

**BOARD OF BEHAVIORAL SCIENCES**

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Meeting Minutes
Marriage and Family Therapist Education/Curriculum Committee
October 27, 2006

Crowne Plaza Hotel SFO
1177 Airport Blvd
Burlingame CA 94010

I. Introductions

The meeting was called to order at 10:03 a.m. Dr. Russ encouraged discussion from the audience, and encouraged the audience members to spread the word about the Committee. Audience members, staff, and committee members introduced themselves.

Committee Members Present:

Dr. Ian Russ, Chair
Donna DiGiorgio
Karen Pines

Staff Present:

Paul Riches, Executive Officer
Mona Maggio, Assistant Executive Officer
Christy Berger, Legislation Analyst
Justin Sotelo, Regulation Analyst

II. Gap Analysis of Curriculum Standards (BBS Occupational Analysis, DACUM Competencies, AAMFT Core Competencies for MFTs, AMFTRB Practice Analysis)

Dr. Russ mentioned that our task is to set the minimum qualifications for the MFT curriculum. He explained that Christy Berger prepared an analysis and comparison of a number of studies of MFT practice to current educational law.

Ms. Berger started with a disclaimer, that she is not a clinician, so her interpretations in the analysis may be somewhat lacking. Additionally, the comparison was fairly difficult because MFT education law contains items that are very general and some that are very specific. She explained that the proposed language is just a first draft and that the Board is very open to feedback.

The results of the analysis showed that MFT education law is lacking in public or community practice. She mentioned that the Board's statutory language may need refinement as there seem to be overlapping requirements. The studies used for comparison in the analysis and the results were as follows:

The BBS MFT Occupational Analysis (OA), which matches up well with the Board's MFT education law. This may be due to the fact that many of the respondents to the OA were in private practice and the MFT educational requirements were likely designed for private practice.

The AAMFT Core competencies also matched up well with MFT education law, except that it does not include any of the competencies defined in AAMFT's Research and

Program Evaluation domain. Dr. Russ had pointed out that some of these competencies seem to be aspirational, and not required for minimum competency.

The MFT DACUM had the greatest number of tasks that did not fit into current MFT education law. This was a difficult comparison because of the way the DACUM was written, in very brief, focused task statements. Of the tasks that did not fit, most were administrative and not directly relevant to clinical practice. Those that are relevant are where administration and clinical skills come together such as report writing.

The AMFTRB Role Delineation Study matched up well with MFT educational law.

Mary Riemersma, Executive Director of the California Association of Marriage and Family Therapists (CAMFT) asked a question about the occupational analysis. She asked whether the right questions were asked to elicit the responses that might have demonstrated there is more training happening in the public sector than have been identified?

Ms. Berger explained that the task and knowledge statements are developed by practitioners from a range of practice settings. She indicated that the majority of respondents to the OA were in private practice, but Ms. Berger did not have the statistics at hand regarding the number of respondents from public practice settings.

Mr. Riches explained that in developing the OA questionnaire, the prior questionnaire is used as a point of reference, and this is done through a focus group process to make changes to it, sometimes they are dramatic, sometimes more incremental.

Ms. Riemersma responded that if you're modifying a prior instrument, you may not be giving thought to different types of competencies, you might leave out a component.

Mr. Riches explained that we know the demographics of those who responded to the survey, but because of how the survey questions are rated, there may be items that did not make the critical index cutoff, which determines the final set of task and knowledge statements. If you have a smaller sample in one area, that could be impacted. He stated that he would be addressing the focus groups regarding the changing practice environment. The specialist that is running the workshops has been briefed on the emerging issues with public practice and has been given a copy of the MFT DACUM.

Dr. Russ asked Ms. Riemersma whether she felt that something was missing in the OA. She responded that probably community and public sector environment is fairly silent, and she wonders whether this is because it's not a large part of the profession, or is it because the right questions have not been asked.

Vonza Thompson, MFT and CEO of Alliance for Community Care, explained that public employers often have to adjust the job duties of a position to match what individuals have been trained to do. So if the Board is only surveying individuals in practice, they are not getting the perspective of the practice settings. The Board may not be getting the full picture. The Mental Health Services Act (MHSA) is supposed to transform the system, so employers have to get current employees up to speed, and if new workers can have a better understanding of what they're going into, they can get a match that's much better than what they're getting now.

Ms. Pines described her years of agency and nonprofit work and her experiences with new MFT employees who often want to learn how to do this type of work. However, she stated that some have no interest. She believes we should make the public practice component voluntary, and not send everyone through the same training when many have no intention of practicing in a public setting.

Dr. Russ asked the public to look at the MHSA training components and what you know to be the reality and tell the committee what elements are missing from MFT requirements. If MFTs are going to be in this workforce, then we need to begin thinking now what those minimum qualifications should be.

A member of the audience stated that some of the directions that the public system is hoping to go also applies to a private practice therapist. One example would be the use of practices backed up by data. Except on the administrative side, it shouldn't be so different for those in private and public practice, except that the public sector tends to work with the more severely disabled.

Mr. Riches asked the audience, what are the three top things that job applicants are lacking. A director of an agency responded that one would be lack of knowledge regarding charting and generic responses regarding selection of interventions for particular clients. Dr. Russ asked whether it was different for interns as opposed to licensees. She stated that it was a problem for both.

An educator in the audience, who is also a member of the Bay Area Mental Health Directors Education and Workforce Collaborative, stated that one challenge of the MHSA is the aspiration toward different structural relationships between the preparation of professionals and the employment of those attracted to working in the public sector. This is beyond content knowledge and skills. He hopes this committee will discuss those needs. He suggested we work with the Collaborative to get a sense of what the missing elements are in the preparation of new employees. Dr. Russ offered to come to a meeting of the Collaborative and bring that information back to the Committee. This person explained he is also a member of the Northern California MFT Educator's Consortium, who have been discussing creating a certificate for MFT public practice, which he hopes will be discussed here. Dr. Russ offered to attend one of their meetings as well.

Ms. Pines mentioned her belief that a certificate is a good way to go because it also provides the opportunity for existing licensees to go into this field.

Olivia Loewy, Executive Director of the American Association of Marital and Family Therapy, California Division (AAMFT-CA) expressed her opposition to the idea of a certificate, due to concerns that this would establish a tiered system. They are concerned that this would discourage professionals from participating in public practice. She encouraged the Board to ensure that anyone licensed will be qualified to work in any setting, rather than the use of a specialty certificate. She believes there needs to be a review of the curriculum, but not extensive. She wondered whether a certificate would actually make a difference to an employer.

Ms. Thompson stated that requiring a separate certificate could have a negative impact on workforce shortages and strikes her as unusual as an employer. She agrees that the system needs to be tinkered with, but does not feel there should be two tracks.

Ms. Riemersma stated that in time, public sector work needs to be interwoven in each class. For example, a law and ethics course would include public and private sector distinctions, and mental health educators need an understanding of the public sector to be able to teach that, and they are not there yet. Because of this, students have somewhat of a culture shock when they go to work in a public setting. Many things will have to be learned on the job, but they should get enough exposure so that they are comfortable with it. Regarding the certificate, it is not intended as a condition to be employed or something the Board would be offering. This is would come out of the private sector and educational institutions collectively determining the necessary education and training to qualify for a certificate to demonstrate that a person has gone over and above the requirements. The employer can hire whomever they want. This is a totally voluntary stopgap measure to fill in until the schools can assimilate changes to their programs.

Mr. Riches stated that we originally wanted to identify the foundational components that schools need to provide so that when they graduate, people have the tools so that they can learn to do the work. Not everything has to happen in the classroom, a lot is learned during the trainee and internship.

A member of the audience stated her support for the curriculum enhancement, stating that the law is outdated and it needs to be determined what is the best preparation for both private practice and community practice, basically good practice in different venues. She stated her support for the idea of a certificate as an option. She asked whether there been thought given more broadly than foundational, such as intern-level additional preparation. There is a lack of conceptual framing about what might be learned better at the intern level.

Dr. Russ asked whether a 48-unit program provides enough education, and if it doesn't what are the real world implications of expanding that?

An educator in the audience stated that their accredited program cannot add units as it is currently at 60, and there are other accrediting bodies they have to be accountable to. In two years, a program cannot address all areas of practice for MFTs. She is in support of a certificate, as many of their MFT students take training to equip them to work in school settings, for example. A certificate would target students who want to go the extra mile. Shouldn't burden all students and programs to add more required units.

Dave Schroeder, a partner (consumer) with Mental Health Associates and the County of Sacramento, stated that he comes from a different viewpoint, that of "what do my fellow consumers need." There is so much expected out of a person working in a public mental health system, why can't there be concentrated training for specialized areas of practice such as with physicians? The MHSA says that the needs of consumers are supposed to drive the system. The partnership is growing between the professionals and those using services. In his view, it shouldn't matter if you're in private or public sector, all persons should have skills to provide services to everybody. Additionally, he acknowledged that the consumer's desire for services are changing rapidly.

Dr. Russ asked Mr. Schroeder to invite other consumers to come to the Board's meetings. He stated that the medicine model is a good model, but the state model, which is the same as ours, licenses people as a general practitioner. Then, the American Medical Association offers certifications in specialty areas of practice. Psychologists have a similar

model. The piece we are talking about right now is the minimum competency for the general practitioner.

An educator in the audience explained that educators have to move in the direction of evidence-driven practices to keep up with changing standards. We should be doing that here as well, we should develop some evidence to guide what we are doing, to understand what those different skill sets are for public practice that are different than private practice that need to be taught. This educator is concerned that a certificate may be detrimental to workforce shortage problems, as employers may begin to require the certificate.

Dr. Russ responded that we do have a lot of data, including an analysis of the workforce, MHSA mandates, as well as the AAMFT and DACUM studies. Dr. Russ invited the audience to contribute studies or other data that they feel may be missing. The educator stated that he agrees with Dr. Russ, and explained that it is more of a concern that we don't know what its going to take to teach these things, how many units or hours, that is the piece that is unclear in terms of data and evidence.

Mr. Riches explained that the Board mandates the major domains of knowledge that need to be addressed, but it is up to the schools to determine the best way to put it into practice. That flexibility is core because as evidence changes, as an educator have to reevaluate programs as the field changes. The Board doesn't want to mandate down to that level.

Duncan Wigg, an educator from Pepperdine University stated his appreciation of Mr. Riches' comments regarding minimum requirements of education as opposed to something expansive. He cautioned that specializations may not be the purview of the Board. It is the charge of the Board to prepare MFTs who are capable as independent practitioners to respond to anybody who walks into their office whether a private or public setting. That spirit is embedded in law already, and needs to be reemphasized. Also need to respond to multicultural needs to Californians, a charge Pepperdine takes very seriously, as they are working to infuse into every aspect of the curriculum. This may be a model for public practice. We have money coming our way and how do we quickly address a work shortage situation. The idea of a certificate is a good effort.

Dr. Russ encouraged groups to work on specialty certificates, and reemphasized that the Board's task is different. The Board is part of this because we know that MFTs are in an area of practice that is changing, and we have the obligation to look at minimum requirements to guarantee that when you get your license, the public is at least safe.

Mr. Riches explained that we have been hearing the same comments from employers for a long time, a sense that MFT preparation was not well-suited to public practice. We are trying to be responsive to that, and taking a look, not presuming one way or another. Also, there is new public policy in California – the MHSA says we must do things differently. Our licensing requirements are aligned with public policy. We have a statutory list of domains, educators have a dynamic environment, and we have sympathy for that.

An educator in the audience stated that changing policy with MHSA is really making schools look at what they are doing and incorporate some of the new model into programs. There is a time lag before students will be coming out of programs with this new knowledge. It works much better is to infuse training into all aspects of program. For example, one class in multi-cultural training is not sufficient; people can't incorporate those issues into practice. This educator encouraged the Board to identify competencies that we

would test in an exam but not mandate that schools add units. This gives schools the ability to infuse into curriculum what students need to be basically competent, but doesn't put a burden of hours and units.

Ms. Loewy endorsed embedding requirements within existing coursework. In community mental health treatment really differs from agency to agency, so even if a student has a specialization, they will still need additional training. Agencies don't expect someone who is ready to just come into their agency and do the work. Also, the MHSA is still in developmental stages as a system being transformed, and agencies will need to train in accordance with the MHSA.

An educator in the audience stated that part of the discussion is student competencies, but also what is the role of the Board. Are there emerging issues with the MHSA that the Board would want to alert, support, and remind the schools, ask whether they are developing this, and how are you going to do it.

Mr. Riches responded that yes, we are doing this for a lot of reasons, but we have a clear statement of public policy, the MHSA tells us to do things, and one thing the Board can do is support change by asking questions, etc.

Dr. Russ encouraged more school participation, as he would like this to be a community discussion.

III. Discussion Regarding MHSA Workforce Draft Strategic Plan and the Integration of MHSA Principles in Marriage and Family Therapist (MFT) Education

- 1. What do schools and agencies do currently to train students to be Culturally Competent?**
- 2. Do schools and agencies use consumers to train students as to the experience of mental illness and to the experience of obtaining treatment?**
- 3. Are schools teaching the MHSA recovery model? What does this mean when someone has a chronic mental illness?**

Dr. Russ presented the three specific questions that are being explored under this agenda item.

Ms. Thompson stated that she and her fellow CEOs believe that the basics of the MHSA need to be infused into their agency. Right now it should be the recovery model as there are many people who are very disabled with tough life experiences because of our current system. The consumer directed piece is very important, so anything we can do to encourage the schools and agencies to work together with consumers and families to see the change in philosophy would be great. Almost every part of training and assessment should shift, this is in attitude, beliefs, and the way we treat each other. The Board can't legislate a lot of that. She asked, other than the Board, who can play a role in getting some of these parts together?

Dr. Russ stated that schools and agencies are working together in consortia, which is essential.

An educator in the audience stated that the Bay Area Workforce Collaborative does that very thing, and that model is being replicated. The MHSA is very actively supporting this kind of communication and also funding it.

Bill Bruff from Saybrook University stated that the MHSA is a call to how do we have a single conversation about these kinds of issues. One of the challenges is not just to get consumers in, but to also create a climate in which consumers can be “out of the closet.” His school has students and faculty who are consumers or have recently been. There is not universal agreement about consumers and what consumer participation means, but we have to do it in partnership with those stakeholders. The recovery model is also being defined. For example, there are psychodynamic models that are antithetical to what some people hold as basic tenets of the recovery model. This can’t be solved by adding laws, but the challenge is how to have meaningful discussion that arrives at a workable effort.

Mr. Riches responded that he believes all of these things need to happen. The Board has a role, we are not going to solve a lot of these problems, but the role is how do we align what we do with these policy changes. It would be naïve to say, we’re not going to do anything in response to something that is transforming the system. The state through the Board has an obligation to make sure our licensing standards meet the needs of the public, some will be proscriptive, some not. A lot of work has to be done on a lot of levels to support this level of change. The collaborative is a great model. We will ask for accountability that you include certain content in your program, but we will not tell you how do you do it.

In response to the agenda questions:

Ben Caldwell, an educator from Alliant University stated in response to question one, cultural competency is infused throughout their curriculum, and has been an active area of focus for a long time; in response to question two regarding consumer participation, our school is deficient in this area. In response to question three, this is a difficult question to answer given the lack of specificity regarding the recovery model. As best as I understand it, we teach parts of it, including the psychosocial recovery model and good documentation.

Mr. Wigg stated in response to question one, cultural competency, including diversity in terms of age and socioeconomic status in addition to other things, is a high priority. They are constantly working to infuse this into the program; in response to question two, Pepperdine has three training clinics, all of which are geared towards clients of lower socio-economic status. However, only a minority of their students get exposure to these clinics. In response to question three, there is an emphasis of the recovery model being defined in contrast to the medical model. There are models of psychotherapy that are more strengths-based which are taught.

Linda Terry, an educator from San Diego State University stated in response to question one, they look for applicants who share the goals of their program, not those wanting to enter private practice. There is a multi-cultural social justice program with an infusion and inclusion approach to diversity, which includes a sequence of three courses focusing on cultural identity development as well as infusion into other courses. They have 75% students of color, and about 10% with a same-sex orientation. Their training program sees about 75% clients of color with about 30% who are non-English speaking.

In response to question two, they do have forums in which a variety of consumer experiences are discussed, but it isn't what she would call a full ongoing dialogue. In response to question three, she concurred with previously stated responses.

An educator in the audience stated that most of the programs including theirs have become sophisticated about integrating multicultural competency into the curriculum. The next step is the faculty who is becoming much more multicultural as well as their student body, more dramatically recently. Regarding consumer involvement, they haven't really grappled with that issue yet and it will take some time before they have this infused into their curriculum. Students are out in the field, but are seeing it from the perspective of a provider, they are not seeing it as a joint venture.

Mr. Bruff stated responses similar to the previous responses and in addition, his school consciously recruits diverse faculty and students, teach a stand-alone diversity course, and also embed cultural diversity in all of the practicum. For the last two years they have worked to address issues of stigma, but have a long way to go. They have had presenters such as CASRA present on their model of consumer participation as well as others, so these are some pilot efforts, but there is a long way to go for full consumer participation.

Mr. Schroeder explained that consumers, especially those from different cultures did not have choices in the past, as far as types of services available. The definition of recovery changes with every individual, and may change on a daily basis for every individual. It is less a definition than a concept. The underlying thing is what does a person need in order to recover. For many years, their choices were mandated, not chosen. They want to be partners. He also expressed his dislike for the word "consumer," and prefers "partner."

Dr. Jennifer Frei from the University of Phoenix stated responses similar to others and stated that they have a specific diversity class, but this is also embedded in other classes. Consumer participation is a short-coming at this point. She explained that they do address the psychosocial model, but they have a way to go regarding the recovery model.

Mr. Riches asked whether the institutions are thinking about existing faculty and how to get them up to speed.

Lesley Zwillinger, an educator from San Francisco State University, stated that they are doing that and are also talking with the DMH about some MHSA education and training funding for training of faculty.

Mr. Wigg stated that Pepperdine just had its first multicultural lab that included faculty, students and alumni who interacted and discussed how both instructors and students can become more culturally competent, and how it can be incorporated into all aspects of the curriculum. There is attention being paid to faith-based resources as well.

An educator in the audience added they have a 2-day faculty retreat once a year, and that is the arena they have used to address these issues, but beyond that it has been single initiatives to get faculty involved, working at agencies, etc.

Dr. Russ posed the question to educators, what is your sense of where your school is at as compared with other schools with their curricula in this area?

Mr. Caldwell stated that he has the sense that they are a little ahead partly because that they take part in these discussions, but not light years ahead.

Ms. Riemersma stated that schools are all over the map, but because she talks with a lot of schools, students, and supervisors, she sees an evolution in the students she is talking to. Used to be largely white, middle-aged and female, but seeing a transformation. Schools are seriously looking at these issues and have had a shift in thinking in that this license, which was once a private practice only profession, is not that way anymore.

Mr. Wigg stated that it is a concern that the schools can be addressing these issues at an academic level, but we lose accountability when it comes to supervision.

The meeting adjourned for lunch at 12:20 p.m. and reconvened at 1:22 p.m.

IV. Solicitation for Responses From Stakeholders Regarding:

- 1. Do the current curriculum requirements allow the schools the flexibility to incorporate the new research and core competencies as established by the AAMFT, the DACUM and the MHSA?**
- 2. Are there topics or types of training that need to be mandated in order to guarantee public safety when MFTs practice in private practice and public agencies?**
- 3. Is the 48 unit requirement sufficient to cover state mandated requirements that have accumulated the core competencies for both private and public practice? Should the state consider a 60 unit requirement for licensure as an MFT?**

Dr. Russ thanked everybody for their participation, encouraged others to get the word out, then restated the three issues under the fourth agenda item.

Mr. Bruff stated that the current curriculum requirements do allow enough flexibility to incorporate new and emerging competencies. Their program consists of 57 units, which includes the 48 units required by the Board. If this requirement went higher, they would have less flexibility as they would be trying to take on new material in addition to that which is already being covered.

Ms. Riemersma stated that the Board may get push back from the schools if they increase unit requirements, as many of the programs are already more than 48 units, but Business and Professions Code (BPC) Section 4980.37 needs to be addressed. It generally states the coursework that is needed, but this needs to be enhanced to address those things we are talking about today. It is very generally stated without putting numbers on it.

Mr. Caldwell stated that if the Board increases units, it presents an access problem in terms of the higher cost. Each time they add a 3-unit course, that is another \$3,000 cost to the student.

Mr. Wigg asked his students what they thought about a 60-unit program, and one person responded you might as well get a doctorate.

Ms. Terry stated that she is currently running a 60-unit program and would rather focus on the knowledge base needed, and how that is framed within the 48 unit requirement. Another important focus should be modifying the 150-hour practicum requirement, as it is not enough. The framing of that experience might be helpful in supporting community-based practice.

Dr. Russ asked the audience to review BPC Section 4980.37 and asked what should be added.

Ms. Riemersma stated that somewhere we need to emphasize culture and linguistic proficiencies, the recovery model and resiliency and those things emphasized under the MHSA.

Mr. Caldwell stated his agreement with Ms. Riemersma. He added that specific to diversity, we are talking about more than ethnicity, which is now how many courses are focused. He suggested adding under BPC Section 4980.37(a)(3) “across a variety of public and private work settings.”

Mr. Wigg from Pepperdine stated that the phrase “a variety of psychotherapeutic techniques” as stated under BPC Section 4980.37(a)(5), is vague, but in the exam the competency areas are very specific. Could we include the recovery model in the licensing exam?

Mr. Caldwell stated that if students know it is going to be on the exam, they will demand that we teach it.

Mr. Bruff suggested adding something about systems of care.

Mr. Riches asked if BPC Sections 4980.37 and 4980.40 are overlapping or completely separate. Want to make sure it reads as a coherent whole.

Ms. Pines believes there is overlap. She wanted to mention that it would be good to have an addition to BPC Section 4980.37(b) where schools are required to include public and private (nonprofit) settings in practicum according to MHSA standards.

Ms. Terry stated that is it time to expand the language under BPC Section 4980.37(a)(3) to application of couple and family relationships and other significant systems as well as the intersection of family to clients and community systems. This would highlight consumer involvement.

Ms. Loewy believes that students are not well trained to document psychotherapy in a way that conceptually makes sense and ties together treatment goals with the ongoing treatment process. This is a problem in both public and private settings. It is a way of thinking about delivering services and treatment planning.

Ms. Riemersma stated that it is important not to overlook individuals, couples, families and children and other kinds of relationships. All need to be adequately addressed. She wants

to see components of the MHSa addressed, but cautioned about using the MHSa terminology, as the terminology may change.

Ms. Thompson stated that that we should be addressing, in conceptual framework, that we will not only will follow MHSa principles, we need to transform the system. Regarding documentation, about 90% of her agency's income is from public sector client, but they also see private pay clients. She sees very little difference in the quality of referral paperwork that comes in. Can't tie the problem with treatment to either private or public practice, however, there is often little documentation from private practitioners.

Ms. Terry stated her belief that there is overlap between BPC Sections 4980.37 and 4980.40.

Mr. Riches stated that staff will work on the overlap.

Dr. Russ asked the audience what else we should be talking about, given our general goal. Who else should we invite, etc.?

Mr. Wigg asked who is talking to consumers and how are those needs incorporated into the discussions?

Dr. Russ stated that he and Mr. Riches are working on ways to do that. They have also spoken with Mr. Schroeder about ways to do that.

Mr. Riches stated that a partner (consumer) focus group would be a great way to get unfiltered, unrestrained input, to give them center stage.

Mr. Schroeder stated that it is hard because many consumers do not have transportation. If the Board wants their input, we should show that we value it by paying them. Many will not do that for free. The state has done that and expanded their expert pool to 400 people. They are paid only \$10 an hour, but it says we value your input.

Mr. Riches stated that the Board will look into that.

A member of the audience stated that her agency started with a pool of 20 experts doing Medi-Cal oversight reviews. That model expanded to other departments including the DMH. If nothing else comes out of this, it has to be consumer driven. She mentioned that a new DACUM will be done on peer supports.

Ms. Thompson stated that there should be outreach to families included. Many have been working very hard for their family member in the system and can be enormously helpful.

Ms. Terry stated her belief that regarding the knowledge base, being able to critique research is important if you're going toward evidence-based practice.

Ms. Riemersma stated that she sees the value and need for research, but does not see this as a component that the Board should be getting into, more at the schools' discretion.

Mr. Schroeder stated that knowledge is great but doesn't always translate into good practice. Life experience is very important. It really makes a difference to hear it from someone who has been there.

Ms. Thompson stated that her agency has a “Rise Above Stigma” panel, which speaks every year to 300 students. It is composed of different people, mostly clients and a family member. She has had responses back from educators that they could see significant difference toward people with a mental illness in the classroom after having a real experience. They hadn’t experienced it that way before.

Ms. Riemersma mentioned that the Southern California Consortium is meeting on the same day in December as the next meeting of this committee. Mr. Riches responded that staff will look into changing the meeting location.

V. Suggestions for Future Agenda Items

The meeting adjourned at 2:11 p.m.