

## MEETING MINUTES

### Marriage and Family Therapist Education Committee

March 9, 2007  
Golden Gate University  
536 Mission Street  
San Francisco, CA 94105

Committee Members Present:

Dr. Ian Russ, MFT, Committee and Board Chair  
Donna DiGiorgio  
Karen Pines

Staff Present:

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

**I. Introductions**

The meeting was called to order at approximately 10:00 a.m. Dr. Russ thanked Golden Gate University for hosting the meeting. He then introduced the committee members and staff present. Audience members introduced themselves. Dr. Russ invited audience members to contact him with comments after the meeting, and encouraged everyone's participation.

Dr. Russ provided a review of the many issues that the Committee has looked at during its prior meetings. He invited people to contact him after the meeting if they have comments regarding any of those issues.

**II. Review and Approval of July 21, 2006 Committee Meeting Minutes**

The Committee concurred to approve the July 21, 2006 minutes of the MFT Education Committee.

**III. Review and Approval of October 27, 2006 Committee Meeting Minutes**

The Committee concurred to approve the October 27, 2006 minutes of the MFT Education Committee.

**IV. Review and Approval of December 8, 2006 Committee Meeting Minutes**

The Committee concurred to approve the December 8, 2006 minutes of the MFT Education Committee.

**V. Presentation by Marianne Baptista, MFT on Training in Recovery Models**

Dr. Russ welcomed Ms. Baptista who is the Training and Education Coordinator for the California Association of Social Rehabilitation Agencies (CASRA).

Ms. Baptista explained that she has worked in public mental health for over 20 years, primarily with adult populations and in nonprofit agencies. She has provided direct service and supervision to MFT and MSW students and interns. She recently provided training to Madera County regarding the Mental Health Services Act (MHSA) which gave her a new look at what people were coming into these jobs with, including an interesting group of consumers who were asked to come to the training prior to being hired for positions in a drop-in counseling center, as well as people who had been licensed for a number of years and people who had just graduated. Ms. Baptista also participated in the MFT DACUM process.

Ms. Baptista explained that she is going to present on more than just the recovery model because if you take away the jargon, everybody is on the same page. She stated her belief that she doesn't think there is anybody who doesn't believe that change is possible, and that it is possible for everyone - people can lead more satisfying lives. That is basically what the recovery model is all about, believing that recovery is possible, and holding that belief for somebody who cannot believe it for themselves.

She explained that the recovery model talks about being person-centered, which means helping people work on their goals and focusing on the quality of life, which MFTs in general are trained to do by helping people to better operate in their community or family. The recovery model engages the whole person, meaning it is a holistic approach. Ms. Baptista explained that she mainly learned how to be a therapist during her practicum and internship. She believes that is where people will learn the specific strategies to provide recovery-oriented services, more so than in the classroom.

Ms. Baptista explained that in general, MFT programs train people to work with clients who have insurance or that can pay. There are huge issues that come up when working with people who live in poverty. For example, she used to work with an agency who received funding through HUD to provide housing, and one of the requirements was that people had to be homeless. However, once people were placed, they were soon leaving. There was a lack of understanding that the culture of homeless is very powerful, there is a strong sense of community, and a lot of protection, and people are very drawn to that. They thought by just putting a roof over their head and having food available that the clients should be overjoyed. They weren't aware of the powerful pull to that community that people had developed. And those are the kinds of things that people can be taught. Another example is the person who calls their therapist to cancel an appointment saying they can't go outside, there are people who are trying to kill them. Well that could be true, and doesn't necessarily mean that this person is delusional, depending where they live and the dangers in their environment.

Therapists need to be aware of the laws, benefits available, and the Americans with Disabilities Act. Therapists also need to be prepared to work with people who have serious mental illness. She described how a lot of people with serious mental illness have very complicated presentations, often with more than one diagnoses, and this is more than people in private practice are used to dealing with. Also the family dynamics and cultural issues are different. For example, how people describe the symptoms of

their mental illness varies widely, so it isn't just a matter of communication style or values around getting treatment, people can describe physical and emotional symptoms in different ways and you have to try to get a sense of what it is they're talking about.

Ms. Baptista explained that medication along with psychosocial intervention are now considered best practices for people with serious mental illness. She is aware that some people in private practice will not work with someone with a serious mental illness, and believes that this really undermines the profession. When people seek out therapy, there needs to be people in private practice who will work with this population.

She explained that the practitioner works as part of a team which can include family members and others in the community, a nurse, case manager, counselor at their residential treatment program and others. Together those people form the team that helps the client accomplish their goals. The client has to approve that all of those people are on their team, but it is very different than the model of the one hour therapy session. Therapists are often working in the community, so we often have a session with clients at a restaurant, in the car, at their home, or anywhere in the community. Services are scheduled as needed, and it can be a 15-minute appointment or session that ends up taking half of a day, based on the client's needs.

Recovery-oriented services presents a different therapeutic relationship, quite different from a private practice. The relationship with the client, while always ethical, can be personal. The client can know what the therapist did over the weekend, or what movie you saw. Both people get to know each other as human beings. She clarified that she is not talking about being friends with the client, but showing that the therapist is a human being. Boundaries are less defined because of the way the therapist works with the person. There may be social events where clients and staff interact. This makes maintaining boundaries very tricky because the therapist still has to maintain boundaries, but they move all the time. It requires a skilled supervisor to help people work through these things. We teach that therapists have to be intentional about the decisions they make about boundaries. We can't just say it's a dual relationship, so don't do it. The therapist has to look at what the client wants, what feels right to the therapist, are their clinical implications to what the client is asking for so that you might not want to do it. For example, there could be a female client who says to her male therapist that she is so depressed and she could use a hug. But if she has been sexually abused, that is probably not appropriate.

So the challenge is to determine what material can be incorporated into existing courses, to develop a fundamentals of public mental health course, and to look at internships in public mental health settings. The one change that would have the most effect would be to provide a facilitator from public mental health in practicum seminars. Ms. Baptista then offered to answer questions from the audience.

Janlee Wong from the National Association of Social Workers California (NASW) stated that the recovery model tends to be comprehensive, but funding is typically for minimal services. He asked how the recovery model would be able to do this integration when the government says no. Ms. Baptista responded that you have to be creative about how services are obtained for people, and that can be done by engaging the community. Often it may be the churches, or it may be housing resources. For example, there may be three clients who need housing and the therapist introduces them to each other and helps them find a place together. Also, it is

the MHSA-funded programs which are mandated to do the recovery model, so that funding is there, but hopefully that will spill over to other government programs.

Mary Riemersma from the California Association of Marriage and Family Therapists (CAMFT) asked what other kinds of things need to be done within the educational system other than a facilitator during practicum. Ms. Baptista stated that it could be addressed in a lot of foundational coursework. The issues of the methods, such as working as a team, the therapeutic relationship and boundaries are best addressed in a practicum seminar, and it needs to be done by someone who understands the reality of the public mental health system. Issues also need to be addressed in law and ethics courses, especially the differences in different settings. For example, many people do not understand that some dual relationships can be beneficial.

Dr. Russ stated that therapists all put clients together in group therapy, but if a therapist had a contract with a person for individual therapy and then started introducing them to others who are also in individual therapy and they also have that contract that implies that their therapy is private and confidential, then there might be a problem. When there are people in group therapy, that contract is different with a different set of goals. It needs to be explained in ethics classes that if you're working for a clinic, then there are different rules than private practice, that the contract is with the clinic.

Dr. Olivia Loewy from the American Association for Marital and Family Therapy, California Division (AAMFT-CA) commented that as far as she knows, most agencies do have paperwork and explanations when there is an intake process that designates the treatment model and what to expect. She addressed Ms. Baptista and stated that this is a paradigm shift in terms of what constitutes professionalism in those different settings. She likes the suggestion of having a public mental health representative in the practicum. Her own experience in a community mental health center when taking in students was that there were contracts and a formal relationship between the schools and the agency. But that was usually the end of it, there was a disconnect. She did not get visits from the schools to see how the students were doing, and maybe they could find a way to connect such as through the regional collaboratives.

Ms. Riemersma stated that she takes several calls every week from interns and trainees working in the public sector, and they very often say the director of their agency expects them to share confidential information, but they are concerned because their relationship is with the client. That is one tiny piece that needs to be conveyed early on, that when you work for an agency, the client is a client of that agency, and information is shared with virtually everybody in the agency.

Ms. Baptista responded that it goes even further than that, that the client actually owns the information, so if they want the therapist to share information, it is really up to them. Mr. Riches stated that it may be a small concept, but it is a concept with huge implications. It speaks to the underlying philosophy that you're not treating the diagnosis, you're treating the person, and that person has connections all over the community. There has been a certain amount of formalism in the traditional private practice model and people tend to reflexively follow the rule of thumb rather than being thoughtful and careful about boundaries and sharing information.

Ms. Baptista responded that it is much more complicated work, where you have to evaluate for each client what is appropriate. Dr. Russ stated that within the agency, the trainee still needs to understand that once you reach outside the agency to talk with

the private psychiatrist who is not a member of the agency that the law requires documentation, releases, etc. so the agency still needs the permission to do that.

Dr. Russ stated that as a therapist, he shares personal information from time to time, which makes him ask himself whether it was about the client, or something else. It does get into difficult areas and we need to help people understand that there are different levels of mistakes, and the group can help monitor that. People who work in isolation don't get that. Ms. Baptista responded that this client population has often been seen in many different therapy settings by the time they qualify for help in the public sector, and traditionally they have been treated in a way in which they are not much included in their treatment. When she does supervision, she advises clinicians not to do anything just because it felt right, they need to be strategic about whatever they do, including self-disclosure. Therapists should do it because they see in some way it will benefit the the client. One of the benefits of hiring consumers in mental health positions is that they can bring that sense of hope and that people can get better, and it is important for them to share some of those experiences. We are really looking at having a relationship with people to the extent that it is possible, as their equal. It is important is that the therapist is comfortable with disclosures, and to know their own personal limits. This therapeutic model is more personal.

Ms. Riemersma responded to Ms. Baptista regarding the use of creativity to resolve issues. She is not sure that this is one of those things that can be taught, but is limited in the education that people get. This may be due to the fear of legal and ethical limitations. People get fearful of doing things that are unusual or outside the norm because they don't feel they have the latitude because things are very structured.

An audience member stated that any good therapist is creative, and although they might not come out of school that way. Once therapists get over the fear that they might make a mistake, people grow in that direction. Dr. Russ stated that this is largely about being creative, but the elements must be learned and practiced a lot and as that happens creativity grows. The board is concerned about the minimum competency to enter the field, to know that the basics are there so that people can grow down the line.

## **VI. Presentation by Rusty Selix of California Council of Community Mental Health Agencies**

Dr. Russ introduced Adrienne Shilton, a Senior Policy Analyst with the California Council of Community Mental Health Agencies (CCMHA), a statewide trade association whose members are the primary providers of mental health and substance abuse services in California. Rusty Selix is their Executive Director, who was a co-author of Proposition 63. This is a follow-up presentation to one that was made to the board a couple of months ago in which he articulated some of the workforce challenges that the member agencies are having. They have been working with CAMFT and AAMFT, and have confirmed that there are plenty of people seeking work, but they don't have the training to be strong candidates. So in response to these challenges, their policy committee initiated a process to obtain information from their members, surveying the skills they need to be a strong candidate for public service.

The purpose of the survey was to list specific competencies and elicit opinions about MFT preparedness. She clarified that Council members are not in a position to recommend specific changes to MFT educational requirements. They received 26 agency responses to their survey, which represents 5,485 employees. Ms. Shilton then reviewed the results of the survey with the audience.

Ms. Shilton introduced Neil Sternberg from Victor Treatment Centers, one of their member agencies, to help articulate how these recommendations could help his and other agencies. Mr. Sternberg stated that his agency is one of the largest nonprofits in the state, serving over 3,000 clients per year in 11 different sites. They employ many MFTs and MFT Interns. He stated that Ms. Baptista already said nearly everything he was prepared to say. The supervisors he employs feel that most professional staff is unprepared for the work for the reasons that Ms. Baptista articulated. Additionally, his agency is having a very difficult time acquiring clinical supervisors. Another issue is that a majority of their staff works well with individuals but have difficulty working with families as a whole. They also have difficulty forming a therapeutic relationship, and have difficulty writing therapeutic plans and progress notes. The state does a lot of auditing, so they have had to get good at documentation, and are spending a tremendous amount of time doing it. If they could hire someone who knows how to do document well, they would be extremely valuable. Dr. Russ asked whether documentation is a skill that could be taught in a classroom. Mr. Sternberg responded that yes, he believes it could be done as there are fairly standard requirements that could be taught. Mr. Riches asked whether his agency provided training that he could share with the Committee. Mr. Sternberg said yes, but it would be great if a number of agencies would get together for that training. Additionally, a manual regarding documentation for the state is being created.

Ms. Riemersma stated that they have been led to believe that each agency requires different types of documentation. Mr. Sternberg responded that he believes that it is fairly consistent from one agency to another.

Mr. Wong asked whether the goal of these notes were for practice or for billing. Mr. Sternberg responded that it is a valuable clinical tool, which then results in good notes for billing. Mr. Wong asked whether the audits are done by auditors or practitioners. Mr. Steinberg responded that most auditors are practitioners. Mr. Sternberg clarified that documentation is a fairly small piece, but he is just giving it as an example of one of the skills that is needed.

Ms. Roye asked Mr. Sternberg to talk about the other challenges that his agency is facing in terms of clinician preparedness. Mr. Sternberg responded that probably one of the largest issues is having the therapist understand the importance of the whole family, to convince therapists that to get the best outcome, the family must be involved. It can be very uncomfortable and anxiety-producing to work with challenging families. It is the hardest part of the work, and most of the therapists would prefer to work with the individual.

Dr. Russ asked whether MFTs have this same problem. Mr. Sternberg responded that if you asked his clinical supervisors, they would say that MSWs are better prepared than MFTs to work with families given the population of severely mentally ill that his agency serves. This is the case with both interns and licensees. Mr. Riches stated that applicants often struggle to get their required 500 hours in providing group or family therapy. Mr. Sternberg stated that there is often a lack of practical experience in this area.

Ms. Riemersma explained that much of the time MFT interns are working in the schools, with kids, but they are not able to provide services to families. This is also the case in private practice. Those opportunities are few and far between. Mr. Sternberg stated that there is a cultural bias that the reason a child is having a problem is

because of the family; therefore therapists want to only treat the child. It is very difficult changing the belief system to the recovery model, bringing everybody together to serve the client. He believes that this happens during training in school, which is frequently based on a medical model for the individual.

Dr. Russ asked the schools to respond. An audience member stated that their curriculum supports working with families, so she was surprised to hear that. Dr. Russ asked whether this represents the experience of the CCMHA. Ms. Shilton responded yes, it does. Dr. Russ asked whether this conversation could be put out to all of their members to get some feedback, as this is pretty powerful, and a big challenge to their identity as family therapists.

An audience member stated that at least 50% of her students are placed in a community mental health setting. It is her experience that many of her students do get some family work, but it is difficult, and a lot of families don't come in. There is a family systems approach even if you are working with an individual.

An audience member asked whether the students are unprepared, or do they just not want to work with families. Mr. Sternberg said that it is not clear. Dr. Russ stated that the family approach is best for issues like substance abuse and sexual abuse.

Ms. Baptista stated that public mental health clients can have incredibly complicated presentations. She guessed that when people get their experience, unless they work with that population, they aren't getting that experience of working with really disabled families. That is probably the main factor, that they don't have that experience, and these families probably way more complicated than an intern would be given anyway.

Ms. DiGiorgio stated she is hearing that there is a huge disconnect. Students are getting the education, but they are not getting the experience in family systems. Dr. Russ stated there may possibly be a bigger disconnect, where the schools are thinking they are providing the right education, and the students leave feeling that they didn't get it. Ms. Riemersma stated that people can only learn something if they have the chance to apply it.

An audience member stated that we are asking people to work with severely dysfunctional and mentally ill people, and if people are saying they aren't ready for it, they are probably right. This information has to be learned in both the classroom and out in the field. They are being trained how to approach families in the school setting, but there is no mentorship in the practicum, so people are unprepared.

Dr. Loewy stated that people are trained in family or systems therapy, and when you work with adult populations in those settings, there are often no families. We need to learn to deal with the larger scope and train people to work with the whole system.

Mr. Wong stated that he is bothered by what looks like pathologizing of families, if you approach families no matter what is going on with them using the recovery model, it is not impossible or hopeless, families can be brought back into some semblance of recovery, but there has to be the right approach.

Mr. Riches stated he feels there is a mentorship gap. The toolbox is being provided, but there is not an infrastructure out there to learn from someone who is experienced performing the therapy.

Mr. Sternberg stated that their clinical supervisors in general frequently express that MSWs are better prepared than the MFTs. He doesn't know what the differences are in the curriculum and has no evidence to support it, but that is the feedback they are getting. Mr. Sternberg admitted that agencies are part of the problem, they don't have a mentorship program and don't provide enough training. It is not an easy problem to solve.

Ms. Riemersma asked the MSWs are getting in school that helps them to be better prepared. An audience member stated that they get case management and resources. Ms. Riemersma clarified that she meant related to family therapy. Mr. Sternberg explained that if you are doing a lot of case management, you are bringing a lot of people together, so that may be a component. Mr. Riches clarified that what he is hearing in the discussion is the mindset exhibited on the part of the interns - the acquisition of some of those skills affects how you think about problems.

Dr. Russ stated there would be two more of meetings of the Committee, so he asked the community to discuss this, possibly through the Internet and professional newsletters, and ask people to respond because it is a big issue. He thanked the presenters and complimented them on the report, and expressed his hope that the schools would make use of this important information.

## **VII. Discussion of Draft Revisions to Curriculum Statutes**

Dr. Russ stated that the draft represents the progression of the thinking by the Committee, and puts it out to the public in a concrete way. He emphasized that it is a concept draft which reflects feedback from conversations during these meetings that will eventually result in legislation at the end of the process. Dr. Russ and Mr. Riches pointed out the changes since the last concept draft.

Ms. Riemersma suggested that if terms like recovery and resilience are going to be included, maybe a brief definition of those terms should be included. She also suggested there be an emphasis on severe mental illness because a lot of schools believe that MFTs cannot treat severe mental illness. She also suggested adding to systems of care "for the severely mentally ill."

Mr. Riches asked whether the draft is getting closer to what should be captured in terms of involving consumers in MFT education. Dr. Russ suggested adding their experience in the treatment of mental illness, or in the systems of mental health, as opposed to just their experience of mental illness.

Dr. Loewy stated her belief that bringing consumers or agency staff in as teachers and instructors would enrich the educational experience in relation to public mental health. An audience member stated that she would add family members to that also. Another audience member stated that they bring in family members to their agency to give talks, and that can be very powerful. Dr. Russ stated that the other side of it is the impact that severe mental illness has on the family, even at lower levels such as severe ADHD. We have to understand the reciprocal quality that illness has on families and communities including isolation and humiliation.

Mr. Wong stated that he sees that recovery is included in the concept draft, but does not see that methods and service delivery using the recovery model have been included.

Dr. Russ stated that we have to add specific coursework in documentation of diagnosis, planning and progress, and that the progress will be measured in certain ways, so that it really is clear. This will eventually translate into the board sending out inquiries to schools regarding where and how these are taught within the curriculum.

Mr. Riches stated that there are several implicit bargains in this draft. We have heard and are respectful of the fact that an enormous amount of material is being taught within the required 48 units, and a great many are no longer 48 unit programs, so we respect that schools will have to be teaching a lot of new content. There is an enormous amount of flexibility being given in this draft. There are virtually no specific unit or hour requirements. Its basically for the schools to figure out, which will create difficulties with specific organizations who have worked to require specific content with a specific number of units. If schools want this flexibility, they need to be prepared to fight for it with us.

Ms. Riemersma asked what has not been included in the draft from current law. Mr. Riches stated that none of the content requirements have been removed, except for specific unit requirements. An educator remarked that this seems very sensible.

Ms. Riemersma stated as an example, that it was a particular legislator's interest that a specific number of hours in aging and long-term care be required, and she asked if we expect to run into any difficulty. Mr. Riches responded yes, that is what he was referring to, and that we are prepared to go there, but people need to stand together with us if it is going to work. Ms. Riemersma responded that she likes the flexibility and believes it should be less objectionable to some of the schools because it gives the educators discretion.

Dr. Russ stated this also goes along with the direction of AAMFT in looking at schools as competent in terms of competency issues for accreditation. Dr. Loewy responded that schools are designing curriculum in relation to competencies, and the MFT licensing examination backs that up. People will be getting what they need because they will need to pass the test. It seems a much more respectful way to set this up.

Mr. Riches asked if we need to look at adding units and in the past people have said no, but given that we are adding new competencies in public mental health, these could be offered as an extension program, not necessarily as credit level courses. An educator responded that she would like to require everything. Another educator stated that it would be easier on students who are getting financial aid to require everything. Another educator stated it would make more sense to require it so that it could be integrated into courses, which makes it more meaningful instead of learning things here and there. An educator from Sonoma State asked that extension courses remain an option because budgetary limitations to hire faculty are so severe, and they may not have the faculty available to teach it in-house.

Dr. Russ said he is hearing that 48 units may not be enough to cover everything, so should units be added or do require the topic but not the units. And if we do it that way, does it diminish accountability.

An educator stated that if something is required in their degree program, it sets a tone for the philosophy of their curriculum. If we don't include it as part of the program, students won't understand it as a shift in the philosophy of treatment.

Ms. DiGiorgio asked if some of the proposed new content could be integrated into existing coursework. Several audience members responded that it would be a challenge.

Dr. Russ stated that he is hearing that this draft really is covering largely what the curriculum needs to cover, and that some people feel it is clear that this additional content cannot be covered in 48 units, or within the existing units for their program.

Dr. Benjamin Caldwell responded that Alliant already has a 50-unit program, and he would rather see the content be required as part of the program because it is a fundamental shift taking place. It is a struggle any time they think about adding units because graduate school is expensive, each unit costs \$900, so it becomes an access issue as more units are added.

Dr. Russ stated that we are in the process of trying to figure out how to get people from a variety of cultures to pursue this as a career and now we are talking about increasing the cost of programs.

Mr. Wong stated that it sounds like there is a need to increase the number of units because material would be added. Mr. Riemersma asked Mr. Wong how many units are required for social work programs. Mr. Wong responded that 60 units are required. Ms. Riemersma stated that this is interesting because social work schools are attracting a more diverse student body even with the higher number of units. Dr. Russ stated that the licensed professional counselor proponents that they would require 60 units after several years.

Mr. Riches stated that it is hard to envision not needing to add material, and that discussion is done, we are adding significant material. He stated that there are three choices. The first option is to add content up front as part of the degree program within existing units. The second, in response to state schools who have a tough time changing content, is an alternative delivery mechanism. The third option is to rebalance the existing curriculum by adding some content and taking some away, which would be difficult.

Dr. Russ stated that he has reviewed the content requirements many times and cannot find anything that can or should be removed.

An audience member stated that when you have a program that is already at 60 units, which is the maximum the system will allow, it will have to be rebalanced.

Dr. Russ encouraged people to tell other faculty about the proposed changes and where they stand, and that it will affect the students, the teaching, and the schools. He asked them to have discussions, because it is very important that people be aware and on board with the changes.

### **VIII. Future Meeting Dates**

The following dates were suggested for future meetings:

Friday, June 15, 2007 in Sacramento;

Friday, September 28, 2007 with the location to be announced.

## **XI. Suggestions for Future Agenda Items**

Ms. Shilton requested a follow-up regarding the school's response to CCMHA's survey. Dr. Russ stated there is a listserv where this could be put out and the responses would be forwarded. Ms. Riemersma stated that CAMFT has a listserv for the schools and it is not being used, so it is ready to go if needed. Additionally, several of the consortia have already been given the survey's results.

The meeting was adjourned at approximately 12:38 p.m.