions with physical disease, consequences, cost, and etiology.

**Diagnosis of Major and “Minor” Depression**
The term “major depression” refers to conditions with a major depressive episode, such as major depressive disorder, bipolar disorder, and related conditions. Major depressive disorder, the most common type of major depression in adults, is characterized by one or more episodes that include the following symptoms: depressed mood, loss of interest or pleasure in activities, significant weight loss or gain, sleep
disturbance, psychomotor agitation or retardation, fatigue, feelings of worthlessness, loss of concentration, and recurrent thoughts of death or suicide. (For further discussion of the diagnosis of major depressive disorder, see Chapter 4.) Major depressive disorder cannot be diagnosed if symptoms last for less than 2 months after bereavement, among other exclusionary factors (DSM-IV).

Most older patients with symptoms of depression do not meet the full criteria for major depression. The new diagnostic entity of minor depression has been proposed to characterize some of these patients. “Minor depression,” a subsyndromal form of depression, is not yet recognized as an official disorder, and DSM-IV proposes further research on it.

Minor depression is more frequent than major depression, with 8 to 20 percent of older community residents displaying symptoms (Alexopoulos, 1997; Gallo & Lebowitz, 1999). The diagnosis of minor depression is not yet standardized; the research criteria proposed in DSM-IV are the same as those for major depression, but a diagnosis would require fewer symptoms and less impairment. Minor depression, in fact, is not thought to be a single syndrome, but rather a heterogeneous group of syndromes that may signify either an early or residual form of major depression, a chronic, though mild, form of depression that does not present with a full array of symptoms at any one time, called dysthymia, or a response to an identifiable stressor (Judd et al., 1994; Pincus & Wakefield-Davis, 1997). Since depression is more difficult to assess and detect in older adults, research is needed on what clinical features might help identify older adults at increased risk for sustained depressive symptoms and suicide.

Both major and minor depression are associated with significant disability in physical, social, and role functioning (Wells et al., 1989). The degree of disability may not be as great with minor depression, but because of its higher prevalence, minor depression is associated with 51 percent more days lost from work than is major depression (Broadhead et al., 1990). Major and minor depression are associated with high health care utilization and poor quality of life (see Unutzer et al., 1997a, for a review).

Late-Onset Depression
Major or minor depression diagnosed with first onset later than age 60 has been termed late-onset depression. Late-onset depression is not a diagnosis; rather, it refers to a subset of patients with major or minor depression whose later age at first onset imparts slightly different clinical characteristics, suggesting the possibility of distinct etiology. Late-onset depression shares many clinical characteristics with early-onset depression, yet some distinguishing features exist. Patients with late-onset depression display greater apathy (Krishnan et al., 1995) and less lifetime personality dysfunction (Abrams et al., 1994). Cognitive deficits may be more prominent, with more impaired executive and memory functioning (Salloway et al., 1996) and greater medial temporal lobe abnormalities on magnetic resonance imaging, similar to those seen in dementia (Greenwald et al., 1997). Other studies, however, have shown no differences in cognition between patients with late- and early-onset depression (Holroyd & Duryee, 1997). The risk of recurrence of depression is relatively high among patients with onset of depression after the age of 60 (Reynolds, 1998).

Risk factors for late-onset depression, based on results of prospective studies, include widowhood (Bruce et al., 1990; Zisook & Shuchter, 1991; Harlow et al., 1991; Mendes de Leon et al., 1994), physical illness (Cadoret & Widmer, 1988; Harlow et al., 1991; Bachman et al., 1992), educational attainment less than high school (Wallace & O’Hara, 1992; Gallo et al., 1993), impaired functional status (Bruce & Hof, 1994), and heavy alcohol consumption (Saunders et al., 1991).

Prevalence and Incidence
Estimates of the prevalence of major depression vary widely, depending on the definition and the procedure used for counting persons with depression (Gallo & Lebowitz, 1999). Researchers applying DSM criteria for major depression have found 1-year U.S. prevalence rates of about 5 percent or less in older people (Gurland

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et al., 1996). The prevalence of major depression declines with age, while depressive symptoms increase (symptoms that now might warrant classification as minor depression). Romanoski and colleagues, on the basis of psychiatric interviews of adults in the Baltimore Epidemiologic Catchment Area, showed that major depression declined with advancing age (Romanoski et al., 1992). Prevalence estimates derived from symptom scales are consistent with the clinical impression that prevalence of depressive symptoms increases with advancing age. Depressive symptoms and syndromes have been identified in 8 to 20 percent of older community residents (Alexopoulos, 1997; Gallo & Lebowitz, 1999) and 17 to 35 percent of older primary care patients (Gurland et al., 1996).

Several incidence studies based on DSM criteria reflect a similar pattern of decline in rates of major depression with advancing age (Eaton et al., 1989; Eaton et al., 1997). The 13-year followup of the participants of the Baltimore Epidemiologic Catchment Area (ECA) sample revealed, however, that the distribution of the incidence of DSM-based major depression across the life span was bimodal, with a primary peak in the fourth decade and a secondary peak in the sixth decade (Eaton et al., 1997). In contrast to studies based on DSM criteria, several incidence studies report increased rates of depressive symptoms with age. A Swedish study reported that rates of depressive symptoms were highest in the older age groups and that rates of depression had increased in the interval from 1947–1957 to 1957–1972 (Hagnell et al., 1982). Incidence studies reveal an increased risk of depression among women as they age, consistent with findings based on prevalence surveys (Hagnell et al., 1982; Eaton et al., 1989; Gallo et al., 1993).

Thus, both prevalence and incidence studies that rely on DSM-based diagnosis of major depression suggest a decline with age, whereas symptom-based assessment studies show increased rates of depression among older adults, especially women. Evidence that older adults are less likely than younger persons to report feelings of dysphoria (i.e., sadness, unhappiness, or irritability) suggests that the standard criteria for depression may be more difficult to apply to older adults (Gallo et al., 1994) or that older adults are disinclined to report such feelings.

Other mood disorders, such as dysthymia, bipolar disorder, and hypomania, also are present in older individuals. Little difference has been found in the prevalence of affective disorders between African Americans and whites over the age of 65 (Weissman et al., 1991). The prevalence of bipolar disorder among people aged 65 and over is reportedly less than 1 percent (Robins & Regier, 1991). Approximately 5 to 10 percent of older patients presenting with mood disorders are manic or hypomanic (Yassa et al., 1988). However, these mood disorders will not be the focus of this section of the report, as they are much less common in older adults than depression.

**Barriers to Diagnosis and Treatment**

The underdiagnosis and undertreatment of depression in primary care represent a serious public health problem (NIH Consensus Development Panel on Depression in Late Life, 1992). One study found that only about 11 percent of depressed patients in primary care received adequate antidepressant treatment (in terms of dose and duration of pharmacotherapy), while 34 percent received inadequate treatment and 55 percent received no treatment (Katon et al., 1992).

There are many barriers to the diagnosis of depression in late life. Some of these barriers reflect the nature of the disorder: depression occurs in a complex medical and psychosocial context. In the elderly, the signs and symptoms of major depression are frequently attributed to “normal aging,” atherosclerosis, Alzheimer’s disease, or any of a host of other age-associated afflictions. Psychosocial antecedents such as loss, combined with decrements in physical health and sensory impairment, can also divert attention from clinical depression.

Another reason for the underdiagnosis is that older patients are less likely to report symptoms of dysphoria and worthlessness, which are often considered hallmarks of the diagnosis of depression. The

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1 Hypomania is marked by abnormally elevated mood, but the symptoms are not severe enough for mania (see Chapter 4).
consequences of underdiagnosis of this subset of patients can be severe. On the basis of a followup of older adults in the Baltimore Epidemiologic Catchment Area sample, persons with depressive symptoms (e.g., sleep and appetite disturbance) without sadness (e.g., hopelessness, worthlessness, thoughts of death, wanting to die, or suicide) were at increased risk for subsequent functional impairment, cognitive impairment, psychological distress, and death over the course of the 13-year interval (Gallo et al., 1997).

Other barriers to diagnosis are patient related. Depression can and frequently does amplify physical symptoms, distracting patients’ and providers’ attention from the underlying depression; and many older patients may deny psychological symptoms of depression or refuse to accept the diagnosis because of stigma. This appears to be particularly the case with older men, who also have the highest rates of suicide in later life (Hoyert et al., 1999).

Provider-related factors also appear to play a role in underdetection of depression and suicide risk. Providers may be reluctant to inform older patients of a diagnosis of depression, owing to uncertainty about diagnosis, reluctance to stigmatize, uncertainty about optimal treatment, concern about medication interactions or lack of access to psychiatric care, and continuing concern about the effectiveness and cost-effectiveness of treatment intervention (NIH Consensus Development Panel on Depression in Late Life, 1992; Unutzer et al., 1997a).

Societal stereotypes about aging also can hamper efforts to identify and diagnose depression in late life. Many people believe that depression in response to the loss of a loved one, increased physical limitations, or changing societal role is an inevitable part of aging. Even physicians appear to hold such stereotyped views. Three-quarters of physicians in one study thought that depression “was understandable” in older persons (Gallo et al., in press), consistent with other studies (Bartels et al., 1997). Suicidal thoughts are sometimes considered a normal facet of old age. These mistaken beliefs can lead to underreporting of symptoms by patients and lack of effort on the part of family members to seek care for patients.

Finally, the health care system itself is increasingly restricting the time spent in patient care, forcing mental health concerns to compete with comorbid general medical conditions. Primary care physicians often report feeling too pressured for time to investigate depression in older people (Glasser & Gravdal, 1997). Given the inseparability of mental and general health in later life particularly, this trend is worrisome.

Course
Across the life span, the course of depression is marked by recurrent episodes of depression followed by periods of remission. In late life, the course of depression tends to be more chronic than that in younger adults (Alexopoulos & Chester, 1992; Callahan et al., 1994; Cole & Bellavance, 1997). This means that recurrences extend for longer duration, while intervals of remission are shorter. It also means that cycles of recurrence and remission persist over a longer period of time. Patients’ response to treatment is highly variable, and the determinants of treatment response and its temporal profile are the subjects of intense research (Reynolds & Kupfer, 1999). A slower, less consistent response, which suggests a higher probability of relapse, is related to older age, presence of acute and chronic stressors, lower levels of perceived social support, higher levels of pretreatment anxiety, and greater biologic dysregulation as reflected in higher levels of rapid eye movement sleep (Dew et al., 1997). The temporal profile of the initial treatment response also may provide important clues about which patients are likely to fare well on maintenance treatment and which ones are likely to have a brittle treatment response and stormy long-term course.

A recent update of the NIH Consensus Development Conference on the Diagnosis and Treatment of Late-Life Depression emphasized the need for more data to guide long-term treatment planning, especially in patients 70 years and older with major depression (Lebowitz et al., 1997). Little is currently known about differences, if any, in speed and rate of remission, relapse, recovery, and recurrence in patients aged 60 to 69 and those aged 70 and above. In a study at the University of Pittsburgh, two groups of patients (ages
60 to 69 and 70+) showed comparable times to remission and recovery, as well as similar absolute rates of remission during acute therapy, relapse during continuation therapy, and recovery. However, patients aged 70 and older experienced a significantly higher rate of recurrence during the first year of maintenance therapy (Reynolds, 1998). Thus, the course of depression and its interaction with treatment are influenced by age. This highlights the importance of research targeted at older age groups instead of reliance on extrapolations from younger patients.

**Interactions With Somatic Illness**

Late-life mental disorders are often detected in association with somatic illness (Reynolds & Kupfer, 1999). The prevalence of clinically significant depression in later life is estimated to be highest—approximately 25 percent—among those with chronic illness, especially with ischemic heart disease, stroke, cancer, chronic lung disease, arthritis, Alzheimer’s disease, and Parkinson’s disease (Borson et al., 1986; Blazer, 1989; Oxman et al., 1990; Callahan et al., 1994; Beekman et al., 1995; Borson, 1995).

The relationship between somatic illness and mental disorders is likely to be reciprocal, but the mechanisms are far from understood. Biological and psychological factors are thought to play a role (Unutzer et al., 1997a). The nature and course of late-life depression can be greatly affected by the coexistence of one or more other medical conditions.

Insomnia and sleep disturbance play a large role in the clinical presentation of older depressed patients. Sleep complaints over time in community-residing older people have been found to vary with the intensity of depressive symptoms (Rodin et al., 1988). Sleep disturbances in older men and women have also been recently linked to poor health, depression, angina, limitations in activities of daily living, and chronic use of benzodiazepines (Newman et al., 1997). Furthermore, persistent or residual sleep disturbance in older patients with prior depressive episodes predicts a less successful maintenance response to pharmacotherapy (Buysse et al., 1996). The prevalence of chronic, primary insomnia in older adults is estimated at 5 to 10 percent (Ohayon et al., 1996).

Relatively little is known about the etiology or pathophysiology of chronic primary insomnia and why it constitutes a risk factor for depression in older adults. An important issue for further research is whether effective treatment for chronic insomnia could prevent the subsequent development of clinical depression in midlife and later.

**Consequences of Depression**

The most serious consequence of depression in later life—especially untreated or inadequately treated depression—is increased mortality from either suicide or somatic illness. Older persons (65 years and above) have the highest suicide rates of any age group. The suicide rate for individuals age 85 and older is the highest, at about 21 suicides per 100,000, a rate almost twice the overall national rate of 10.6 per 100,000 (CDC, 1999). The high suicide rate among older people is largely accounted for by white men, whose suicide rate at age 85 and above is about 65 per 100,000 (CDC, 1999). Trends from 1980 to 1992 reveal that suicide rates are increasing among more recent cohorts of older persons (Kachur et al., 1995). Since national statistics are unlikely to include more veiled forms of suicide, such as nursing home residents who stop eating, estimates are probably conservative.

Suicide in older adults is most associated with late-onset depression: among patients 75 years of age and older, 60 to 75 percent of suicides have diagnosable depression (Conwell, 1996). Using a “psychological autopsy,” Conwell and coworkers investigated all suicides within a geographical region and found that with increasing age, depression was more likely to be unaccompanied by other conditions such as substance abuse (Conwell et al., 1996). While thoughts of death may be developmentally expected in older adults, suicidal thoughts are not. From a stratified sample of primary care patients over age 60, Callahan and colleagues estimated the prevalence of specific suicidal thoughts at 0.7 to 1.2 percent (Callahan et al., 1996b). Unfortunately, no demographic or clinical variables distinguished depressed suicidal patients from depressed nonsuicidal patients (Callahan et al., 1996b).
Swedish researchers found much higher rates of suicidal ideation after interviewing adults aged 85 years and older. They found a 1-month prevalence of any suicidal feelings in 9.6 percent of men and 18.7 percent of women (Skoog et al., 1996). Suicidal feelings were strongly associated with depression. For example, 6.2 percent of the participants who did not meet criteria for depression or anxiety reported suicidal thoughts, while almost 50 percent of those meeting criteria for depression reported such thoughts. The higher prevalence of suicidal feelings in this study, compared with that cited earlier, is likely due to the older age of subjects and to methodological differences.

Studies of older persons who have committed suicide have revealed that older adults had seen their physician within a short interval of completing suicide, yet few were receiving mental health treatment. Caine and coworkers studied the records of 97 adults aged 50 years and older who completed suicide (Caine et al., 1996). Of this group, 51 had seen their primary care physician within 1 month of the suicide. Forty-five had psychiatric symptoms. Yet in only 29 of the 45 individuals were symptoms recognized, in only 19 was treatment offered, and in only 2 of these 19 cases was the treatment rendered considered adequate. Treatment was deemed inadequate if an incorrect medicine (such as a benzodiazepine for severe major depression) or inadequate dose was prescribed. This line of research highlights important opportunities for suicide prevention.

Depression also can lead to increased mortality from other diseases, such as heart disease and possibly cancer. How depression exerts these effects is not yet understood. In nursing home patients, major depression increases the likelihood of mortality by 59 percent, independent of physical health measures (Rovner, 1993). In the case of myocardial infarction, depression elevates mortality risk fivefold (Frasure-Smith et al., 1993, 1995). Depression also has been linked to the onset of cancer, but results have been inconsistent. Yet a new epidemiological study, considered the most compelling to date, finds that chronic depression (lasting an average of about 4 years) raises the risk of cancer by 88 percent in older people (Penninx et al., 1998). Thus, increased understanding of depression in older people may be, literally, a matter of life and death.

Cost
The high prevalence of depressive syndromes and symptoms in older adults exacts a large economic toll. Depression as a whole for all age groups is one of the most costly disorders in the United States (Hirschfeld et al., 1997). The direct and indirect costs of depression have been estimated at $43 billion each year, not including pain and suffering and diminished quality of life (Finkelstein et al., 1996). Late-life depression is particularly costly because of the excess disability that it causes and its deleterious interaction with physical health. Older primary care patients with depression visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer at the hospital (Callahan et al., 1994; Cooper-Patrick et al., 1994; Callahan & Wolinsky, 1995; Unutzer et al., 1997b).

Etiology of Late-Onset Depression
Despite major advances, the etiology of depression occurring at any age is not fully understood, although biological and psychosocial factors clearly play an important and interactive role.

With respect to late-onset depression, several risk factors have been identified. Persistent insomnia, occurring in 5 to 10 percent of older adults, is a known risk factor for the subsequent onset of new cases of major depression both in middle-aged and older persons (Ford & Kamerow, 1989). Grief following the death of a loved one also is an important risk factor for both major and minor depression. At least 10 to 20 percent of widows and widowers develop clinically significant depression during the first year of bereavement. Without treatment, such depressions tend to persist, becoming chronic and leading to further disability and impairments in general health (Zisook & Shuchter, 1993). A final pathway to late-onset depression, suggested by computed tomography and magnetic resonance imaging studies, may involve structural, neuroanatomic factors. Enlarged lateral
ventricles, cortical atrophy, increased white matter hyperintensities, decreased caudate size, and vascular lesions in the caudate nucleus appear to be especially prominent in late-onset depression associated with vascular risk factors (Ohayon et al., 1996; Baldwin & Tomenson, 1995). These findings have generated the vascular hypothesis of late-onset depression; namely, that even in the absence of a clear stroke, disorders that cause vascular damage, such as hypertension, coronary artery disease, and diabetes mellitus, may induce cerebral pathology that constitutes a vulnerability for depression (Alexopoulos et al., 1997; Steffens & Krishnan, 1998).

### Treatment of Depression in Older Adults

A broad array of effective treatments, both pharmacological and psychosocial, exists for depression. Despite the pervasiveness of depression and the existence of effective treatments, a substantial fraction of patients receive either no treatment or inadequate treatment, as described earlier. Some of the barriers relate to underdiagnosis, while others relate to treatment where there are patient, provider, and clinical barriers (for more details see Unutzer et al., 1996).

### Pharmacological Treatment

There is consistent evidence that older patients, even the very old, respond to antidepressant medication (Reynolds & Kupfer, 1999). About 60 to 80 percent of older patients respond to treatment, while the placebo response rate is about 30 to 40 percent (Schneider, 1996). These rates are comparable to those in other adults (see Chapter 4). Treatment response is typically defined by a significant reduction—usually 50 percent or greater—in symptom severity. Yet because patients 75 years old and older typically have higher prevalence of medical comorbidity, both they and their physicians are often reluctant to add another medication to an already complex regimen in a frail individual. However, newer antidepressants are less frequently associated with factors contraindicating their use. Moreover, because the very old are also at high risk for adverse medical outcomes of depression and for suicide, treatment may be favored. Despite the availability of effective treatments, a minority of patients properly diagnosed with depression receive adequate dosage and duration of pharmacotherapy, as noted earlier.

In general, pharmacological treatment of depression in older people is similar to that in other adults, but the selection of medications is more complex because of side effects and interactions with other medications for concomitant somatic disorders. Treatment of minor depression is generally the same as treatment for major depression, but there is not a large body of evidence to support this practice. Studies are under way to identify effective pharmacological treatments for minor depression (Lebowitz et al., 1997).

The following paragraphs describe the major classes of medications for treatment of depression in older adults. They focus on side effects and other concerns that distinguish the treatment of depression in older adults from that in younger ones.

#### Tricyclic Antidepressants

Tricyclic antidepressants (TCAs) have been widely used to treat depressed patients of all ages. Alexopoulos and Salzman (1998) reviewed studies of TCAs in older depressed patients and concluded that these compounds are similar in efficacy across the age spectrum, but the side effect profiles differ considerably. Widespread use of the TCAs in older adults is limited by adverse reactions. While anticholinergic effects such as dry mouth, urinary retention, and constipation can be annoying in younger adults, they can lead to severe problems in older adults. For example, constipation can lead to impaction, and dry mouth can prevent the wearing of dentures. The anticholinergic effects of the TCAs may also cause tachycardia or arrhythmias and can further compromise preexisting cardiac disease (Roose et al., 1987; Glassman et al., 1993). Central anticholinergic effects may result in acute confusional states or memory problems in the depressed older adult (Branconnier et al., 1982). Orthostatic hypotension, which may lead to falls and hip fractures, is also a concern when the TCAs are administered. Nevertheless, TCAs are still frequently used in older adults.
Selective Serotonin Reuptake Inhibitors and Other Newer Antidepressants

Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, paroxetine, and sertraline, whose use is increasing across age groups, may be especially useful in the treatment of late-life depression, because these agents are reported to have fewer anticholinergic and cardiovascular side effects than the TCAs. The more commonly observed side effects with SSRIs include sexual dysfunction and gastrointestinal effects such as nausea, vomiting, and loose stools. Treatment with the SSRIs may also produce insomnia, anxiety, and restlessness. The few studies that have examined the efficacy of these compounds in older adults have shown efficacy similar to the TCAs and fewer side effects (see Small & Salzman, 1998, for a review). While the relative efficacy of SSRIs and TCAs is still debated, SSRIs are easier to prescribe because of simpler dosing patterns and more manageable side effects.

One concern when prescribing the SSRIs in older adults is the potential for drug-drug interactions. This is of clinical importance since older adults commonly receive a large number of medications. The SSRIs vary in their inhibition of the cytochrome p450 family of isoenzymes. Knowledge of these patterns of inhibition in the SSRIs and other medications commonly used in older adults (such as other psychoactive compounds, calcium channel blockers, or warfarin) can help to avoid or minimize interactions. Other newer non-SSRI antidepressants (venlafaxine, bupropion, trazodone, and nefazodone) are often suggested for treating later life depression because their side effects are better tolerated by older adults.

Some compounds that are useful in other individuals may be less useful for treatment of older patients. For example, despite evidence of the efficacy of monamine oxidase inhibitors (see Alexopoulos & Salzman, 1998, for a review), clinical use is often restricted to patients who are refractory to other antidepressant drugs. This is due to potentially life-threatening pharmacodynamic interactions with sympathomimetic drugs or tyramine-containing foods and beverages. The sympathomimetic amines (e.g., phenylpropanolamine and pseudoephedrine) may be present in over-the-counter decongestant products that older patients are prone to self-administer. An additional concern is the risk of orthostatic hypotension, which occurs even at therapeutic doses (Alexopoulos & Salzman, 1998). In addition, bupropion has been shown in older patients to be as effective as TCAs (Branconnier et al., 1983; Kane et al., 1983). Although generally well tolerated, its use requires added caution because of an increased risk of seizures and thus should be avoided in patients with seizure disorder or focal central nervous system disease. Its advantages include a relatively low incidence of cardiovascular complications and a lack of confusion.

Multimodal Therapy

Combining pharmacotherapy with psychosocial interventions also appears to be effective in older depressed patients. A high response rate of about 80 percent was found for acute and continuation treatment with combined nortriptyline and interpersonal psychotherapy. The response rate was similar between so-called “young old” patients (primarily in their 60s and early 70s) and patients in their 30s and 40s (Reynolds et al., 1996). Yet older patients showed a somewhat longer time to remission than did other patients (about 2 weeks longer) and twice the rate of relapse during continuation treatment (about 15 percent versus 7 percent). However, because the trial was not controlled, it is not known whether multimodal treatment was more effective than either pharmacological or psychosocial treatment alone.

Treatment resistance—defined by the lack of recovery in spite of combined treatment with nortriptyline and interpersonal psychotherapy—was seen in about 18 percent of older patients with recurrent major depression (nonpsychotic unipolar depression) (Little et al., 1998). Nortriptyline and interpersonal psychotherapy (IPT) have been shown to be effective maintenance treatments for late-life depression. After 3 years of comparing various treatments, the percentage of older adults who did not experience recurrence were 57 percent of older adults receiving nortriptyline, 36
percent receiving IPT, and 80 percent of those receiving nortriptyline plus IPT. Those receiving a placebo and routine clinical visits had a 90 percent recurrence rate (Reynolds et al., 1999).

Course of Treatment
Although 60 to 80 percent of older patients with moderate to severe unipolar depression2 can be expected to respond well to antidepressant treatment (especially combined treatment with medication and psychotherapy), the clinical response to antidepressant treatment in later life follows a variable course, with a median time to remission of 12 weeks (J. L. Cummings & D. J. Kupfer, personal communication, 1999). Thus, treatment response takes 1 month or more longer than that for other adults, for whom treatment response takes an average of 6 to 8 weeks (see Chapter 4). In addition to highly variable trajectories to recovery, reliable prediction of response status (recovery/nonrecovery) is generally not possible in older adults before 4 to 5 weeks of treatment. The delayed onset of antidepressant activity in older adults leads to unique problems. Suffering and disability are prolonged, which often reduces compliance and may increase risk for suicide. The development of strategies to accelerate treatment response and to improve the early identification of nonresponders would be an important advance (Reynolds & Kupfer, 1999).

Data from naturalistic studies have identified several predictors of relapse and recurrence in late-life depression, including a history of frequent episodes, first episode after age 60, concurrent somatic illness, especially a history of myocardial infarction or vascular disease, high pretreatment severity of depression and anxiety, and cognitive impairment, especially frontal lobe dysfunction. These factors appear to interact with low treatment intensity—that is, at dosage and duration below recommended levels—in determining more severe courses of illness. Despite the evidence that high treatment intensity is effective in preventing relapse and recurrence (Reynolds et al., 1995), naturalistic studies have shown that intensity of treatment prescribed by psychiatrists begins to decline within 16 weeks of entry and approximately 10 weeks prior to recovery (Alexopoulos et al., 1996). Residual symptoms of excessive anxiety and worrying predict early recurrence after tapering continuation treatment in older depressed patients (Meyers, 1996).

Although progress has been made in identifying effective pharmacological and combined treatments for late-life depression, there is a need for more outcome studies with newer antidepressants. In addition, studies examining effectiveness in real-world settings—rather than in clinical trials conducted in academic clinical sites—are particularly crucial in the older population because of medical comorbidity and provision of care in primary, rather than specialty, care.

Electroconvulsive Therapy
Electroconvulsive therapy (ECT) is regarded as an effective intervention for some forms of treatment-resistant depression across the life cycle (NIH & NIMH Consensus Conference, 1985; Depression Guideline Panel, 1993). It may offer a particularly attractive benefit: risk ratio in older persons with depression (NIH Consensus Development Panel on Depression in Late Life, 1992; Sackeim, 1994). Chapter 4 reviews research on ECT and considers risk-benefit issues and controversy surrounding them. As described there, ECT entails the electrical induction of seizures in the brain, administered during a series of 6 to 12 treatment sessions on an inpatient or outpatient basis. Practice guidelines recommend that ECT should be reserved for severe cases of depression, particularly with active suicidal risk or psychosis; patients unresponsive to medications; and those who cannot tolerate medications (NIH & NIMH Consensus Conference, 1985; Depression Guideline Panel, 1993). For those patients, the response rate to ECT is on the order of 50 to 70 percent, and there is no evidence that ECT is any less effective in older individuals than younger ones (Sackeim, 1994; Weiner & Krystal, 1994). ECT is advantageous for older people with depression because of the special problems they encounter with medications, including sensitivity to anticholinergic

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2 Unipolar depression refers to the depression in patients with major depressive disorders but not to the depression in patients with bipolar disorders.
toxicity, cardiac conduction slowing, and hypotension (see above). Although the newer antidepressants offer a more favorable side-effect profile than do the older tricyclics, their efficacy in melancholic depression, for which ECT is particularly helpful (Rudorfer et al., 1997), is not yet firmly established. Moreover, as noted earlier, older adults respond more slowly than younger ones to antidepressant medications, rendering the faster onset of action of ECT another advantage in the older patient (Markowitz et al., 1987). Immobility and reduced food and fluid intake in the older person with depression may pose a greater imminent physical health risk than would typically be the case in a younger patient, again strengthening the case for considering ECT early in the treatment hierarchy (Sackeim, 1994).

Although the clinical effectiveness of ECT is documented and acknowledged, the treatment often is associated with troubling side effects, principally a brief period of confusion following administration and a temporary period of memory disruption (Rudorfer et al., 1997). As described in Chapter 4, there may also be longer term memory losses for the time period surrounding the use of ECT. Although the exception rather than the rule, persistent memory loss following ECT is reported. Its actual incidence is unknown. There are no absolute medical contraindications to ECT. However, a recent history of myocardial infarct, irregular cardiac rhythm, or other heart conditions suggests the need for caution due to the risks of general anesthesia and the brief rise in heart rate, blood pressure, and load on the heart that accompany ECT administration. On the other hand, the safety of ECT is enhanced by the time-limited nature of treatment sessions, which enables this intervention to be administered under controlled conditions, for example, with a cardiologist or other specialist in attendance. Following completion of a course of ECT, maintenance treatment, typically with antidepressant or mood-stabilizing medication or less frequent maintenance ECT, in most cases is required to prevent relapse (Rudorfer et al., 1997).

**Psychosocial Treatment of Depression**

Most research to date on psychosocial treatment of mental disorders has concentrated on depression. These studies suggest that several forms of psychotherapy are effective for the treatment of late-life depression, including cognitive-behavioral therapy, interpersonal psychotherapy, problem-solving therapy, brief psychodynamic psychotherapy, and reminiscence therapy, an intervention developed specifically for older adults on the premise that reflection upon positive and negative past life experiences enables the individual to overcome feelings of depression and despair (Butler, 1974; Butler et al., 1991). Group and individual formats have been used successfully.

A meta-analysis of 17 studies of cognitive, behavioral, brief psychodynamic, interpersonal, reminiscence, and eclectic therapies for late-life depression found treatment to be more effective than no treatment or placebo (Scogin & McElreath, 1994). The following paragraphs spotlight some of the key studies incorporated into this meta-analysis and provide evidence from newer studies.

Cognitive-behavioral therapy is designed to modify thought patterns, improve skills, and alter the emotional states that contribute to the onset, or perpetuation, of mental disorders. In a 2-year followup study of cognitive-behavioral therapy, 70 percent of all patients studied no longer met criteria for major depression and maintained treatment gains (Gallagher-Thompson et al., 1990). In another trial, group cognitive therapy was found to be effective. Older patients with major depression partially randomized to receive group cognitive therapy with alprazolam (a benzodiazepine) or group cognitive therapy with placebo had more improvement in depressed mood and sleep efficiency than patients who received alprazolam alone or placebo alone (Beutler et al., 1987). Cognitive-behavioral therapy also has been demonstrated to be effective in other late-life disorders, including anxiety disorders (Stanley et al., 1996; Beck & Stanley, 1997). Cognitive-behavioral therapy’s effectiveness for mood symptoms in Alzheimer’s disease is discussed in the section on psychosocial treatments of Alzheimer’s disease.
Problem-solving therapy postulates that deficiencies in social problem-solving skills enhance the risk for depression and other psychiatric symptoms. Through improving problem-solving skills, older patients are given the tools to enable them to cope with stressors and thereby experience fewer symptoms of psychopathology (Hawton & Kirk, 1989). Problem-solving therapy has been found effective in the treatment of depression of older patients. For example, problem-solving therapy was found to significantly reduce symptoms of major depression, leading to the greatest improvement in a randomized controlled study comparing problem-solving therapy, reminiscence therapy, and placement on a waiting list for treatment (Arean et al., 1993). In a randomized study of depressed younger primary care patients, six sessions of problem-solving therapy were as effective as amitriptyline, with about 50 to 60 percent of patients in each group recovering (Mynors-Wallis et al., 1995).

Interpersonal psychotherapy was initially designed as a time-limited treatment for midlife depression. It focuses on grief, role disputes, role transitions, and interpersonal deficits (Klerman et al., 1984). This form of treatment may be especially meaningful for older patients given the multiple losses, role changes, social isolation, and helplessness associated with late-life depression. Controlled trials suggest that interpersonal psychotherapy alone, or in combination with pharmacotherapy, is effective in all phases of treatment for late-life major depression. Interpersonal psychotherapy was as effective as the antidepressant nortriptyline in depressed older outpatients, and both were superior to placebo (Sloane et al., 1985; Reynolds et al., 1992; Schneider, 1995). In an open trial, a treatment protocol combining interpersonal psychotherapy with nortriptyline and psychoeducational support groups led to minimal attrition and high remission rates (approximately 80 percent) in older patients with recurrent major depression (Reynolds et al., 1992, 1994). Finally, interpersonal psychotherapy also is effective in the treatment of depression following bereavement (Pasternak et al., 1997).

Brief psychodynamic therapy, typically of 3 to 4 months’ duration, also is successful in older depressed patients. Brief psychodynamic therapy is distinguished from traditional psychodynamic therapy primarily by duration of treatment. The goals of brief psychodynamic therapy vary according to patients’ medical health and function. In disabled older people, the purpose of psychodynamic psychotherapy is to facilitate mourning of lost capacities, promote acceptance of physical limitations, address fears of dependency, and promote resolution of interpersonal difficulties with family members (Lazarus & Sadavoy, 1996). In older patients who are not disabled, psychodynamic psychotherapy deals with the resolution of interpersonal conflicts, adaptation to loss and stress, and the reconciliation of personal accomplishments and disappointments (Pollock, 1987). Brief psychodynamic therapy has been found to be as effective as cognitive-behavioral therapy in reducing symptoms of late-life major depression. An early study found brief psychodynamic therapy to yield higher relapse and recurrence rates than did cognitive and behavioral therapy (Gallagher & Thompson, 1982). However, with a greater number of patients, brief psychodynamic therapy was determined to be as effective as cognitive and behavioral therapy (and superior to being on a waiting list) in preventing recurrences of major depression up to 2 years after treatment (Gallagher-Thompson et al., 1990).

Alzheimer’s Disease
Alzheimer’s disease, a disorder of pivotal importance to older adults, strikes 8 to 15 percent of people over the age of 65 (Ritchie & Kildea, 1995). Alzheimer’s disease is one of the most feared mental disorders because of its gradual, yet relentless, attack on memory. Memory loss, however, is not the only impairment. Symptoms extend to other cognitive deficits in language, object recognition, and executive functioning. Behavioral symptoms—such as psychosis, agitation, depression, and wandering—are common and impose tremendous strain on caregivers. Diagnosis is challenging because of the lack of

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3 Executive functioning refers to the ability to plan, organize, sequence, and abstract.
biological markers, insidious onset, and need to exclude other causes of dementia.

This section covers assessment and diagnosis, behavioral symptoms, course, prevalence and incidence, cost, etiology, and treatment. It features Alzheimer’s disease because it is the most prevalent form of dementia. However, many of the issues raised also pertain to other forms of dementia, such as multi-infarct dementia, dementia of Parkinson’s disease, dementia of Huntington’s disease, dementia of Pick’s disease, frontal lobe dementia, and others.

Assessment and Diagnosis of Alzheimer’s Disease

Mild Cognitive Impairment
Declines in cognitive functioning have been identified both as part of the normal process of aging and as an indicator of Alzheimer’s disease. DSM-IV first designated this as “age-related cognitive decline” and, more recently, as “mild cognitive impairment” (MCI). MCI characterizes those individuals who have a memory problem but do not meet the generally accepted criteria for Alzheimer’s disease such as those issued by the National Institute of Neurological and Communicative Disorders and Stroke–Alzheimer’s Disease and Related Disorders Association or DSM-IV. MCI is important because it is known that a certain percentage of patients will convert to Alzheimer’s disease over a period of time (probably in the range of 15 to 20 percent per year). Thus, if such individuals could be identified reliably, treatments could be given that would delay or prevent the progression to diagnosed Alzheimer’s disease. This is the rationale for the Alzheimer’s Disease Cooperative Study trial of vitamin E or donepezil for MCI, which began in 1999, and it is also the basis for the use of neuroimaging in early diagnosis. The evaluation of MCI spans the boundary between normal aging and Alzheimer’s disease, and this topic is being evaluated in a number of research groups.

The diagnosis of Alzheimer’s disease depends on the identification of the characteristic clinical features and on the exclusion of other common causes of dementia. There are currently no biological markers for Alzheimer’s disease except for pathological verification by biopsy or at autopsy (or through rare autosomal dominant mutations). With the reliance on clinical criteria and the need for exclusion of other causes of dementia, the current approach to Alzheimer’s disease diagnosis is time- and labor-intensive, costly, and largely dependent on the expertise of the examiner. Although genetic risk factors, such as Apo-E status (see etiology section), give some indication of the relative risk for Alzheimer’s disease, they are as yet rarely useful on an individual basis.

The diagnosis of Alzheimer’s disease not only requires the presence of memory impairment but also another cognitive deficit, such as language disturbance or disturbance in executive functioning. The diagnosis also calls for impairments in social and occupational functioning that represent a significant functional decline (DSM-IV). The other causes of dementia that must be ruled out include cerebrovascular disease, Parkinson’s disease, Huntington’s disease, subdural hematoma, normal-pressure hydrocephalus, brain tumor, systemic conditions (e.g., hypothyroidism, vitamin B₁₂ or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis, HIV infection), and substance-induced conditions.

Some diagnostic schemes distinguish between possible, probable, and definite Alzheimer’s disease (McKhann et al., 1984). With these criteria, probable Alzheimer’s disease is confirmed to be Alzheimer’s disease at autopsy with 85 to 90 percent accuracy (Galasko et al., 1994). Definite Alzheimer’s disease can only be diagnosed pathologically through biopsy or at autopsy. The pathological hallmarks of Alzheimer’s disease are neurofibrillary tangles (intracellular aggregates of a cytoskeletal protein called tau found in degenerating or dead brain cells) and neuritic plaques (extracellular deposits largely made up of a protein called amyloid β-peptide) (Cummings, 1998b). (See Figure 5-2.)

The diagnosis of dementia can be complicated by the possibility of other disorders that coexist with, or share features of, Alzheimer’s disease. For example,
delirium is a common condition in older patients and can be confused with dementia in its acute stages. Other types of dementia, such as vascular dementia, share cognitive and behavioral symptoms with Alzheimer’s disease, and thus may be difficult to distinguish from Alzheimer’s disease. The cognitive symptoms of early Alzheimer’s disease and those associated with normal age-related decline also may be similar. Finally, cognitive deficits are prominent in both late-life depression and schizophrenia. While the severity of deficits is less in these disorders than that in later stages of dementia, distinctions may be difficult if the dementia is early in its course.

A further challenge in the identification of Alzheimer’s disease is the widespread societal view of “senility” as a natural developmental stage. Early symptoms of cognitive decline may be excused away or ignored by family members and the patient, making early detection and treatment difficult. The clinical diagnosis of Alzheimer’s disease relies on an accurate history of the patient’s symptoms and rate of decline. Such information is often impossible to obtain from the patient due to the prominence of memory dysfunction. Family members or other informants are usually helpful, but their ability to provide useful information sometimes is hampered by denial or lack of knowledge about signs and symptoms of the disorder.

With diagnosis so challenging, Alzheimer’s disease and other dementias are currently underrecognized, especially in primary care settings, where most older patients seek care. In a study in the United Kingdom, O’Connor and colleagues found that general practitioners recognized only 58 percent of patients identified by research psychiatrists using a structured diagnostic interview (O’Connor et al., 1988). Similarly, in a study conducted in the United States, Callahan and colleagues found that only 3.2 percent of patients with mild cognitive impairment were recognized by general practitioners as having intellectual compromise, and only 23.5 percent of those with moderate to severe dementia were identified as having a dementia syndrome (Callahan et al., 1995). The reasons for primary care provider difficulty with diagnosis are speculated to include lack of knowledge or skills, misdiagnosis of depression as dementia, lack of time, and lack of adequate referrals to specialty mental health care.

The urgency of addressing obstacles to recognition and accurate diagnosis is underscored by promising studies that point to the pronounced clinical advantages of early detection. Therapies that slow the progression of Alzheimer’s disease or improve existing symptoms are likely to be most effective if given early in the clinical course. Recognition of early Alzheimer’s disease, in addition to facilitating pharmacotherapy, has a variety of other benefits that improve the plight of patients and their families. Direct benefits to patients include improved diagnosis of other potentially reversible causes of dementia, such as hypothyroidism, and identification of sources of Alzheimer’s disease’s excess disability such as depression and anxiety that can be targeted with nonpharmacological interventions. Family members benefit from early detection by having more time to adjust and plan for the future and by having the opportunity for greater patient input into decisions regarding advanced directives while the patient is still at a mild stage of the illness (Cummings & Jeste, 1999).

Diagnosis of Alzheimer’s disease would be greatly improved by the discovery of a biological marker that correlates strongly with neuropathological signs of
Alzheimer’s disease, reflects the severity of pathological changes in Alzheimer’s disease, and precedes the appearance of clinical symptomatology. Ideally, such a marker also would be used to monitor the effectiveness of treatment on the clinical manifestations of Alzheimer’s disease, would show specificity for Alzheimer’s disease with few false positives (i.e., a diagnosis of Alzheimer’s disease in someone who does not have the disease), and would be convenient and inexpensive enough to justify wide use, including screening (Cummings & Jeste, 1999). Discovery of such a marker is clearly a research priority.

**Behavioral Symptoms**

Alzheimer’s disease is associated with a range of symptoms evident in cognition and other behaviors; these include, most notably, psychosis, depression, agitation, and wandering. Other behavioral symptoms of Alzheimer’s disease include insomnia; incontinence; catastrophic verbal, emotional, or physical outbursts; sexual disorders; and weight loss. Behavioral symptoms, however, are not required for diagnosis. While behavioral symptoms have received less attention than cognitive symptoms, they have serious ramifications: patient and caregiver distress, premature institutionalization, and significant compromise of the quality of life of patients and their families (Rabins et al., 1982; Ferris et al., 1987; Finkel et al., 1996; Kaufer et al., 1998). Alzheimer’s disease, especially behavioral symptoms, appears to place patients at risk for abuse by caregivers (Coyne et al., 1993).

Behavioral symptoms occur at some point during the disease with high frequencies: 30 to 50 percent of individuals with Alzheimer’s disease experience delusions, 10 to 25 percent have hallucinations, and 40 to 50 percent have symptoms of depression (Mega et al., 1996; Cummings et al., 1998b). Patients with psychotic disorders have greater cognitive impairment, more rapidly progressive dementia, and greater frontal and temporal dysfunction on functional brain imaging (Jeste et al., 1992; Sultzer et al., 1995). Patients with psychotic illness also exhibit more agitation, depression, wandering, anger, personality change, family or marital problems, and lack of self-care (Rockwell et al., 1994). Depression in patients with Alzheimer’s disease accelerates loss of functioning in everyday activities (Ritchie et al., 1998). Even modest reduction in behavioral symptoms can produce substantial improvements in functioning and quality of life.

**Course**

Patients with Alzheimer’s disease experience a gradual decline in functioning throughout the course of their illness. Typically, a loss of 4 points per year on the Mini Mental Status Exam is detected, but there is a great deal of heterogeneity in the rate of decline (Olichney et al., 1998). Memory dysfunction is not only the most prominent deficit in dementia but also is the most likely presenting symptom. Deficits in language and executive functioning, while common in the disorder, tend to manifest later in its course (Locascio et al., 1995). Depression is prevalent in the early stages of dementia and appears to recede with functional decline (Locascio et al., 1995). Although this may reflect decreasing awareness of depression by the patient, it also could reflect inadequate detection of depression by health professionals. Behavioral symptoms, such as agitation, seem to be more prevalent in the later stages of Alzheimer’s disease (Patterson & Bolger, 1994); however, psychosis has been observed in patients with varying levels of severity (Borson & Raskind, 1997). The duration of illness, from onset of symptoms to death, averages 8 to 10 years (DSM-IV).

**Prevalence and Incidence**

Alzheimer’s disease is a prominent disorder of old age: 8 to 15 percent of people over age 65 have Alzheimer’s disease (Ritchie & Kildea, 1995). The prevalence of dementia (most of which is accounted for by Alzheimer’s disease) nearly doubles with every 5 years of age after age 60 (Jorm et al., 1987). Although more women than men have Alzheimer’s disease (that is, the prevalence of the disease appears to be higher among women), this may reflect women’s longer life spans, because studies do not show marked gender differences in incidence rates (Lebowitz et al., 1998). Incidence
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studies also reveal age-related increases in Alzheimer’s disease (Breteler et al., 1992; Paykel et al., 1994; Hebert et al., 1995; Johansson & Zarit, 1995; Aervarson & Skoog, 1996). One percent of those age 60 to 64 are affected with dementia; 2 percent of those age 65 to 69; 4 percent of those age 70 to 74; 8 percent of those 75 to 79; 16 percent of those age 80 to 84; and 30 to 45 percent of those age 85 and older (Jorm et al., 1987; Evans et al., 1989).

The “graying of America” is likely to result in an increase in the number of individuals with Alzheimer’s disease, yet shifts in the composition of the affected population also are anticipated. Increased education is correlated with a lower frequency of Alzheimer’s disease (Hill et al., 1993; Katzman, 1993; Stern et al., 1994), and future cohorts are expected to have attained greater levels of education. For example, the portion of those currently 75 years of age and older—those most vulnerable to Alzheimer’s disease—with at least a high school education is 58.7 percent. Of those currently age 60 to 64 who will enter the period of maximum vulnerability by the year 2010, 75.5 percent have at least a high school education. A higher educational level among the at-risk cohort may delay the onset of Alzheimer’s disease and thereby decrease the overall frequency of Alzheimer’s disease (by decreasing the number of individuals who live long enough to enter the period of maximum vulnerability). However, this trend may be counterbalanced or overtaken by greater longevity and longer survival of affected individuals. Specifically, improvements in general health and health care may lengthen the survival of dementia patients, increasing the number of severely affected patients and raising their level of medical comorbidity. Similarly, through dissemination of information to patients and clinicians, better detection, especially of early-stage patients, is expected. Increased use of putative protective agents, such as vitamin E, also may increase the number of patients in the middle phases of the illness (Cummings & Jeste, 1999).

Cost

The growing number of patients with Alzheimer’s disease is likely to have serious public health and economic consequences. Direct and indirect costs for medical and long-term care, home care, and loss of productivity for caregivers are estimated at nearly $100 billion each year (Ernst & Hay, 1994; National Institute on Aging, 1996). This economic burden is borne mostly by families of patients with Alzheimer’s disease, although a significant portion of the direct costs is covered by Medicare, Medicaid, and private insurance companies. Costs are especially high among patients with behavioral symptoms, who often require earlier or more frequent institutionalization (Ferris et al., 1987).

Etiology of Alzheimer’s Disease

Biological Factors

The etiology of Alzheimer’s disease is still incompletely understood yet is thought to entail a complex combination of genetic and environmental factors. Genetic factors appear to play a significant role in the pathogenesis of Alzheimer’s disease. In the familial form, Alzheimer’s disease is caused by mutations in chromosomes 21, 14, and 1 and is transmitted in an autosomal dominant mode. Each of these mutations appears to result in overproduction of the protein found in neuritic plaques, β-amyloid. Onset of the familial form is usually early, but the course and nature of the disorder appear to be influenced by environmental factors (Cummings et al., 1998b). However, the familial form accounts for only a small proportion of cases of Alzheimer’s disease (less than 5 percent) (Cummings et al., 1998b).

Approximately 50 percent of individuals with a family history of Alzheimer’s disease, if followed into their 80s and 90s, develop the disorder (Mohs et al., 1987). Certain genotypes (the pattern of genetic inheritance in an individual) appear to confer risk for the more common late-onset form of Alzheimer’s disease. For example, the ApoE-e4 allele on chromosome 19, which increases the deposition of β-amyloid, has been shown to increase risk for developing Alzheimer’s disease (Corder et al., 1993).

4 An allele is a variant form of a gene.
Other possible candidate genes are under study (Kang et al., 1997).

Other biological risk factors for the development of Alzheimer’s disease include aging and cognitive capacities (Cummings et al., 1998b). The mechanisms by which these traits confer increased risk have not yet been fully determined; however, several neurobiologic changes related to normal aging of the brain may play a role in the increased risk for Alzheimer’s disease with increasing age. These include neuron and synaptic loss, decreased dendritic span, decreased size and density of neurons in the nucleus basalis of Meynert, and lower cortical acetylcholine levels (Cummings et al., 1998b). These findings, as well as extrapolations from the prevalence and incidence curves for Alzheimer’s disease, have led some to suggest that most individuals would eventually develop Alzheimer’s disease if the human life span was extended (for example, to age 120).

**Protective Factors**

Several protective factors that delay the onset of Alzheimer’s disease have been identified. Genetic endowment with the ApoE-e2 allele decreases the risk for Alzheimer’s disease (Duara et al., 1996), although the mechanism of action is not yet fully understood. Higher educational level also is related to delayed onset of Alzheimer’s disease (Stern et al., 1994; Callahan et al., 1996a). The use of certain medications, such as nonsteroidal anti-inflammatory drugs (Andersen et al., 1995; McGeer et al., 1996) and estrogen replacement therapy (Paganini-Hill & Henderson, 1994), may delay onset of the disorder. Vitamin E and the drug selegiline (also known as deprenyl) appear to delay the occurrence of important milestones in the course of Alzheimer’s disease, including nursing home placement, severe functional impairments even as the disease progresses, and death (Sano et al., 1997).

The mechanism of action of these protective agents is not fully understood but is thought to counter the deleterious action of oxidative stress (via antioxidants such as vitamin E or estrogen) (Behl et al., 1995) or the action of inflammatory mediators associated with plaque formation (via anti-inflammatories) (Mrak et al., 1995).

**Histopathology**

The pathophysiology of Alzheimer’s disease appears to be linked to the histopathologic changes in Alzheimer’s disease, which include neuritic plaques, neurofibrillary tangles, synaptic loss, hippocampal granulovacuolar degeneration, and amyloid angiopathy. Most of the genetic and epigenetic risk factors have been related in some way to β-amyloid. Thus, the generation of β-amyloid peptide is increasingly regarded as the central pathological event in Alzheimer’s disease (Cummings et al., 1998b; Hardy & Higgins, 1992).

Effective intervention for Alzheimer’s disease may involve interfering with the multiple steps within the putative Alzheimer’s disease pathogenetic cascade. Targets of intervention include reducing β-amyloid generation from the amyloid precursor protein, decreasing β-amyloid aggregation and formation of beta-pleated sheets, and interfering with amyloid-related neurotoxicity. In addition, therapies could involve interruption of neuronal cell death, inhibition of the inflammatory response occurring in neuritic plaques, use of growth factors and hormonal therapies, and replenishment of deficient neurotransmitters. Because complete blockade of steps within the β-amyloid cascade may interfere with normal cerebral metabolic processes, efficacious interventions could involve partial interruptions (Cummings & Jeste, 1999).

Researchers in the molecular neuroscience of Alzheimer’s disease are exploring a number of important aspects of pathophysiology and etiology. As understanding of mechanisms of cell death and neuronal degeneration increases, new opportunities for the development of therapeutics are expected to emerge (National Institute on Aging, 1996).

**Role of Acetylcholine**

Loss of the neurotransmitter acetylcholine also is thought to play an instrumental role in the pathogenesis of Alzheimer’s disease. Postmortem studies of Alzheimer’s disease consistently have demonstrated the
loss of basal forebrain and cortical cholinergic neurons and the depletion of choline acetyltransferase, the enzyme responsible for acetylcholine synthesis (Mesulam, 1996). The degree of this central cholinergic deficit is correlated with the severity of dementia, which has led to the “cholinergic hypothesis” of cognitive deficits in Alzheimer’s disease. This hypothesis has led, in turn, to promising clinical interventions discussed below. It should be emphasized, however, that acetylcholine is not necessarily the only neurotransmitter involved in Alzheimer’s disease; research has not ruled out the contributions of other substances in pathogenesis of the disease.

Pharmacological Treatment of Alzheimer’s Disease
Pharmacological treatment of Alzheimer’s disease is a promising new focus for interventions. A delay in onset of Alzheimer’s disease for 5 years might reduce the prevalence of Alzheimer’s disease by as much as one-half (Breitner, 1991). In other words, to influence the prevalence of Alzheimer’s disease, it may be necessary only to delay the onset of the disease to the point where mortality from other sources supersedes the incidence of Alzheimer’s disease. Thus, a central goal in Alzheimer’s disease treatment research is the identification of agents that prevent the occurrence, defer the onset, slow the progression, or improve the symptoms of Alzheimer’s disease. Progress has been made in this research arena, with several agents showing beneficial effects in Alzheimer’s disease.

Acetylcholinesterase Inhibitors
Recent attempts to treat Alzheimer’s disease have focused on enhancing acetylcholine function, using either cholinergic receptor agonists (e.g., nicotine) or, most commonly, using acetylcholinesterase (AChE) inhibitors (e.g., physostigmine, vnelacrine, tacrine, donepezil, or metrifonate) to increase the availability of acetylcholine in the synaptic cleft. Such treatments have generally been beneficial in ameliorating global cognitive dysfunction and, more specifically, are most effective in improving attention (Norberg, 1996; Lawrence & Sahakian, 1998). Amelioration of learning and memory impairments, the most prominent cognitive deficits in Alzheimer’s disease, have been found less consistently (Lawrence & Sahakian, 1998), although some studies have shown improvements (Thal, 1996). It has been argued that failure of AChE inhibitors and nicotine to improve learning and memory may be due to high levels of neurodegeneration in the medial temporal lobe (Lawrence & Sahakian, 1998). Neuronal degeneration in this region of the brain leaves neurons impervious to the benefits of some types of replacement therapy. Detailed neuropsychological studies of the effects of the newer cognitive enhancers, donepezil and metrifonate (an experimental drug), have not yet been published, but global cognitive functioning appears to be improved with both compounds (Cummings et al., 1998a; Rogers et al., 1998).

Treatment with these AChE inhibitors also appears to benefit noncognitive symptoms in Alzheimer’s disease, such as delusions (Raskind et al., 1997) and behavioral symptoms (Kaufer et al., 1996; Morris et al., 1998).

Treatment of Behavioral Symptoms
The behavioral symptoms of Alzheimer’s disease have received less therapeutic attention than cognitive symptoms. Few double-blind, placebo-controlled studies of medications for behavioral symptoms of Alzheimer’s disease have been performed. For the most part, behavioral symptoms have been treated with medications developed for primary psychiatric symptoms. The emergence of new antipsychotic and antidepressant medications requires that these agents be studied specifically for Alzheimer’s disease. The observation that cholinergic agents used to enhance cognition in Alzheimer’s disease may have beneficial behavioral effects also needs further exploration (Kaufer et al., 1996; Bodick et al., 1997; Raskind et al., 1997).

One area that has been studied is the treatment of depression in Alzheimer’s disease. Treatment with the antidepressants paroxetine and imipramine has been shown to be effective in depressed Alzheimer’s disease patients (Reifler et al., 1989; Katona et al., 1998). Treatment may not only be effective for relieving
depressive symptoms but also for its potential to improve functional ability (Pearson et al., 1989; Ritchie et al., 1998).

Several challenges are encountered with the pharmacological treatment of Alzheimer’s disease. First, because of the cognitive deficits that are the hallmark of dementia, caregiver assistance is crucial for compliance with pharmacotherapy regimens. Second, although the current pharmacotherapies are likely to be most useful if administered early in the course of the disorder, early detection of Alzheimer’s disease is encumbered by the lack of a verified biological or biobehavioral marker. Third, little is currently known about the optimal duration of treatment with pharmacotherapies.

Psychosocial Treatment of Alzheimer’s Disease Patients and Caregivers
Psychosocial interventions are extremely important in Alzheimer’s disease. Although there has been some research on preserving cognition, most research has focused on treating patients’ behavioral symptoms and relieving caregiver burden. Support for caregivers is crucial because caregivers of older patients are at risk for depression, anxiety, and somatic problems (Light & Lebowitz, 1991). Psychosocial interventions targeted either at patients or family caregivers can improve outcomes for patients and caregivers alike.

Psychosocial techniques developed for use in patients with cognitive impairment may be helpful in Alzheimer’s disease. Strengthening ways to deal with cognitive losses may reduce functional limitations for patients with the early stages of Alzheimer’s disease, before multiple brain systems become compromised. For example, training in the use of memory aids, such as mnemonics, computerized recall devices, or copious use of notetaking, may assist patients with mild dementia. While initial research on the use of cognitive rehabilitation in dementia is promising, further studies are needed (Pliskin et al., 1996).

Of the behavioral symptoms experienced by patients with Alzheimer’s disease, depression and anxiety occur most frequently during the early stages of dementing disorders, whereas psychotic symptoms and aggressive behavior occur during later stages (Alexopoulos & Abrams, 1991; Devanand et al., 1997). Early evidence suggested that cognitive and behavioral therapies are beneficial in treating depressed older patients with dementia (Teri & Gallagher-Thompson, 1991; Teri & Uomoto, 1991). Cognitive therapy, seen as more promising for the early stages of dementia, strives to help patients cope with depression by reducing cognitive distortions and by fostering more adaptive perceptions. Behavioral therapy, seen as more promising for more moderately or severely affected adults with dementia, targets family caregivers directly—and patients indirectly—by helping caregivers identify, plan, and increase pleasant activities for the patient, such as taking a walk, designed to improve their mood (Teri & Gallagher-Thompson, 1991).

Further affirmation for behavioral therapy for depression of patients with Alzheimer’s disease recently was provided by a controlled clinical trial. The trial compared two types of behavioral therapy with a typical care condition and a waiting list control. One of the behavioral therapies targeted family caregivers to help them increase pleasant events for the patients, while the other gave caregivers more latitude in choosing which behavioral problem-solving strategies to deal with patients’ depression. Both behavioral therapies led to significant improvement in patients’ depressive symptoms. Moreover, the caregivers also showed significant improvement in their own depressive symptoms (Teri et al., 1997).

For alleviating caregiver and family distress, a broad array of psychosocial interventions was assessed in a meta-analysis of 18 studies (Knight et al., 1993). The interventions included psychoeducation, support, cognitive-behavioral techniques, self-help, and respite care. Individual and respite programs were found moderately effective at reducing caregiver burden and dysphoria, but group interventions were only marginally effective. Subsequent research buttressed the utility of adult day care in reducing caregivers’ stress and depression and in enhancing their well-being (Zarit et al., 1998). Beyond direct benefits to caregivers, support interventions also have benefited patients and have saved resources. For example, a
psychosocial intervention—individual and family counseling plus support group participation—aimed at caregiving spouses was shown to delay institutionalization of patients with dementia by almost a year in a randomized trial (Mittelman et al., 1993, 1996). Targeted behavioral techniques also improved the quality of caregivers’ sleep (McCurry et al., 1996), whereas psychoeducation and family support appeared to promote better patient management (Zarit et al., 1985).

The virtues of psychosocial interventions also extend to patients with Alzheimer’s disease in nursing homes. Until the late 1980s, nursing homes employed restraints and sedatives and other medications to control behavioral symptoms in patients with dementia. But the untoward consequences, in terms of injuries from physical restraints and increased patient disorientation, led to nursing home reform practices required by the Federal Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987 (Cohen & Cairl, 1996). In the past few years, a range of behavioral interventions for nursing home staff has been shown to be effective in improving behavioral symptoms of Alzheimer’s disease, such as incontinence (Burgio et al., 1990; Schnelle et al., 1995), dressing problems (Beck et al., 1997), and verbal agitation (Burgio et al., 1996; Cohen-Mansfield & Werner, 1997). A major problem is that interventions are not maintained or implemented correctly by nursing home staff (Schnelle et al., 1998). New approaches seek to teach and maintain behavior management skills of nursing home assistants through a formal staff management system (Barinaga, 1998; Stevens et al., 1998).

Other Mental Disorders in Older Adults

Anxiety Disorders

Prevalence of Anxiety
Anxiety symptoms and syndromes are important but understudied conditions in older adults. Overall, community-based prevalence estimates indicate that about 11.4 percent of adults aged 55 years and older meet criteria for an anxiety disorder in 1 year (Flint, 1994; Table 5-1). Phobic anxiety disorders are among the most common mental disturbances in late life according to the ECA study (Table 5-1). Prevalence studies of panic disorder (0.5 percent) and obsessive-compulsive disorder (1.5 percent) in older samples reveal low rates (Table 5-1) (Copeland et al., 1987a; Copeland et al., 1987b; Bland et al., 1988; Lindesay et al., 1989). Although the National Comorbidity Survey did not cover this age range, and the ECA did not include this disorder, other studies showed a prevalence of generalized anxiety disorder in older adults ranging from 1.1 percent to 17.3 percent higher than that reported for panic disorder or obsessive-compulsive disorder (Copeland et al., 1987a; Skoog, 1993). Worry or “nervous tension,” rather than specific anxiety syndromes may be more important in older people. Anxiety symptoms that do not fulfill the criteria for specific syndromes are reported in up to 17 percent of older men and 21 percent of older women (Himmelfarb & Murrell, 1984).

In addition, some disorders that have received less study in older adults may become more important in the near future. For example, post-traumatic stress disorder (PTSD) is expected to assume increasing importance as Vietnam veterans age. At 19 years after combat exposure, this cohort of veterans has been found to have a PTSD prevalence of 15 percent (cited in McFarlane & Yehuda, 1996). As affected patients age, there is a continuing need for services. In addition, research has shown that PTSD can manifest for the first time long after the traumatic event (Aarts & Op den Velde, 1996), raising the specter that even more patients will be identified in the future.

Treatment of Anxiety
The effectiveness of benzodiazepines in reducing acute anxiety has been demonstrated in younger and older patients, and no differences in the effectiveness have been documented among the various benzodiazepines. Some research suggests that benzodiazepines are marginally effective at best in treating chronic anxiety in older patients (Smith et al., 1995).
The half-life of certain benzodiazepines and their metabolites may be significantly extended in older patients (particularly for the compounds with long half-life). If taken over extended periods, even short-acting benzodiazepines tend to accumulate in older individuals. Thus, it is generally recommended that any use of benzodiazepines be limited to discrete periods (less than 6 months) and that long-acting compounds be avoided in this population. On the other hand, use of short-acting compounds may predispose older patients to withdrawal symptoms (Salzman, 1991).

Side effects of benzodiazepines may include drowsiness, fatigue, psychomotor impairment, memory or other cognitive impairment, confusion, paradoxical reactions, depression, respiratory problems, abuse or dependence problems, and withdrawal reactions. Benzodiazepine toxicity in older patients includes sedation, cerebellar impairment (manifested by ataxia, dysarthria, incoordination, or unsteadiness), cognitive impairment, and psychomotor impairment (Salzman, 1991). Psychomotor impairment from benzodiazepines can have severe consequences, leading to impaired driver skills and motor vehicle crashes (Barbone et al., 1998) and falls (Caramel et al., 1998).

Buspirone is an anxiolytic (antianxiety) agent that is chemically and pharmacologically distinct from benzodiazepines. Controlled studies with younger patients suggest that the efficacy of buspirone is comparable to that of the benzodiazepines. It also has proven effective in studies of older patients (Napoliello, 1986; Robinson et al., 1988; Bohm et al., 1990). On the other hand, buspirone may require up to 4 weeks to take effect, so initial augmentation with another antianxiety medication may be necessary for some acutely anxious patients (Sheikh, 1994). Significant adverse reactions to buspirone are found in 20 to 30 percent of anxious older patients (Napoliello, 1986; Robinson et al., 1988). The most frequent side effects include gastrointestinal symptoms, dizziness, headache, sleep disturbance, nausea/vomiting, uneasiness, fatigue, and diarrhea. Still, buspirone may be less sedating than benzodiazepines (Salzman, 1991; Seidel et al., 1995).

Although the efficacy of antidepressants for the treatment of anxiety disorders in late life has not been studied, current patterns of practice are informed by the efficacy literature in adults in midlife (see Chapter 4).

**Schizophrenia in Late Life**
Although schizophrenia is commonly thought of as an illness of young adulthood, it can both extend into and first appear in later life. Diagnostic criteria for schizophrenia are the same across the life span, and DSM-IV places no restrictions on age of onset for a diagnosis to be made. Symptoms include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior (the so-called “positive” symptoms), as well as affective flattening, alogia, or avolition (the so-called “negative” symptoms). Symptoms must cause significant social or occupational dysfunction, must not be accompanied by prominent mood symptoms, and must not be uniquely associated with substance use.

**Prevalence and Cost**
One-year prevalence of schizophrenia among those 65 years or older is reportedly only around 0.6 percent, about one-half the 1-year prevalence of the 1.3 percent that is estimated for the population aged 18 to 54 (Tables 5-1 and 4-1).

The economic burden of late-life schizophrenia is high. A study using records from a large California county found the mean cost of mental health service for schizophrenia to be significantly higher than that for other mental disorders (Cuffel et al., 1996); the mean expenditure among the oldest patients with schizophrenia (> 74 years old) was comparable to that among the youngest patients (age 18 to 29). While long-term studies have shown that use of nursing homes, state hospitals, and general hospital care by patients with all mental disorder diagnoses has declined in recent decades, the rate of decline is lower for older patients with schizophrenia (Kramer et al., 1973; Redick et al., 1977). The high cost of these settings

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5 Alogia refers to poverty of speech, and avolition refers to lack of goal-directed behavior.
contributes to the greater economic burden associated with late-life schizophrenia.

**Late-Onset Schizophrenia**
Studies have compared patients with late onset (age at onset 45 years or older) and similarly aged patients with earlier onset of schizophrenia (Jeste et al., 1997); both were very similar in terms of genetic risk, clinical presentation, treatment response, and course.

Among key differences between the groups, patients with late-onset schizophrenia were more likely to be women in whom paranoia was a predominant feature of the illness. Patients with late-onset schizophrenia had less impairment in the specific neurocognitive areas of learning and abstraction/cognitive flexibility and required lower doses of neuroleptic medications for management of their psychotic symptoms. These and other differences between patients with early- and late-onset illness suggest that there might be neurobiologic differences mediating the onset of symptoms (DeLisi, 1992; Jeste et al., in press).

**Course and Recovery**
The original conception of “dementia praecox,” the early term for schizophrenia, emphasized progressive decline (Kraepelin, 1971); however, it now appears that Kraepelin’s picture captures the outcome for a small percentage of patients, while one-half to two-thirds significantly improve or recover with treatment and psychosocial rehabilitation (Chapter 4). Although the rates of full remission remain unclear, some patients with schizophrenia demonstrate remarkable recovery after many years of chronic dysfunction (Nasar, 1998). Research suggests that a factor in better long-term outcome is early intervention with antipsychotic medications during a patient’s first psychotic episode (See Chapter 4).

A recent cross-sectional study that compared middle-aged with older patients, all of whom lived in community settings, found some similarities and differences (Eyler-Zorrilla et al., 1999). The older patients experienced less severe symptoms overall and were on lower daily doses of neuroleptics than middle-aged patients who were similar in demographic, clinical, functional, and broad cognitive measures. In addition, positive symptoms were less prominent (or equivalent) in the older group, depending on the measure used. Negative symptoms were more prominent (or equivalent) in the older group, and older patients scored more poorly on severity of dyskinesia. Older patients were impaired relative to middle-aged ones on two measures of global cognitive function. This finding, however, appeared to reflect a normal degree of decline from an impaired baseline, as the degree of change in cognitive function with age in the patient group was equivalent to that seen in the comparison group.

A recent study used the Direct Assessment of Functional Status scale (DAFS) (Loewenstein et al., 1989) to compare the everyday living skills of middle-aged and older adults with schizophrenia with those of people without schizophrenia of similar ages (Klapow et al., 1997). The patients exhibited significantly more functional limitations than the controls did across most DAFS subscales. In another recent study that used a measure of overall disease impact, the Quality of Well-Being Scale, older outpatients with schizophrenia manifested significantly lower quality of well-being than did comparison subjects, and their scores were slightly worse than those of ambulatory AIDS patients (Patterson et al., 1996).

Thus, while schizophrenia may be less universally deteriorating than previously has been assumed, older patients with the disorder continue nonetheless to exhibit functional deficits that warrant research and clinical attention.

**Etiology of Late-Onset Schizophrenia**
Recent studies support a neurodevelopmental view of late-onset schizophrenia (Jeste et al., 1997). Equivalent degrees of childhood maladjustment have been found in patients with late-onset schizophrenia and early-onset schizophrenia, for example, suggesting that some liability for the disorder exists early in life. Equivalent degrees of minor physical anomalies in patients with late-onset schizophrenia and early-onset schizophrenia...
suggest the presence of developmental defects in both groups (Lohr et al., 1997). The presence of a genetic contribution to late-onset and early-onset schizophrenia is evident in increased rates of schizophrenia among first-degree relatives (Rokhlina, 1975; Castle & Howard, 1992; Castle et al., 1997).

If late-onset schizophrenia is neurodevelopmental in origin, an explanation for the delayed onset may be that late-onset schizophrenia is a less severe form of the disorder and, as such, is less likely to manifest early in life. Recent research suggests that in several arenas—for example, neuropsychological impairments in learning, retrieval, abstraction, and semantic memory as well as electroencephalogram abnormalities—the deficits of patients with late-onset schizophrenia are less severe (Heaton et al., 1994; Jeste et al., 1995b; Olichney et al., 1995, 1996; Paulsen et al., 1995, 1996). Also, negative symptoms are less pronounced and neuroleptic doses are lower in patients with late-onset schizophrenia (Jeste et al., 1995b). The etiology and onset of schizophrenia in younger adults often are explained by a diathesis-stress model in which there is a genetic vulnerability in combination with an environmental insult (such as obstetric complications), with onset triggered by maturational changes or life events that stress a developmentally damaged brain (Feinberg, 1983; Weinberger, 1987; Wyatt, 1996). Under this multiple insult model, patients with late-onset schizophrenia may have had fewer insults and thus have a delayed onset. An alternative or complementary explanation for the delayed onset in late-onset schizophrenia is the possibility that these patients possess protective features that cushion the blow of any additional insults. The preponderance of women among patients with late-onset schizophrenia has fueled hypotheses that estrogen plays a protective role.

The view of late-onset schizophrenia as a less severe form of schizophrenia, in which the delayed onset results from fewer detrimental insults or the presence of protective factors, suggests a continuous relationship between age at onset and severity of liability. An alternative view is that late-onset schizophrenia is a distinct neurobiological subtype of schizophrenia. The preponderance of women and of paranoid subtype seen in late-onset schizophrenia supports this view. These two etiologic theories of late-onset schizophrenia call for further research.

**Treatment of Schizophrenia in Late Life**

Pharmacological treatment of schizophrenia in late life presents some unique challenges. Conventional neuroleptic agents, such as haloperidol, have proven effective in managing the “positive symptoms” (such as delusions and hallucinations) of many older patients, but these medications have a high risk of potentially disabling and persistent side effects, such as tardive dyskinesia (Jeste et al., in press). The cumulative annual incidence of tardive dyskinesia among older outpatients (29 percent) treated with relatively low daily doses of conventional antipsychotic medications is higher than that reported in younger adults (Jeste et al., in press).

Recent years have witnessed promising advances in the management of schizophrenia. Studies with mostly younger schizophrenia patients suggest that the newer “atypical” antipsychotics, such as clozapine, risperidone, olanzapine, and quetiapine, may be effective in treating those patients previously unresponsive to traditional neuroleptics. They also are associated with a lower risk of extrapyramidal symptoms and tardive dyskinesia (Jeste et al., in press). Moreover, the newer medications may be more effective in treating negative symptoms and may even yield partial improvement in certain neurocognitive deficits associated with this disorder (Green et al., 1997).

The foremost barriers to the widespread use of atypical antipsychotic medications in older adults are (1) the lack of large-scale studies to demonstrate the effectiveness and safety of these medications in older patients with multiple medical conditions, and (2) the higher cost of these medications relative to traditional neuroleptics (Thomas & Lewis, 1998).
Alcohol and Substance Use Disorders in Older Adults

Older people are not immune to the problems associated with improper use of alcohol and drugs, but as a rule, misuse of alcohol and prescription medications appears to be a more common problem among older adults than abuse of illicit drugs. Still, because few studies of the incidence and prevalence of substance abuse have focused on older adults—and because those few were beset by methodological problems—the popular perception may be misleading.

A persistent research problem has been that diagnostic criteria for substance abuse were developed and validated on young and middle-aged adults. For example, DSM-IV criteria include increased tolerance to the effects of the substance, which results in increased consumption over time; yet, changes in pharmacokinetics and physiology may alter drug tolerance in older adults. Decreased tolerance to alcohol among older individuals may lead to decreased consumption of alcohol with no apparent reduction in intoxication. Criteria that relate to the impact of drug use on typical tasks of young and middle adulthood, such as school and work performance or child rearing, may be largely irrelevant to older adults, who often live alone and are retired. Thus, abuse and dependence among older adults may be underestimated (Ellor & Kurz, 1982; Miller et al., 1991; King et al., 1994).

Epidemiology

Alcohol Abuse and Dependence

The prevalence of heavy drinking (12 to 21 drinks per week) in older adults is estimated at 3 to 9 percent (Liberto et al., 1992). One-month prevalence estimates of alcohol abuse and dependence in this group are much lower, ranging from 0.9 percent (Regier et al., 1988) to 2.2 percent (Bailey et al., 1965). Alcohol abuse and dependence are approximately four times more common among men than women (1.2 percent vs. 0.3 percent) ages 65 and older (Grant et al., 1994). Although lifetime prevalence rates for alcoholism are higher for white men and women between ages 18 and 29, African American men and women have higher rates among those 65 years and older. For Hispanics, men had rates between those of whites and African Americans. Hispanic females had a much lower rate than that for whites and African Americans (Helzer et al., 1991). Longitudinal studies suggest variously that alcohol consumption decreases with age (Temple & Leino, 1989; Adams et al., 1990), remains stable (Ekerdt et al., 1989), or increases (Gordon & Kannel, 1983), but it is anticipated that alcohol abuse or dependence will increase as the baby boomers age, since that cohort has a greater history of alcohol consumption than current cohorts of older adults (Reid & Anderson, 1997).

Mise of Prescription and Over-the-Counter Medications

Older persons use prescription drugs approximately three times as frequently as the general population (Special Committee on Aging, 1987), and the use of over-the-counter medications by this group is even more extensive (Kofoed, 1984). Annual estimated expenditures on prescription drugs by older adults in the United States are $15 billion annually, a fourfold greater per capita expenditure on medications compared with that of younger individuals (Anderson et al., 1993; Jeste & Palmer, 1998). Not surprisingly, substance abuse problems in older adults frequently may result from the misuse—that is, underuse, overuse, or erratic use—of such medications; such patterns of use may be due partly to difficulties older individuals have with following and reading prescriptions (Devor et al., 1994). In its extreme form, such misuse of drugs may become drug abuse (Ellor & Kurz, 1982; DSM-IV).

Research studies that have relied on medical records review show consistently that alcohol abuse and dependence are significantly more common than other forms of substance abuse and dependence (Finlayson & Davis, 1994; Moos et al., 1994). Yet prescription drug dependence is not uncommon and, as Finlayson and Davis (1994) found, the greatest risk factor for abuse of prescription medication was being female. This finding is supported by other studies showing that older women are more likely than men to
visit physicians and to be prescribed psychoactive drugs (Cafferata et al., 1983; Baum et al., 1984; Mossey & Shapiro, 1985; Adams et al., 1990). In contrast, an analysis of data from the National Household Survey on Drug Abuse concluded that older men were more likely than women to report use of sedatives, tranquilizers, and stimulants (Robins & Clayton, 1989). Older adults of both sexes are at risk for analgesic abuse, which can culminate in various nephropathies (Elseviers & De Broe, 1998).

Benzodiazepine use represents an area of particular concern for older adults given the frequency with which these medications are prescribed at inappropriately high doses (Shorr et al., 1990) and for excessive periods of time. A national survey of approximately 3,000 community-dwelling persons found that older persons were overrepresented among the 1.6 percent who had taken benzodiazepines daily for 1 year or longer (71 percent > 50 years; 33 percent > 65 years of age) (Mellinger et al., 1984). Benzodiazepine users were more likely to be older, white, female, less educated, separated/divorced, to have experienced increased stressful life events, and to have a psychiatric diagnosis (Swartz et al., 1991).

In contrast to alcohol and licit medications, older adults infrequently use illicit drugs. Less than 0.1 percent of older individuals in the Epidemiologic Catchment Area study met DSM-III (American Psychiatric Association, 1980) criteria for drug abuse/dependence during the previous month (Regier et al., 1988). This compared with a 1-month prevalence rate of 3.5 percent among 18- to 24-year-olds. ECA data further suggest a lifetime prevalence of illegal drug use of 1.6 percent for persons older than 65 years (Anthony & Helzer, 1991).

The development of addiction to illicit drugs after young adulthood is rare, while mortality is high (Atkinson et al., 1992). For example, over 27 percent of heroin addicts died during a 24-year period (Hser et al., 1993), and 5.6 percent of deaths associated with heroin or morphine use were among persons older than 55 (National Institute on Drug Abuse, 1992).

Older Adults and Mental Health

As is projected to occur with trends in alcohol consumption, the low prevalence of older adults’ drug use and abuse in the late 1990s may change as the baby boomers age. Annual “snapshot” data extrapolated from the National Household Survey on Drug Abuse, which has been conducted since 1971, afford a glimpse of trends. Patterson and Jeste (1999) recently compared prevalence estimates of those born during the baby boom with an older (> 35 years) non-baby-boomer cohort. The difference between baby boomers and the previous cohort translated in 1996 into an excess of approximately 1.1 million individuals using drugs. Their excess drug use, combined with their sheer numbers, means that more drug use is expected as this cohort ages, placing greater pressures on treatment programs and other resources.

Projections also suggest that the costs of alcohol and substance abuse are likely to rise in the near future. Across age ranges, drug abuse and alcohol abuse have been estimated to cost over $109.8 billion and $166.5 billion, respectively (Harwood et al., 1998). Although no studies have estimated the annual costs of alcohol and substance abuse among older adults, there is evidence that the presence of drug abuse and dependence greatly increases health care expenditures among individuals with comorbid medical disorders. For example, in a study of over 3 million Medicare patients who were hospitalized and discharged with a diagnosis of cardiovascular disease, average annual hospital charges were $17,979 for older patients with a concomitant diagnosis of drug dependence and $14,253 for those with a concomitant diagnosis of drug abuse, compared with only $11,387 for older patients with no concomitant drug disorder (Ingster & Cartwright, 1995). In addition, increased expenditures due to the presence of a drug disorder were greatest among older patients who also had a mental disorder.

Course

A longstanding assumption holds that substance abuse declines as people age. Winick (1962) proposed one of the most popular theories to explain apparent decreases in substance abuse, particularly narcotics, with aging. His “maturing out” theory posits that
factors associated with aging processes and length of abuse contribute to a decline in the number of older narcotic addicts. These factors include changes in developmental stages and morbidity and mortality associated with use of substances. Consistent with these hypotheses, substance abusers have higher mortality rates compared with age-matched nonabusers (Finney & Moos, 1991; Moos et al., 1994). However, some research contradicts the “maturing out” theory. For example, some studies show that persons who have been addicted for more than 5 years do not become abstinent as they age (Haastrup & Jepsen, 1988; Hser et al., 1993). Also, addicts approaching 50 years of age who were followed for more than 20 years remained involved in criminal activities (Hser et al., 1993). These findings emphasize the need to focus more attention on substance abuse in late life, especially in light of demographic trends.

Treatment of Substance Abuse and Dependence

The treatment of substance abuse and dependence in older adults is similar to that for other adults. Treatment involves a combination of pharmacological and psychosocial interventions, supplemented by family support and participation in self-help groups (Blazer, 1996a).

Pharmacotherapy for substance abuse and dependence in older adults has been targeted mostly at the acute management of withdrawal. When there is significant physical dependence, withdrawal from alcohol can become a life-threatening medical emergency in older adults. The detoxification of older adult patients ideally should be done in the inpatient setting because of the potential medical complications and because withdrawal symptoms in older adults can be prolonged. Benzodiazepines are often used for treatment of withdrawal symptoms. In older adults, the doses required to treat the signs and symptoms of withdrawal are usually one-half to one-third of those required for a younger adult. Short- or intermediate-acting forms usually are preferred.

Pharmacological agents for treatment of substance dependence rarely have been studied in older adults. Disulfiram use in older adults to promote abstinence is not recommended because of the potential for serious cardiovascular complications. Compounds recently proposed for use in treatment of addiction, such as flagyl, deserve further study. A rare controlled clinical trial of substance abuse treatment in older patients recently revealed naltrexone to be effective at preventing relapse with alcohol dependence (Oslin et al., 1997).

Service Delivery

Overview of Services

New perspectives are evolving on the nature of mental health services for older adults and the settings in which they are delivered. Far greater emphasis is being placed on community-based care, which entails care provided in homes, in outpatient settings, and through community organizations. The emphasis on community-based care has been triggered by a convergence of demographic, consumer, and public policy imperatives. In terms of demographics, approximately 95 percent of older persons at a given point in time live in the community rather than in institutions, such as nursing homes (U.S. Department of Health and Human Services, Administration on Aging, and American Association of Retired Persons [U.S.DHHS, AoA & AARP], 1995). Of those living in the community, approximately 30 percent, mostly women, live alone (U.S. DHHS, AoA & AARP, 1995). Most older persons prefer to remain in the community and to maintain their independence. Yet living alone makes them even more reliant on community-based services if they have a mental disorder.

Service delivery also is being shaped by public policy and the emergence of managed care. The escalating costs of institutional care, combined with the recognition of past abuses, stimulated policies to limit nursing home admissions and to shift treatment to the community (Maddox et al., 1996). Mental disorders are leading risk factors for institutionalization (Katz & Parmelee, 1997). Therefore, to keep older people in the community, where they prefer to be, more energies are being marshaled to promote mental health and to prevent or treat mental disorders in the community. In
other words, treating mental disorders is seen as a means to stave off costly institutionalization—resulting either from a mental disorder or a comorbid somatic disorder. An untreated mental disorder, for example, can turn a minor medical problem into a life-threatening and costly condition. Problems with forgetting to take medication (e.g., with dementia), developing delusions about medication (e.g., with schizophrenia), or lowering motivation to refill prescriptions (e.g., with depression) can increase the likelihood of having more severe illnesses that demand more intensive and expensive institutional care. Therefore, promotion of mental health and treatment of mental disorders are crucial elements of service delivery.

The delivery of community-based mental health services for older adults faces an enormous challenge. Services for older adults are insufficient and fragmented, often divided between systems of health, mental health, and social services (Gatz & Smyer, 1992; Cohen & Cairl, 1996). Under these three systems, services include medical and psychosocial care, rehabilitation, recreation, housing, education, and other supports. Yet although every community has an Administration on Aging to assist with services for older adults generally, there is no administrative body responsible for integrating the daunting array of services needed specifically for individuals with severe mental illnesses. Similar problems are encountered with coordinating services for children, as discussed in Chapter 3. Local mental health authorities and systems of care have been effective in coordinating care for some groups of adults, but no special administrative mental health entities exist for older adults. The fragmentation of service systems for older people in the United States stands in contrast to the United Kingdom and Ireland, where governmental authorities coordinate their care (Reifler, 1997). Older adults eventually may benefit from the local mental health authorities developing in the United States, but thus far these authorities have been focused on services for other adults. Because of ethnic diversity in the United States, systems of care must also deal with the special needs of older Americans who have limited English proficiency and different cultural backgrounds.

The following section describes the nature and settings in which older people receive mental health services. It concentrates on primary care, adult day centers and other community care settings, and nursing homes. A recurrent theme across these settings is the failure to address mental health needs of older people. Selected issues in financing of services for older adults are discussed briefly at the end of this section, but most of the issues related to financing policy (e.g., Medicare, Medicaid) and managed care are discussed in Chapter 6.

**Service Settings and the New Landscape for Aging**

Demographic, consumer, and public policy imperatives have propelled tremendous growth in the diversity of settings in which older persons simultaneously reside and receive care (Table 5-2). Care is no longer the strict province of home or nursing home. The diversity of home settings in suburban and urban communities extends from naturally occurring retirement communities to continuing care retirement communities to newer types of alternative living arrangements. These settings include congregate or senior housing, senior hotels, foster care, group homes, day centers (where people reside during the day), and others. The diversity of institutional settings includes nursing homes, general hospitals (with and without psychiatric units), psychiatric hospitals, and state mental hospitals, among others. In fact, the range of settings, and the nature of the services provided within each, has blurred the distinction between home and nursing home (Kane, 1995).

Across the range of settings, the duration of care can be short term or long term, depending on patients’ needs. The phrase, “long-term care,” has come to refer to a range of services for people with chronic or degenerative illness or disabilities who require support over a prolonged period of time. In the past, long-term care was synonymous with nursing home care or other forms of institutional care, but the term has come to
**Table 5-2. Settings for mental health services for older adults**

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*Two other settings (not included in this table) are board and care homes and assisted living facilities. These are residential facilities that serve as a bridge between community and institutional settings and have elements of each.

apply to a full complement of institutional or community-based settings.

Within the continuum of services, one new perspective—conceived as the *landscape for aging*—strives to tailor the environment to the needs of the person through a combined focus on health and residential requirements (Cohen, 1994). Whether at home, in a retirement community, or in a nursing home, this health and home perspective is deemed to be crucial to achieving high quality of life for older adults. Over the past 30 years, improvements in the health side of this perspective have occurred, but the home part has lagged. The challenge is to stimulate an interdisciplinary collaboration between systems of care and consumers.

One important area for an interdisciplinary approach is the extent to which a given setting fosters independent functioning versus dependent functioning, an issue influencing mental health and quality of life. Though certainly not a goal, some settings inadvertently foster dependency rather than independence. Nursing homes and hospitals, for example, are understandably more focused on what individuals cannot do, as opposed to what they can do. Yet their major focus on incapacity (the nursing and health focus) runs the risk of overshadowing function and independence (the home and humanities focus). In other settings, the balance between dependence and independence shifts in the other direction, with the risk of nursing and health needs being inadequately addressed. In recent years, the emphasis has been on “aging in place,” either at home or in the community, rather than in alternate settings.

The *landscape for aging* is a construct within which to examine the depth and breadth of human experience in later life (Cohen, 1998b). A health and humanities focus across this landscape offers a design for dealing with mental health problems as well as with health promotion to harness human potential. The landscape for aging, with its health and humanities orientation, is a construct designed to stir new thinking in research, practice, and policy. It also defines a clear need for new mental health services’ development and delivery, training, research, and policies to address the range of sites, each with its own unique characteristics and growing populations. The service systems, however, have yet to embrace a broader view.

**Primary Care**

Primary care represents a pivotal setting for the identification and treatment of mental disorders in older people. Many older people prefer to receive mental health treatment in primary care (Unutzer et al., 1997a), a preference bolstered by public financing policies that encourage their increasing reliance on primary, rather than specialty, mental health care (Mechanic, 1998). Primary care offers the potential advantages of proximity, affordability, convenience, and coordination of care for mental and somatic disorders, given that comorbidity is typical.

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6 Primary care includes services provided by general practitioners, family physicians, general internists, certain specialists designated as primary care physicians (such as pediatricians and obstetrician-gynecologists), nurse practitioners, physician assistants, and other health care professionals. General medical settings include all primary care settings plus all non-mental health specialty care.
The potential advantages of primary care, however, have yet to be realized. Diagnosis and treatment of older people’s mental disorders in the primary care setting are inadequate. The efficacious treatments described in the depression section of this chapter are not being practiced, particularly not in primary care and other general medical settings. As documented earlier, a significant percentage of older patients with depression are underdiagnosed and undertreated. The concern about inadequate treatment of late-life depression in primary care is magnified by growing enrollment in managed care.

Primary care is generally not well equipped to treat chronic mental disorders such as depression or dementia. It has limited capacity to identify patients with common mental disorders and to provide the proactive followup that is required to retain patients in treatment. To ensure better treatment of late-life depression in primary care, there is heightening awareness of the need for new models for mental health service delivery (Unutzer et al., 1997a). New models of service delivery in primary care include mental health teams, consultation-liaison models,7 and integration of mental health professionals into primary care (Katon & Gonzales, 1994; Schulberg et al., 1995; Katon et al., 1996, 1997; Stolee et al., 1996; Gask et al., 1997). For example, the intervention developed by Katon and colleagues introduced a structured depression treatment program into the primary care setting. The program included behavioral treatment to inculcate more adaptive coping strategies and counseling to enhance compliance with antidepressant medications. Patients were randomized in a controlled trial comparing this structured depression program with usual care by primary care physicians. The investigators found patients participating in the program to have displayed better medication adherence, better satisfaction with care, and a greater decrease in severity of major depression (Katon et al., 1996).

Models that integrate mental health treatment into primary care, while thus far designed largely for depression, also may have utility for other mental disorders seen in primary care. Nevertheless, primary care is not appropriate for all patients with mental disorders. Primary care providers can be guided by a set of recommendations for appropriate referrals to specialty mental health care (American Association for Geriatric Psychiatry, 1997).

Adult Day Centers and Other Community Care Settings

Over the past few decades, adult day centers have developed as an important service delivery approach to providing community-based long-term care. Adult day centers, although heterogeneous in orientation, provide a range of services (usually during standard “9 to 5” business hours), including assessment, social, and recreation services, for adults with chronic and serious disabilities. They represent a form of respite care designed to give caregivers a break from the responsibility of providing care and to enable them to pursue employment. Over the past 30 years, adult day centers have grown in number from fewer than 100 to over 4,000, under the sponsorship of community organizations or residential facilities. A large national demonstration program on adult day centers showed that they can care for a wide spectrum of patients with Alzheimer’s disease and related dementias and can achieve financial viability (Reifler et al., 1997; Reifler et al., in press). There also is evidence that adult day centers are cost-effective in terms of delaying institutionalization, and participants show improvement in some measures of functioning and mood (Wimo et al., 1993, 1994).

There are several approaches to delivering services in adult day centers. There is no research evidence that any one model of service delivery is superior to another. For example, a social model has been developed by Little Havana Activities & Nutrition Centers of Dade County (Florida). The Little Havana Senior Center provides mental health, health, social, nutritional, transportation, and recreational services, emphasizing both remedial and preventive services.

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7 Consultation-liaison models provide a bridge between psychiatry and the rest of medicine. In most models, a mental health specialist is called in as a consultant at the request of a primary care provider or works as a regular member of a team of health care providers.
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The center focuses on the predominantly Cuban population of South Florida. Yet much more research is needed to demonstrate the relative effectiveness of different models of adult day services (Reifler et al., 1997).

Beyond adult day centers, other innovative models of community-based long-term care strive to incorporate mental health services. Few have been evaluated and none implemented on a wide scale. These models include the social/health maintenance organization (S/HMO) (Greenberg et al., 1988), On Lok Senior Services Program, and life care communities or continuing care retirement communities (Robinson, 1990b). These new features of the landscape of aging show promise, but there is insufficient evidence of cost-effectiveness and generalizability of these models, particularly the mental health component. Perhaps the lack of a research base and limited market account for the slow pace of their proliferation in the United States.

Nursing Homes
Most older adults live in the community and only a minority of them live in nursing homes; of the latter, about two-thirds have some kind of mental disorder (Burns, 1991). The majority have some type of dementia, while others have disabling depression or schizophrenia (Burns, 1991). Despite the high prevalence of people with mental disorders in nursing homes, these settings generally are ill equipped to meet their needs (Lombardo, 1994).

Deinstitutionalization of state mental hospitals beginning in the 1960s encouraged the expanded use of nursing homes for older adults with mental disorders. This trend was enhanced by Medicaid incentives to use nursing homes instead of mental hospitals. But the shift to nursing homes was not accompanied by alterations in care. In 1986, the Institute of Medicine issued a landmark report documenting inappropriate and inadequate care in nursing homes, including the excessive use of physical and chemical restraints (IOM, 1986). This subsequent visibility of problems prompted the passage in 1987 of the Nursing Home Reform Act (also known as the Omnibus Budget Reconciliation Act of 1987). This legislation restricted the inappropriate use of restraints and required preadmission screening for all persons suspected of having serious mental illness. The purpose of the screening was to exclude from nursing homes people with mental disorders who needed either more appropriate acute treatment in hospitals or long-term treatment in community-based settings. Preadmission screening also was designed to improve the quality of psychosocial assessments and care for nursing home residents with mental disorders. Nursing home placement is appropriate for patients with mental disorders if the disorders have produced such significant dysfunction that patients are unable to perform activities of daily living.

To meet the legislation’s requirements, nursing homes must have the capacity to deliver mental health care. Such capacity depends on trained mental health professionals to deliver appropriate care and treatment. Unfortunately, prior to and even after passage of the Omnibus Budget Reconciliation Act of 1987, Medicaid policies discouraged nursing homes from providing specialized mental health services, and Medicaid reimbursements for nursing home patients have been too low to provide a strong incentive for participation by highly trained mental health providers (Taube et al., 1990). The emphasis on community-based care, combined with inadequate nursing home reimbursement policies, has limited the development of innovative mental health services in nursing homes. Major barriers persist in the delivery of appropriate care to mentally ill residents of nursing homes.

Services for Persons With Severe and Persistent Mental Disorders
Older adults with severe and persistent mental disorders (SPMD) are the most frequent users of long-term care either in community or institutional settings. SPMD in older adults includes lifelong and late-onset schizophrenia, delusional disorder, bipolar disorder, and recurrent major depression. It also includes Alzheimer’s disease and other dementias (and related behavioral symptoms, including psychosis), severe treatment-refractory depression, or severe behavioral problems requiring intensive and prolonged psychiatric
intervention. Although these groups of disorders have different courses of illness and outcomes, they have many overlapping clinical features, share the common need for mental health long-term care services, and are frequently treated together in long-term care settings (Burns, 1991; Gottesman et al., 1991; American Psychiatric Association, 1993). It is estimated that 0.8 percent of persons older than 55 years in the United States have SPMD (Kessler et al., 1996).

As a result of the dramatic downsizing and closure of state hospitals in past decades, 89 percent of institutionalized older persons with SPMD now live in nursing homes (Burns, 1991). However, institutions are expected to play a substantially smaller role than community-based settings in future systems of mental health long-term care (Bartels et al., in press). First, the majority of older adults with SPMD presently live in the community (Meeks & Murrell, 1997; Meeks et al., 1997) and prefer to remain there. Second, experience with the Preadmission Screening and Resident Review mandated by the Omnibus Budget Reconciliation Act of 1987 has been mixed. It may have slowed inappropriate admissions to nursing homes, restricted inappropriate use of restraints, and reduced overuse of psychotropic medications, but it did not otherwise improve the quality of mental health services (Lombardo, 1994). Furthermore, states’ opposition to what they perceived to be Federal government interference in local health care policy and a general trend toward deregulation subsequently curtailed Federal nursing home reform. Finally, the growing costs of nursing home care are stimulating dramatic reforms in reimbursement and policy, including state mandates to limit Medicaid expenditures by decreasing nursing home beds and Federal reform by Medicare to implement prospective payment for nursing home services (Bartels & Levine, 1998). To accommodate the mounting number of individuals who have disorders requiring chronic care, future projections suggest the greatest growth in services will be in home and community-based settings (Institute for Health and Aging, 1996), increasingly financed through capitated and managed care arrangements.

Older adults with SPMD are high users of services (Cuffel et al., 1996; Semke & Jensen, 1997) and require mental health long-term care that is comprehensive, integrated, and multidisciplinary (Moak, 1996; Small et al., 1997; Bartels & Colenda, 1998). The mental health care needs of this population include specialized geropsychiatric services (Moak, 1996); integrated medical care (Moak & Fisher, 1991; Small et al., 1997); dementia care (Small et al., 1997; Bartels & Colenda, 1998); home and community-based long-term care; and residential and family support services, intensive case management, and psychosocial rehabilitation services (Aiken, 1990; Robinson, 1990a; Schaftt & Randolph, 1994; Lipsman, 1996). With adequate supports, older persons with SPMD can be maintained in the community, sometimes at lower cost, and with equal or improved quality of life in comparison with institutions (Bernstein & Hensley, 1988; Mosher-Ashley, 1989; Leff, 1993; Trieman et al., 1996).

However, current mental health policies have left many older persons with SPMD with decreased access to mental health care in both community and institutional settings (Knight et al., 1998). Community-based mental health services for older people are largely provided through the general medical sector, partly due to poor responsiveness to the needs of older people by community mental health organizations (Light et al., 1986). Yet reliance on the general medical sector also has not met their needs because of its focus on acute care (George, 1992). In addition, most home health agencies provide only limited short-term mental health care. The long-term care programs that exist primarily aid older adults with chronic physical disabilities or cognitive impairment but fail to address impairments in mood and behavior (Robinson, 1990a). An additional barrier is that the majority of community-residing older adults do not seek mental health services, except for medication (Meeks & Murrell, 1997), despite continued need (Meeks et al., 1997). Those without family support generally live in nursing homes, assisted living facilities, and board and care homes. These three are forms of residential care that offer some combination of housing, supportive
services, and, in some cases, medical care. In short, more resources must be devoted to programs that integrate mental health rehabilitative services into long-term care in both community and institutional settings.

**Financing Services for Older Adults**

Financing policies furnish incentives that favor utilization of some services over others (e.g., nursing homes rather than state mental hospitals) or preclude the provision of needed services (e.g., mental health services in nursing homes). Details on financing and organizing mental health services, with a special focus on access, are presented in Chapter 6. Selected issues germane to older adults are addressed here.

Historically, Federal financing policy has imposed special limits on reimbursement for mental health services. Medicaid precluded payment for care in so-called “institutions for mental diseases,” Medicaid’s term for mental hospitals and the small percentage of nursing homes with specialized mental health services. This Medicaid policy provided a disincentive for the majority of nursing homes to specialize in delivering mental health services for fear of losing Medicaid payments (Taube et al., 1990). Under Medicare, the most salient limits were higher copayments for outpatient mental health services and a limited number of days for hospital care. Medicare’s special limits on outpatient mental health services were changed over the past decade, resulting in significantly increased access to and utilization of such services (Goldman et al., 1985; Rosenbach & Ammering, 1997). The concern, however, is that the gains made as a result of policy changes easily could be eroded by the shift to managed care (Rosenbach & Ammering, 1997).

**Increased Role of Managed Care**

Projections are that 35 percent of all Medicare beneficiaries will be in managed care plans by the year 2007, amounting to approximately 15.3 million people (Komisar et al., 1997). Although the managed care industry has the potential to provide a range of integrated services for people with long-term care needs, managed care’s awareness of and response to chronic care are rudimentary (Institute for Health and Aging, 1996). Despite the potential of systems of managed health care, such as HMOs, to provide comprehensive preventive, acute, and chronic care services, their current specialized geriatric programs and clinical case management for older persons tend to be inadequate or poorly implemented (Friedman & Kane, 1993; Pacala et al., 1995; Kane et al., 1997). In addition, older patients are likely to be poorly served in primary care settings (including primary care HMOs) because of minimal use of specialty providers and suboptimal pharmacological management (Bartels et al., 1997). Further, current systems lack the array of community support, residential, and rehabilitative services necessary to meet the needs of older persons with more severe mental disorders (Knight et al., 1995). These shortcomings are unlikely to be remedied until more research becomes available demonstrating cost-effective models for treating older people with mental illness.

**Carved-In Mental Health Services for Older Adults**

The types of mental health services available within managed care organizations vary greatly with respect to how services are provided. In some organizations, mental health care is directly integrated into the package of general health care services ("carved-in" mental health services), while it is provided in others through a contract with a separate specialty mental health organization that provides only these services and accepts the financial risk ("carved-out" mental health services).

Proponents of carved-in mental health services argue that this model better integrates physical and mental health care, decreases barriers to mental health care due to stigma, and is more likely to produce cost-offsets and overall savings in general health care expenditures. These features are particularly relevant to older persons, as they commonly have comorbid somatic disorders for which they take multiple medications that may affect mental disorders, often avoid specialty mental health settings, and incur significant health care expenses related to psychiatric
symptoms (George, 1992; Paveza & Cohen, 1996; Moak, 1996; Riley et al., 1997). Unfortunately, mental health specialty services for older persons tend to be a low priority in managed health care organizations, by comparison with medical or surgical specialty services (Bartels et al., 1997). More importantly, carved-in mental health care may have superior potential for individuals with diagnoses such as minor depression and anxiety disorders but tends to shortchange older patients with SPMD who require intensive and long-term mental health care (Mechanic, 1998). The range of outreach, rehabilitative, residential, and intensive services needed for patients with SPMD is likely to exceed the capacity, expertise, and investment of most general health care providers.

Economic factors also may limit the usefulness of mental health carve-ins in serving the needs of older individuals with SPMD. First, evidence from private sector health plans suggests that without mandated parity, insurers offer inferior coverage of mental health care (Frank et al., 1997b, 1997c). Furthermore, if providers or payers compete for enrollees, there is strong incentive to avoid enrollees expected to have higher costs from mental health problems (e.g., older persons with SPMD). To avoid such discrimination, equal coverage of mental health care would have to be mandated through legislation on mental health parity or through specialized contract requirements with managed care organizations.

**Carved-Out Mental Health Services for Older Adults**

Proponents of mental health service carve-outs for older persons argue that separate systems of financing and services are likely to be superior for individuals needing specialty mental health services, especially those with SPMD. In particular, advocates suggest that carved-out mental health organizations have superior technical knowledge, specialized skills, a broader array of services, greater numbers and varieties of mental health providers with experience treating severe mental disorders, and a willingness and commitment to service high-risk populations (Riley et al., 1997). From an economic perspective, since competition is largely over the carve-out contract with the payer (generally a public organization or an employer), there is less incentive to compete on risk selection, and risk adjustment becomes unnecessary. In addition, mental health carve-out organizations may be better equipped to provide rehabilitative and community support mental health services necessary to care for older persons with SPMD. Finally, growth of innovative outpatient alternatives could be stimulated by reinvestment of savings by the payer from any decrease in inpatient service use.

Unfortunately, research is lacking on outcomes and costs for older persons with SPMD in mental health carve-outs. A carve-out arrangement could lead to adverse clinical outcomes in older patients due to fragmentation of medical and mental health care services in a population with high risk of complications of comorbidity and polypharmacy. Also, from a financial perspective, the combination of physical and mental comorbidities seen in older adults, especially those with SPMD, may reduce the economic advantages of carved-out services (Bazemore, 1996; Felker et al., 1996; Tsuang & Woolson, 1997). If the provider cannot appropriately manage services and costs associated with the combination of somatic and mental health disorders, anticipated savings may not materialize. Furthermore, fragmentation of reimbursement streams would likely complicate the assessment of cost-effectiveness or cost-offsets. For example, apparent savings of mental health carve-outs under Medicare actually may be due to shifting costs when an individual is also covered under Medicaid. In this situation, Medicaid may cover prescription drugs, long-term care, and other services that are not paid for by Medicare. In order to offer true efficiencies, Medicare mental health carve-outs need to find a way to bridge the fragmentation of financing care for older persons.

**Outcomes Under Managed Care**

There do not appear to be any studies of mental health outcomes for older adults under managed care. In general, the available research on mental health outcomes for other adults consistently finds that
managed care is successful at reducing mental health care costs (Busch, 1997; Sturm, 1997), yet clinical outcomes (especially for the most severely and chronically ill) are mixed and difficult to interpret due to differences in plans and populations served. Several studies suggest that outcomes under managed care for younger adults are as favorable as, or better than, those under fee-for-service (Lurie et al., 1992; Cole et al., 1994). In contrast, others report that the greater use of nonspecialty services for mental health care under managed care is associated with less cost-effective care (Sturm & Wells, 1995), and that older and poor chronically ill patients may have worse health outcomes or outcomes that vary substantially by site and patient characteristics (Ware et al., 1996). A recent review of health outcomes for both older and younger adults in the managed care literature (Miller & Luft, 1997) concluded that there were no consistent patterns that suggested worse outcomes. However, negative outcomes were more common in patients with chronic conditions, those with diseases requiring more intensive services, low-income enrollees in worse health, impaired or frail elderly, or home health patients with chronic conditions and diseases. These risk factors apply to older adults with SPMD, suggesting that this group is at high risk for poor outcomes under managed care programs that lack specialized long-term mental health and support services. To definitively address the question of mental health outcomes for older persons under managed care, appropriate outcome measures for older adults with mental illness will need to be developed and implemented in the evolving health care delivery systems (Bartels et al., in press).

**Support and Self-Help Groups**

Support groups, which are an adjunct to formal treatment, are designed to provide mutual support, information, and a broader social network. They can be professionally led by counselors or psychologists, but when they are run by consumers or family members, they are known as self-help groups. The distinction is somewhat clouded by the fact that mental health professionals and community organizations often aid self-help groups with logistical support, start-up assistance, consultation, referrals, and education (Waters, 1995). For example, self-help support groups sponsored by the Alzheimer’s Association use professionals to provide consultation to groups orchestrated by lay leaders.

Support groups for people with mental disorders and their families have been found helpful for adults (see Chapter 4). Participation in support groups, including self-help groups, reduces feelings of isolation, increases knowledge, and promotes coping efforts. What little research has been conducted on older people is generally positive but has been limited mostly to caregivers (see later section) and widows (see below), rather than to older people with mental disorders.

Despite the scant body of research, there is reason to believe that support and self-help group participation is as beneficial, if not more beneficial, for older people with mental disorders. Older people tend to live alone

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8 Consumers are people engaged in and served by mental health services.
and to be more socially isolated than are other people. They also are less comfortable with formal mental health services. Therefore, social networks established through support and self-help groups are thought to be especially vital in preventing isolation and promoting health. Support programs also can help reduce the stigma associated with mental illness, to foster early detection of illnesses, and to improve compliance with formal interventions.

Earlier sections of this chapter documented the untoward consequences of prolonged bereavement: severe emotional distress, adjustment disorders, depression, and suicide. Outcomes have been studied for two programs of self-help for bereavement. One program, They Help Each Other Spiritually (THEOS), had robust effects on those who were more active in the program. Those widows and widowers displayed the improvements on health measures such as depression, anxiety, somatic symptoms, and self-esteem (Lieberman & Videka-Sherman, 1986). The other program, Widow to Widow: A Mutual Health Program for the Widowed, was developed by Silverman (1988). The evaluation in a controlled study found program participants experienced fewer depressive symptoms and recovered their activities and developed new relationships more quickly (Vachon, 1979; Vachon et al., 1980, 1982).

**Education and Health Promotion**

There is a need for improved consumer-oriented public information to educate older persons about health promotion and the nature of mental health problems in aging. Understanding that mental health problems are not inevitable and immutable concomitants of the aging process, but problems that can be diagnosed, treated, and prevented, empowers older persons to seek treatment and contributes to more rapid diagnosis and better treatment outcomes.

With respect to health promotion, older persons also need information about strategies that they can follow to maintain their mental health. Avoiding disease and disability, sustaining high cognitive and physical function, and engaging with life appear to be important ways to promote mental and physical health (Rowe & Kahn, 1997). The two are interdependent.

Established programs for health promotion in older people include wellness programs, life review, retirement, and bereavement groups (see review by Waters, 1995). Although controlled evaluations of these programs are infrequent, bereavement and life review appear to be the best studied. Bereavement groups produce beneficial results, as noted above, and life review has been found to produce positive outcomes in terms of stronger life satisfaction, psychological well-being, self-esteem, and less depression (Haight et al., 1998). Life review also was investigated through individualized home visits to homebound older people in the community who were not depressed but suffered chronic health conditions. Life review for these older people was found to improve life satisfaction and psychological well-being (Haight et al., 1998).

Another approach to promoting mental health is to develop a “social portfolio,” a program of sound activities and interpersonal relationships that usher individuals into old age (Cohen, 1995b). While people in the modern work force are advised to plan for future economic security—to strive for a balanced financial portfolio—too little attention is paid to developing a balanced social portfolio to help to plan for the future. Ideally, such a program will balance *individual* with *group* activities and *high mobility/energy* activities requiring significant physical exertion with *low mobility/energy* ones. The social portfolio is a mental health promotion strategy for helping people develop new strengths and satisfactions.

**Families and Caregivers**

Among the many myths about aging is that American families do not care for their older members. Such myths are based on isolated anecdotes as opposed to aggregate data. Approximately 13 million caregivers, most of whom are women, provide unpaid care to older relatives (Biegel et al., 1991). Families are committed to their older members and provide a spectrum of assistance, from hands-on to monetary help (Bengston et al., 1985; Sussman, 1985; Gatz et al., 1990; Cohen,
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Problems occur with older individuals who have no children or spouse, thereby reducing the opportunity to receive family aid. Problems also occur with the “old-old,” those over 85 whose children are themselves old and, therefore, unable to provide the same intensity of hands-on help that younger adult children can provide. These special circumstances highlight the need for careful attention to planning for mental health service delivery to older individuals with less access to family or informal support systems.

Conversely, a large and growing number of older family members care for chronically mentally ill and mentally retarded younger adults (Bengston et al., 1985; Gatz et al., 1990; Eggebeen & Wilhelm, 1995). Too little is known about ways to help the afflicted younger individuals and their caregiving parents. Families are eager to help themselves, and society needs to find ways to better enable them to do so.

There is a great need to better educate families about what they can do to help promote mental health and to prevent and treat mental health problems in their older family members. Families fall prey to negative stereotypes that little can be done for late-life mental health problems. They need to know that mental health problems in later life, like physical health problems, can be treated. They need to understand how to better recognize symptoms or signals of impending mental health problems among older adults so that they can help their loved ones receive early interventions. They need to know what services are available, where they can be found, and how to help their older relatives access such help when necessary.

The plight of family caregivers is pivotal. As noted earlier, the burden of caring for an older family member places caregivers at risk for mental and physical disorders. Virtually all studies find elevated levels of depressive symptomatology among caregivers, and those using diagnostic interviews report high rates of clinical depression and anxiety (Schultz et al., 1995). Ensuring their mental and physical health is not only vital for their well-being but also is vital for the older people in their care. Support groups and services aimed at caregivers can improve their health and quality of life, can improve management of patients in their care, and can delay their institutionalization.

Communities and Social Services

Family support is often supplemented by enduring long-term relationships between older people and their neighbors and community, including religious, civic, and public organizations (Scott-Lennox & George, 1996). Linkages to these organizations instill a sense of belonging and companionship. Such linkages also provide a safety net, enabling some older people to live independently in spite of functional decline.

While the vast majority of frail and homebound older people receive quality care at home, abuse does occur. Estimates vary, but most studies find rates of abuse by caregivers (either family or nonfamily members) to range up to 5 percent (Coyne et al., 1993; Scott-Lennox & George, 1996). Abuse is generally defined in terms of being either physical, psychological, legal, or financial. The abuse is most likely to occur when the patient has dementia or late-life depression, conditions that impart relatively high psychological and physical burdens on caregivers (Coyne et al., 1993). A recent report by the Institute of Medicine describes the range of interventions for protection against abuse of older people, including caregiver participation in support groups and training programs for behavioral management (especially for Alzheimer’s disease) and social services programs (e.g., adult protective services, casework, advocacy services, and out-of-home placements). While there are very few controlled evaluations of these services (IOM, 1998), communities need to ensure that there are programs in place to prevent abuse of older people. Programs can incorporate any of a number of effective psychosocial and support interventions for patients with Alzheimer’s disease and their caregivers—interventions that were presented earlier in this section and the section on Alzheimer’s disease.

Communities need to ensure the availability of adult day care and other forms of respite services to aid caregivers striving to care for family members at home. They also can provide assistance to self-help and other support programs for patients and caregivers. In the
process of facilitating or providing services, communities need to consider the diversity of their older residents—racial and ethnic diversity, socio-economic diversity, diversity in settings where they live, and diversity in levels of general functioning. Such diversity demands comprehensive program planning, information and referral services (including directories of what is available in the community), strong outreach initiatives, and concerted ways to promote accessibility. Moreover, each component of the community-based delivery system targeting older adults should incorporate a clear focus on mental health. Too often, attention to mental health services for older people and their caregivers is negligible or absent, despite the fact, as noted earlier, that mental health problems and caregiver distress are among the leading reasons for institutionalization (Lombardo, 1994). Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to society, in spite of physiologic changes due to aging and increasing health problems.

Conclusions
1. Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to the society, in spite of physiologic changes due to aging and increasing health problems.
2. Continued intellectual, social, and physical activity throughout the life cycle are important for the maintenance of mental health in late life.
3. Stressful life events, such as declining health and/or the loss of mates, family members, or friends often increase with age. However, persistent bereavement or serious depression is not “normal” and should be treated.
4. Normal aging is not characterized by mental or cognitive disorders. Mental or substance use disorders that present alone or co-occur should be recognized and treated as illnesses.
5. Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes. In particular, dementia, depression, and schizophrenia, among other conditions, will all present special problems in this age group: a. Dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life; b. Depression contributes to the high rates of suicide among males in this population; and c. Schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.
6. There are effective interventions for most mental disorders experienced by older persons (for example, depression and anxiety), and many mental health problems, such as bereavement.
7. Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for mental disorders enjoyed by younger adults, when these interventions are modified for age and health status.
8. Treating older adults with mental disorders accrues other benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider’s directions and advice, particularly about taking medications.
9. Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults. Opportunities are missed to improve mental health and general medical outcomes when mental illness is underrecognized and undertreated in primary care settings.
10. Barriers to access exist in the organization and financing of services for aging citizens. There are specific problems with Medicare, Medicaid, nursing homes, and managed care.

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Predictors of depression among aged widows and widowers: A literature review and preliminary results. Gerontologist.


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To: Board Members

From: Sean O’Connor
Board of Behavioral Sciences

Date: September 29, 2009

Telephone: (916) 574-7830

Subject: Legal Concerns Regarding Employment Settings Mandating Registrants Pay for Supervision

Background

In June 2009, a licensee contacted the Board of Behavioral Sciences (BBS) regarding practice of mandating employees that are registrants of the BBS pay for the supervision they receive in their employment setting. Prior to contacting the BBS, the licensee inquired with the California Association of Marriage and Family Therapists (CAMFT) and the Labor Board regarding this practice. Each entity responded that such an arrangement is inappropriate under current law.

In preparing a response to the licensee, BBS staff consulted with legal counsel, who cited various provisions of both the Business and Professions Code and the Labor Code that affirmed that mandating that a registrant pay for supervision received from his or her employer is inappropriate.

Example of the Issue

Two examples best illustrate where forcing a registrant to pay for supervision is inappropriate:

First, consider a registrant who works for a non-profit and charitable organization. This registrant provides psychotherapy as an employee to clients of the setting, and he or she requires at least one hour of individual or two hours of group supervision in order to count the work experience towards BBS licensing requirements. The organization has a supervisor on staff that provides supervision to the employee but charges the employee $300 each month for the provision of this supervision. The Labor Code makes such an arrangement inappropriate.

In the event that the employer cannot provide supervision to the registrant, and the registrant seeks out his or her OWN supervision from an individual outside of his or her employment setting, the registrant may pay that individual for supervision because there is no employer-employee relationship.
The difference in the two scenarios above is the perceived mandate of paying for supervision. In one scenario, supervision is provided by the employer of the registrant, and the registrant is required to pay his or her own employer. In the second scenario, supervision could not be provided by the registrant’s employer, and the registrant sought out and found appropriate supervision from an individual who is not an owner or agent of the registrant’s employer.
There are two sources of law, the federal Fair Labor Standards Act and the California Labor Code, regarding the payment of wages to an employee. Generally, if an employee is allowed to work, the time spent working is compensable. (29 U.S.C. § 203(g); *IBP Inc. v. Alvarez* (2005) 546 U.S. 21, 24 (defining “work or employment” as “physical or mental exertion (whether burdensome or not) controlled or required by the employer and pursued necessarily and primarily for the benefit of the employer and his business.)

If an employer pays an employee wages, that employer is generally prohibited from deducting money from an employee’s wages. (Cal. Labor Code §§ 216, 221.) This would include a practice where the employee is paid the full amount of his or her full wages and is then required to pay a certain amount back to the employer to cover the costs of supervision. (See Cal. Labor Code § 221.)

The law contemplates only a few permissible bases for either withholding money from an employee’s wages or requiring the employee to pay his or her employer. (Labor Code § 224.) These permissible deductions or withholdings include: (1) those required by state or federal law, (2) deductions specifically authorized by the employee to cover insurance premiums or other deductions not amounting to a rebate or deduction from the standard wage set by an agreement, or (3) where a deduction to cover health, welfare or pension plan contributions is expressly authorized by a wage agreement. (*Id.; Koehl v. Verio, Inc.* (2006) 142 Cal.App.4th 1313 (emphasis added).)

Additionally, the Board’s own laws, specifically Business and Professions Code sections 4980.43(b) and 4980.43(e)(1) encourage employers to provide fair remuneration to interns and require experience to be gained either as an employee or as a volunteer.
The Board’s laws generally contemplate that interns should be paid for their work as employees. To the extent that interns are paid as employees, their employer may not require such interns to pay for the required supervision.
To: Board Members  
From: Paul Riches  
Executive Officer  

Subject: Eligibility for Licensed Clinical Social Work (LCSW) Examinations

Current law (Business and Professions Code Section 4996.2, attached) requires that candidates for licensure as an LCSW must hold a masters degree in social work, complete 3200 hours of supervised experience, and pass the BBS administered examinations. It also provides that individuals licensed as clinical social workers in other states for more than two years may take the examinations and be eligible for licensure without documented supervised experience (Business and Professions Code Section 4996.17, attached). This change was made to recognize the practice experience gained in other states as a qualification for licensure.

Ordinarily, current law clearly addresses the many situations of applicants for licensure. However, the board has been contacted by an individual who presents a confounding situation. This individual first obtained a license as a marriage and family therapist and has practiced under that license for some time. Subsequently the individual completed a masters degree in social work and would like to be licensed as a clinical social worker as well. Current law requires that this individual complete another 3200 hours of supervised experience prior to taking the licensing examinations. Given that this individual has already completed 3000 hours of supervised experience and now acts as both a therapist and a supervisor for marriage and family therapy interns and associate clinical social workers, it is difficult to construct a rationale for requiring the additional supervised hours.

The Policy and Advocacy Committee considered this request at its April 10, 2009 meeting and directed staff to develop a legislative proposal to allow practice experience as a licensed mental health professional to be credited toward the supervised experience requirements for LCSWs.

Attached to this memo is proposed draft language that would allow an individual licensed as a marriage and family therapist for at least the previous four years and who has completed a masters degree in social work to take the examinations for licensure as a clinical social worker.
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§4996.2. QUALIFICATIONS OF LICENSES

Each applicant shall furnish evidence satisfactory to the board that he or she complies with all of the following requirements:

(a) Is at least 21 years of age.

(b) Has received a master's degree from an accredited school of social work.

(c) Has had two years of supervised post-master's degree experience, as specified in Section 4996.20, 4996.21, or 4996.23, or has held a current, active license in California as a marriage and family therapist for at least the four previous years.

(d) Has not committed any crimes or acts constituting grounds for denial of licensure under Section 480. The board shall not issue a registration or license to any person who has been convicted of any crime in this or another state or in a territory of the United States that involves sexual abuse of children or who is required to register pursuant to Section 290 of the Penal Code or the equivalent in another state or territory.

(e) Has completed adequate instruction and training in the subject of alcoholism and other chemical substance dependency. This requirement applies only to applicants who matriculate on or after January 1, 1986.

(f) Has completed instruction and training in spousal or partner abuse assessment, detection, and intervention. This requirement applies to an applicant who began graduate training during the period commencing on January 1, 1995, and ending on December 31, 2003. An applicant who began graduate training on or after January 1, 2004, shall complete 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. This 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.

(g) Has completed a minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 1807 of Title 16 of the California Code of Regulations. This training or coursework may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course.

(h) Has completed a minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 1807.2 of Title 16 of the California Code of Regulations. This training or coursework may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course.

§4996.17. ACCEPTANCE OF EDUCATION AND EXPERIENCE GAINED OUTSIDE OF CALIFORNIA

(a) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially the equivalent of the requirements of this chapter.

(b) The board may issue a license to any person who, at the time of application, has held a valid active clinical social work license issued by a board of clinical social work examiners or corresponding authority of any state, if the person passes the board administered licensing examinations as specified in Section 4996.1 and pays the required fees. Issuance of the license is conditioned upon all of the following:
The applicant has supervised experience that is substantially the equivalent of that required by this chapter. If the applicant has less than 3,200 hours of qualifying supervised experience, time actively licensed as a clinical social worker shall be accepted at a rate of 100 hours per month up to a maximum of 1,200 hours.

(2) Completion of the following coursework or training in or out of this state:

(A) 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.

(B) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder.

(C) A minimum of 15 contact hours of training or coursework in alcoholism and other chemical substance dependency, as specified by regulation.

(D) A minimum of 15 contact hours of coursework or training in spousal or partner abuse assessment, detection, and intervention strategies.

(3) The applicant's license is not suspended, revoked, restricted, sanctioned, or voluntarily surrendered in any state.

(4) The applicant is not currently under investigation in any other state, and has not been charged with an offense for any act substantially related to the practice of social work by any public agency, entered into any consent agreement or been subject to an administrative decision that contains conditions placed by an agency upon an applicant's professional conduct or practice, including any voluntary surrender of license, or been the subject of an adverse judgment resulting from the practice of social work that the board determines constitutes evidence of a pattern of incompetence or negligence.

(5) The applicant shall provide a certification from each state where he or she holds a license pertaining to licensure, disciplinary action, and complaints pending.

(6) The applicant is not subject to denial of licensure under Section 480, 4992.3, 4992.35, or 4992.36.

(c) The board may issue a license to any person who, at the time of application, has held a valid, active clinical social work license for a minimum of four years, issued by a board of clinical social work examiners or a corresponding authority of any state, if the person passes the board administered licensing examinations as specified in Section 4996.1 and pays the required fees. Issuance of the license is conditioned upon all of the following:

(1) Completion of the following coursework or training in or out of state:

(A) 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.

(B) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder.

(C) A minimum of 15 contact hours of training or coursework in alcoholism and other chemical substance dependency, as specified by regulation.

(D) A minimum of 15 contact hours of coursework or training in spousal or partner abuse assessment, detection, and intervention strategies.

(2) The applicant has been licensed as a clinical social worker continuously for a minimum of four years
prior to the date of application.

(3) The applicant's license is not suspended, revoked, restricted, sanctioned, or voluntarily surrendered in any state.

(4) The applicant is not currently under investigation in any other state, and has not been charged with an offense for any act substantially related to the practice of social work by any public agency, entered into any consent agreement or been subject to an administrative decision that contains conditions placed by an agency upon an applicant's professional conduct or practice, including any voluntary surrender of license, or been the subject of an adverse judgment resulting from the practice of social work that the board determines constitutes evidence of a pattern of incompetence or negligence.

(5) The applicant provides a certification from each state where he or she holds a license pertaining to licensure, disciplinary action, and complaints pending.

(6) The applicant is not subject to denial of licensure under Section 480, 4992.3, 4992.35, or 4992.36.