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Abstract

The turn of the century saw a shift from input-based to outcome-based education in Marriage and Family Therapy (MFT) training. An attempt was also made to establish core competencies that practitioners of MFT should attain to provide effective client care. These developments had a significant impact on version 11.0 and 12.0 of the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) Accreditation Standards. Since then, MFT educators have used these standards and guidelines to transition their programs from input-based to competency-based education. The MFT program at a West Coast University was the first COAMFTE accredited program to propose an alternative competency model requiring the completion of 300 direct client contact hours instead of 500 hours for all students in the program, when it went through the process of reaccreditation in 2019. The program was granted renewal of accreditation in May 2020. Since then, version 12.5 of the COAMFTE Accreditation Standards have been released and this University's competency model is aligned with these new standards. This article provides an overview of the competency model used by the MFT program at this University which can serve as an example for other MFT programs. Trends and future directions in competency-based MFT education are also discussed.

Keywords: Competency model, MFT education, Core competencies

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Introduction

Over the last few decades there has been a shift in Marriage and Family Therapy (MFT) education and training. This shift has had educational and training institutions move from input-based education to outcome-based education (Nelson & Smock, 2005; Nelson et al., 2007). The profession has also worked to establish core competencies that practitioners of MFT should attain to provide effective client care in a responsible manner (Nelson et al., 2007). In 2003, a task force was convened by the American Association for Marriage and Family Therapy (AAMFT), to develop Marriage and Family Therapy Core Competencies (MFT-CC). Core competencies for MFTs are defined as "a collection of the basic or minimum skills that each practitioner should possess in order to provide safe and effective care" (Graves, 2005, as cited in Nelson et al., 2007, p. 419). The task force was charged to develop an outline and overview of domains of knowledge and skills that define the entry-level skills necessary for the independent practice as an MFT (Nelson et al., 2007). During this process six domains and five subdomains were identified. The six domains include Admission to Treatment; Clinical Assessment and Diagnosis; Treatment Planning and Case Management; Therapeutic Interventions; Legal Issues, Ethics, and Standards; and Research and Program Evaluation (Nelson et al., 2007). The subdomains identified for each domain are Conceptual Skills, Perceptual Skills, Executive Skills, Evaluative Skills, and Professional Skills (Nelson & Johnson, 1999). The result was a list of 128 core competencies that fell within the six domain categories.

Once the MFT-CC were developed, they needed to be implemented in the curriculum of MFT programs. The AAMFT, supported the implementation of the MFT-CC by creating the Beta Test Group (BTG) (Nelson et al., 2007; Northey & Gehart, 2019). The BTG consisted of eight MFT programs, most of which were accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). The members of the BTG were provided with resources (e.g., two meetings per year, consultations, opportunities to share curricula and assessment instruments) to implement the core competencies (Nelson et al., 2007). The BTG worked closely with AAMFT to address any concerns with the domains and to assist with the further refinement of the core competencies through implementation and assessment (Chenail, 2009). Eventually, the BTG offered MFT educators, resources for transitioning to competency-based education without necessarily offering a systematic plan to do so (Northey & Gehart, 2019).

Since a significant number of core competencies were expected to be attained after graduation from a COAMFTE accredited program, the identification of the core competencies led to significant changes in COAMFTE Standards of Accreditation Version 11.0 (Commission on Accreditation for Marriage and Family Therapy Education, 2005). The new standards reflected this shift to outcome-based education and emphasized the acquisition of the MFT-CC. The standards offered greater flexibility in how they were used to educate students. The individual programs were offered freedom in how they taught different competencies and evaluated the achievement of student learning outcomes (Commission on Accreditation for Marriage and Family Therapy Education, 2005). Miller, Todahl & Platt (2010) refer to Berttalanffy's concept of equifinality in the context of competency standards. They espouse the belief that establishing competency standards should leave room for many different paths

possible to achieve competence. Therefore, "a 'one-size-fits-all' orientation to competent clinical practice must be resisted" (Miller et al., 2010, p. 63). In COAMFTE Standards of Accreditation Version 10.3, educational programs were required to provide their students with 500 client contact hours as part of the Standard Curriculum. It was assumed that 500 client contact hours would sufficiently prepare clinicians who had completed their degree program to enter the profession. However, these input driven standards did not require programs to demonstrate that their students had achieved a level of competence before graduation. In contrast, COAMFTE Standards of Accreditation Version 11.0 shifted from looking at what was taught to what was learned. Instead of focusing on the completion of 500 client contact hours or a certain amount of coursework, the focus shifted to programs demonstrating that students graduating from the program had acquired knowledge and skills to practice competently as an MFT (Gehart, 2011). Programs were required to clearly define a set of competencies to measure student learning, that included the identification of Professional MFT Principles (PMFTPs). Most programs chose to include the AAMFT Core Competencies as part of the PMFTPs even though it was not a requirement. With the publication of the COAMFTE Standards of Accreditation Version 12.0 (Commission on Accreditation for Marriage and Family Therapy Education, 2017), the standards continued to follow an outcome-based education philosophy. However, to ensure excellence in programs, accreditation required an adherence to a combination of input-based and output-based standards. The standards state that, "Input-based standards provide consistency across programs, contribute to a common understanding of minimum standards with accredited programs, and facilitate portability of education for licensure. This approach is all done within a broader focus on outcomes that establishes the effectiveness of the programs" (Commission on Accreditation for Marriage and Family Therapy Education, 2017, p. 5).

In response to this shift in focus to outcome-based education in the COAMFTE Accreditation Standards Versions 11.0 and 12.0, the MFT program at this University developed a competency model demonstrating that students achieve competency after completing 300 client contact hours, of which, 40% (120 hours) must be relational. Currently there is no evidence in the literature to suggest that 500 or 300 client contact hours would assist students in achieving clinical competency. We chose 300 client contact hours since this would help our students meet the requirement for pre-graduation hours in two-thirds of the U.S. states. In addition, it has not been demonstrated that additional hours beyond 300 client contact hours would lead to greater competence. This competency model was presented to the COAMFTE when the MFT program at this University went through the process of reaccreditation in 2019. The program was granted renewal of accreditation in May 2020. Since then, the COAMFTE Accreditation Standards Version 12.5 has been published (Commission on Accreditation for Marriage and Family Therapy Education, 2020) and the required number of direct client contact hours has been reduced from 500 to 300. COAMFTE has given programs greater flexibility and freedom to determine the number of direct client contact hours required to achieve competency. Whether programs continue to require 500 direct client contact hours, reduce them to 300 or require a number between 500 and 300 may depend on many factors. The option of a university-based clinic with on-site supervisors who can closely monitor the supervisees, sharpen their clinical skills, and provide frequent live observation may lead to a steeper slope for development. On the other hand, supervisees placed at different sites with off-site supervisors may have a slower progression in competence, depending on their ability to provide this level of oversight. In addition, students starting to see clients at a later stage in the program (second year or later) after they have completed more of their coursework may be better prepared to see clients and may

require fewer direct client contact hours to achieve the same level of competence. The requirement of 500 direct client contact hours may also delay the students' ability to graduate on time, if clinical sites cannot meet these requirements. The reduction in hours may provide the option of timely graduation without necessarily compromising on the rigor of the training by focusing on competencies and evaluating outcomes.

The MFT program at this University was the first COAMFTE-accredited MFT program to have proposed an alternative competency model requiring the completion of 300 direct client contact hours instead of 500 hours for all students in the program. This article will describe the competency model proposed by the MFT program at this University.

Miller's Pyramid

This University's MFT program's competency model is based on Miller's pyramid (Miller, 1990). Miller (1990) outlines a model for the assessment of clinical competency in medical students. This model is easily translated to the assessment of clinical competency of students in mental health professions. As illustrated in Fig 1 Miller's pyramid of clinical competence, Miller's pyramid divides the development of clinical competence into four hierarchical processes. At the bottom of the pyramid is "knows". At this level, knowledge is assessed using written examinations, written assignments, and traditional multiple-choice questions. The next step in the pyramid is "knows how". At this step, the student can demonstrate the "application of knowledge" (Witheridge, Ferns & Scott-Smith, 2019). The student must demonstrate the ability to assess a clinical situation, analyze and interpret the information obtained during the assessment, formulate a diagnosis, and create a treatment plan to manage the clinical situation. The third step of the pyramid is "shows how". At this step, the student's performance is assessed in a simulated setting such as a role play. Finally, the top of

the pyramid is "does". At this step, the student's clinical performance is assessed through direct observation in a real clinical setting.

Fig. 1 Miller's pyramid of clinical competence

A parallel can be seen between Miller's pyramid and the themes in the pathway towards competency identified by Miller et al. (2010). Miller et al. (2010) reviewed competency literature from different disciplines and identified common training steps towards competency. Miller et al. (2010) identified that the first step is didactic, wherein the students are expected to acquire knowledge and learn the basic concepts relevant to their field. The second step involves the evaluation of the acquisition of knowledge. This may be through examinations in different courses and also a comprehensive examination aimed at assessing the level of overall retention (Miller et al., 2010). The third step is the application of knowledge in their professional field. For MFTs this would be working as a trainee in a clinical setting. Miller et al. (2010) identify the fourth step which is concurrent with the third step and involves a period of supervision by a clinical supervisor. The supervisor is able to observe the trainee and provide evaluation and feedback. The final step involves a capstone event where the trainee is able to demonstrate a level of professional competence. Miller et al. (2010) found that these steps are driven by the competencies that have been identified by the discipline's professional organization.

MFT Program's Competency Model

Competence refers to an individual's capability and demonstrated ability to understand and perform certain tasks in an appropriate and effective manner consistent with the expectations for a person qualified by education and training in a particular profession or

specialty thereof (Kaslow, 2004, p. 775). Professional competence is "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2000, p. 227). This definition goes beyond the demonstration of skill-based competence (i.e., knows how) to performance-based competence (i.e., does). From this perspective, competence is a dynamic construct which is developmental in nature rather than a static end state that one attains (Falender & Shafranske, 2007). This University's MFT Program's Competency Model also views competence as a dynamic and developmental construct.

Based on Miller's pyramid, competency is measured through acquired knowledge (knows), demonstration of learning (knows how and shows how), and application of learning to practice (does). For the purposes of this model, knowledge is defined as information and skills acquired by a person through didactic and experiential methods of teaching. Demonstration of learning is defined as the ability of students to show what they have learned through didactic and experiential methods of teaching. Application of learning to practice is defined as the ability of students to integrate what they have learned through didactic and experiential methods of teaching into their clinical practice.

It is important to mention the MFT program mission, program goals, student learning outcomes and target/benchmarks (Fig 2) prior to describing how we evaluate the acquisition of knowledge, demonstration of learning and application of learning to practice. With the shift to outcome-based learning, an attempt was made to choose targets that were as close as possible to "real world" skills and knowledge, to measure the achievement of student learning outcomes (Gehart, 2011). The mission statement of the MFT program is "to provide students with the

academic and professional training to become multiculturally competent, ethical and systems-oriented marriage and family therapists who are critical consumers of research in the field".

Fig. 2 MFT program's mission, program goals, student learning outcomes and targets/benchmarks

Evaluation of the Acquisition of Knowledge

Coursework. Students are required to complete 60-credit hours of coursework during their plan of study. The evaluative mechanisms established in each of these courses helps ensure that students are acquiring knowledge needed to be competent MFTs. Since the adoption of COAMFTE Standards of Accreditation Version 11.0, there has been an emphasis on integrating assignments with detailed scoring rubrics into courses. Rubrics help to provide quantifiable and clear descriptions of expectation for student performance at each level (Gehart, 2011).

Comprehensive Examination. As a requirement of graduation, students must pass the Program Comprehensive Examination, which is one of three milestone assessments. The test is based on six core areas of training that are critical for development as an MFT, for licensure with the California Board of Behavioral Sciences and in other states. The examination consists of 150 multiple choice questions - 25 from each area (Assessment, Psychopathology, Theories, Ethics, Crisis and Treatment). Students have four hours to complete the test. A score of 70% is required to pass the examination. Taking the Comprehensive Examination prepares students for the MFT licensure examination.

Evaluation of the Demonstration of Learning

The Clinical Advancement Examination is another one of three program milestone

assessments, which helps to evaluate the demonstration of learning.

Clinical Advancement Examination. During the semester prior to their last year in the program, all students participate in the Clinical Advancement Examination process. Each student is given 20 minutes to study a relational vignette and prepare their responses to a series of six questions. The student meets with a committee of three MFT faculty for up to ninety minutes to answer questions in the following areas: (1) Assessment strategies and measures helpful in formulating a diagnosis and treatment plan; (2) Crisis management issues that need immediate attention; (3) Legal and ethical issues that are present in the case; (4) Diversity considerations present; (5) Diagnostic impressions and additional information that would be helpful in formulating a diagnosis; and (6) Treatment planning based on a specific conceptual framework. It is the committee's responsibility to determine whether students are prepared to formally be permitted to proceed into the practicum phase of the program and start seeing clients. The committee is interested in understanding the thought process underlying what the student says out aloud. The committee asks the student questions related to the process of legal and ethical decision making, implementing diversity considerations, arriving at a preliminary diagnosis, and executing a treatment plan based on their theory of choice. These questions help to assess the "application of knowledge" or the "knows how" step of Miller's pyramid. In addition, the committee may also ask the student to demonstrate how they would assess a suicidal client or assess for child abuse, elder abuse, or domestic violence. During this process, the committee assesses the students' ability to ask their clients important questions to assess their presenting issues. In this process, students have the opportunity to "show how" they would apply their knowledge to clinical practice.

Role play assignments. Role plays conducted as part of course assignments also provide an opportunity to "show how" the students would apply their knowledge to clinical practice. One role play assignment that takes place in the program's Crisis Management course, is focused on the safety planning process, and helps to develop skills related to assessment, intervention and crisis management with clients presenting with suicidal ideation. The students take turns playing the role of therapist, client, and observer. After the simulated session, the therapist is expected to write a case note, the client writes their reflections, and the observer notes the clinical skills demonstrated by the role play therapist. The instructor also provides feedback to the role play therapist. The students have the opportunity to play all three roles three times.

Evaluation of Application of Learning to Practice

The application of learning to practice is evaluated through our practicum classes (MFT 694 Practicum I and MFT 696 Practicum Collaborations) as well as the Capstone Project, which is one of three milestone assessments in the program. The Capstone Project is completed during the final year as part of the MFT 694 Practicum I class.

MFT 694 Practicum I. Students are required to provide therapy to clients at the program's on-site clinic. Our students have completed more of their required coursework before they start seeing clients in the practicum phase of the program, in the last year in the program. As a result, our students demonstrate a strong level of preparedness in their clinical work. During this year, students are enrolled in MFT 694 Practicum I. The on-site clinic serves a diverse population of clients from the community. Exposure to diverse client populations with a wide variety of presenting issues, provides the students with a very rich clinical experience. At least 40% of a student's direct client contact hours (120 hours) are relational in nature, working systemically with couples and families. In addition to this rich clinical experience, students are

very closely supervised by experienced AAMFT Approved Supervisors or AAMFT Approved Supervisor Candidates, who identify with different theoretical orientations including solution-focused, psychodynamic, emotion-focused, intergenerational, and cognitive-behavioral models. The students receive more than fifty hours of live supervision (video supervision, co-therapy with their supervisor or observation from behind a one- way mirror) at the on-site clinic, with state-of-the-art equipment for recording and live supervision. At the on-site clinic, students have a 1:1 student-to-supervisor ratio in individual supervision and 4:1 student-to-supervisor ratio in group supervision. These ratios exceed those of AAMFT (individual 2:1 and group 6:1) and the California Board of Behavioral Sciences (BBS) (group 8:1). Not only are students informally evaluated based on video and live supervision they receive, each semester that students are enrolled in MFT 694 Practicum I, they are also formally evaluated on a live observation session and a case presentation that includes showing of video clips of their work with the client. At the end of each semester, the supervisor also evaluates each supervisee on the Basic Skills Evaluation Device (BSED) (Nelson & Lee, 1999). Receiving a rating of "meets expectations" or higher on the different items on the BSED demonstrates that students are achieving competency as expected for their developmental stage. Tracking the trajectory of ratings on the BSED during their final year in practicum allows the supervisors to track the supervisees' development in clinical competence.

MFT 696 Practicum Collaborations. The students participate in two practicum collaborations during the year. Currently, the students can choose from three practicum collaborations. In one of these collaboration experiences, MFT students work with students and faculty from graduate health science professions and pharmacy students in a clinical program for stroke survivors and their caregivers. In a second collaboration, MFT students, work with

students and faculty from the Physical Therapy department in a clinical program for parents of children with cerebral palsy. The students conduct relational interviews to assess the impact of the stroke on the family system and provide resources as appropriate. Students also gain experience in learning how the effects of a cognitive/physical disability impact the family system. At the third practicum collaboration, the students have the opportunity to run relational therapy groups for middle school and high school students and their parents, many of whom are identified from disadvantaged groups. At the end of each practicum collaboration experience, students are evaluated on their professional, legal, and ethical behavior as well as clinical and communication skills, which provide support and evidence that the students demonstrate overall clinical competence.

Capstone Project. During the final year in the Program, students are required to complete a Capstone Project with a focus on conceptualizing and integrating treatment from a relational/systemic focus. As part of the Capstone Project, students are required to develop a Theory of Change Paper and refine it over the course of more than one year, through in-depth study and feedback received from supervisors during their clinical training. As part of the Capstone Project, students are also expected to complete a Comprehensive Written Case Report and Oral Case Presentation based on a relational client they have been seeing at the on-site clinic. Given that the Capstone Project encompasses both the theoretical and practice components and tracks the developmental trajectory, successful completion demonstrates that the program is accomplishing its mission.

AAMFT Core Competencies as a Firm Foundation

The MFT Program at this University is firmly rooted in the AAMFT Core Competencies, ensuring that our students meet all core competencies through didactic and

clinical training received during their plan of study. Evaluative mechanisms established to assess competence ensure that the students are meeting AAMFT Core Competencies. The courses students are required to complete while enrolled in the program cover all six primary domains of the AAMFT Core Competencies. As mentioned earlier, all students have to pass the Comprehensive Examination in their third year of the program. The Comprehensive Examination assesses the conceptual skills of students in four of the primary domains of the AAMFT Core Competencies including Clinical Assessment and Diagnosis; Treatment Planning and Case Management; Therapeutic Interventions; and Legal Issues, Ethics and Standards.

The Clinical Advancement Examination process assesses the perceptual skills of students. Questions asked cover five of the primary domains of the AAMFT Core Competencies including Admission to Treatment; Clinical Assessment and Diagnosis; Treatment Planning and Case Management; Therapeutic Interventions; and Legal Issues, Ethics and Standards.

The rich clinical experience in different settings allows students to develop perceptual, executive, evaluative and professional skills in five domains of the AAMFT Core Competencies including Admission to Treatment; Clinical Assessment and Diagnosis; Treatment Planning and Case Management; Therapeutic Interventions; and Legal Issues, Ethics and Standards. To help illustrate that specific core competencies in these domains are met, the clients' reactions or responses to interventions are assessed through the on-site clinic's Client Satisfaction Survey, which is administered to clients every semester.

During supervision there is a focus on all domains and subdomains of the AAMFT Core Competencies. Clinical supervisors use the BSED developed by Nelson and Johnson

(1999) to evaluate their supervisees to ensure that they are meeting the AAMFT Core Competencies. The BSED captures many of the AAMFT Core Competencies. If the student obtains a rating of "meets expectation" or above on an item, the student is considered to have achieved the desired competency level in that area for their developmental stage.

As part of the Capstone Project, the Theory of Change Paper assesses the conceptual skills of students on different domains of the AAMFT Core Competencies. The Comprehensive Written Case Report and Oral Case Presentation assess the perceptual, executive, evaluative and professional skills of the students on all the six domains of the AAMFT Core Competencies.

Data Collection

Data collection is a crucial step in the competency model (Gehart, 2011). Systems have been established that require faculty members to submit data for different targets of student learning outcomes. The targets and benchmarks for each of the student learning outcomes are provided in Fig 2. Depending on the target, data are collected either every semester (BSED, Capstone Project and Clinical Advancement Examination), two times during the year (Comprehensive Examination) or on an annual basis (graduation rates, social location paper, research proposal assignment, job placement rate and licensure examination pass rate). Data are tracked over time and are used for program evaluation and improvement. If benchmarks are met, it provides empirical proof for the fact that the program is graduating competent MFT students. If benchmarks are not met, the program has remediation plans in place that are employed to help students reach the required level of competency before graduation. In addition, the program faculty and staff meet to discuss what worked, what did not work and how the model can be

improved. The model is not static, but rather dynamic and ever evolving. Therefore, changes can be made as deemed necessary.

Consistency of Outcomes for all Students

All MFT students go through the evaluative mechanism mentioned in the sections on evaluation of knowledge, evaluation of demonstration of learning and evaluation of application of learning to practice. All students must either pass the evaluation (if there is a pass/fail element) or must meet expectations on the evaluation, to be able to graduate. The MFT Program has remediation plans in situations where students do not complete the requirements of the clinical competency model.

Remediation plan for Comprehensive Exam. In case a student fails the Comprehensive Examination, the student is provided feedback, from the Department Chair and Program Manager, based on their performance in different sections. In addition, an individualized remediation plan is created for the student to better equip them to pass the examination. The student can take the Comprehensive Examination up to two times before they are dismissed from the program.

Remediation plan for the Clinical Advancement Examination. Students can either "pass", be considered "deficient" or "fail" on each domain of the Clinical Advancement Examination. If the student gets a rating of "deficient" on any domain, they may pass with either "recommendations" or "stipulations". If the student receives "stipulations" the student is required to show proof of having completed outlined requirements (e.g., write an additional paper, develop assessment questions or a treatment plan for a case vignette provided) before they can start seeing clients in the on-site clinic. If the student "fails" on any one domain, the

student fails the Clinical Advancement Examination. If the student "fails" the Clinical Advancement Examination, the student is required to meet with the Clinic Director of the on-site clinic for mentoring for a minimum of five hours before they can retake the Clinical Advancement Examination. The Clinic Director helps the student practice using case vignettes, fills gaps in knowledge and conducts mock examinations during her meetings with the student.

Remediation plan for the Capstone Project. Students can either "pass," "pass with recommendations," or "fail with stipulations." If students pass with recommendations or fail with stipulations, an individualized remediation plan is created for them, which must be followed for them to graduate.

Clinical hour requirement. If a student fails to complete the 300 clinical hours, 120 relational hours or 50 live observation hours requirement for graduation, the student is required to continue in the MFT Program for additional semester(s) to complete this requirement.

Summary of Competency Model

This model is grounded in the program's mission, program goals and student learning outcomes. Given the requirement to pass the Clinical Advancement Examination and Comprehensive Examination; complete the Capstone Project with a focus on systemic factors; the rich clinical experience gained at a university based clinic that serves a diverse client population, with a wide variety of presenting problems which helps the students to get more than 120 relational hours; interdisciplinary programs and community outreach efforts that are focused on the family; and high quality supervision from AAMFT- approved supervisors with different theoretical orientations and styles, leading up to more than 50 hours of live

supervision, makes for a strong competency model. The fact that the clinical training and evaluative mechanisms used in the program are rooted in the AAMFT Core Competencies and the program meets the pre-graduation licensing requirements of two-thirds of states in the United States, some of which have the most stringent state licensing board requirements, further strengthens the MFT program's competency model.

Discussion

Nelson and Smock (2005) had predicted that with the COAMFTE moving in the direction of outcome-based education, "in addition to demonstrating that a program can provide a structure and context conducive to learning, input-driven standards (a certain number and kind of courses and a certain number of hours of clinical experience supervised in a particular way) will likely fade and serve only as guidelines for teaching strategies. Standards that replace them may require that students be able to articulate an understanding of family therapy concepts and models of therapy, or that they demonstrate certain competencies that are pertinent to the general practice of mental health, and specifically, family therapy" (p. 357). Fifteen years later this MFT Program's competency model, which is in keeping with the current COAMFTE standards, is one example that demonstrates this. The COAMFTE Accreditation Standards Version 12.5 have also seen a change in this direction and the required number of direct client contact hours for graduation have been reduced from 500 to 300. This shift away from the requirement to complete a certain number of hours to demonstrate competency is not limited to the field of family therapy. In the field of counselor education, Akos, Wasik, McDonald, Soler and Lys (2019) propose that the timetable to achieve competency may depend on several factors such as past professional and life experiences, emotional maturity, disposition and personal motivation of the trainee. In support of this

argument, Miller et al. (2010) highlight the importance of the admissions and screening process as a very significant step to achieving competence. The MFT program has a very rigorous admissions and screening process. The program enrolls 18-20 students on average during the fall semester and six to seven students during spring semester. Applicants must have a minimum 3.3 Grade Point Average (GPA), take four undergraduate mental health, research courses (Introduction to Psychology, Developmental Psychology, Abnormal Psychology and Research Methods), demonstrate work or volunteer experience in the field of mental health as well as write a three-page statement of intent, articulating their interest in pursuing a degree in mental health. Applicants who meet these requirements, are invited to an on-campus interview, where they meet individually and in a group context with program faculty/staff and other applicants. A rigorous admissions review is conducted post-interview and candidates are selected to be offered admissions. MFT faculty/staff review the process of admissions after each cycle and discuss ways to maintain rigor. Throughout the time in the program, each cohort of MFT students are monitored to ensure that they meet the program's rigor. If students exhibit any difficulties, the program has mechanisms in place to mentor and advise the student to assist in their growth and development towards competency. For example, the readiness for students to start seeing clients at the on-site clinic is assessed through the Clinical Advancement Examination. If a student fails the examination, indicating a lack of readiness to start seeing clients, the student then receives personal mentoring from the Clinic Director before they can reappear for the examination.

The MFT program's Competency Model follows the themes in the pathway towards competency identified by Miller et al. (2010). The first step which is didactic, corresponds with the stage when students engage in coursework and acquire knowledge. The second step where

students may take an examination to assess overall retention parallels the Comprehensive Examination taken by students at the University. At the third step, students apply academic knowledge in the professional field translating to when students start seeing clients in the University's on-site community clinic. During the fourth step, students receive mentorship and supervision. At the University we are fortunate to have an on-site clinic where all students in the program, receive live and video supervision from AAMFT Approved Supervisors. The final step involves a capstone event where students complete their Capstone Project in their last semester prior to graduation. This further reiterates that the steps that students take in their path towards competency align with the steps found almost universally across disciplines.

Kaslow et al. (2007) provide guiding principles and recommendations for the assessment of competence. They highlight the importance of including both formative and summative assessments in assessing competence. Formative assessments are an ongoing and developmental process of assessing competence and providing feedback for improvement during training and throughout professional development (Kaslow et al., 2007; Roberts et al., 2005). A summative assessment is an endpoint or outcome assessment of a developmental process (Roberts et al., 2005). Formative and summative assessments are often viewed as separate, but in fact they are intertwined. Summative assessments are most effective if there is a formative component (Kaslow et al., 2007). The MFT program utilizes the Capstone Project as a summative assessment, but it starts off as a formative assessment when trainees are in their first semester in the on-site clinic. Over the course of their final year, supervisors provide feedback for improvement on their Theory of Change Paper, Comprehensive Case Report and Oral Case Presentation which constitute the Capstone Project. The students provide previous versions of their papers and evaluations to future supervisors. When evaluating their work, the

supervisor also assesses whether the supervisee incorporated the previous supervisors' feedback in their revisions. This helps to provide continuity in this assessment. The scores of students on these three components of the Capstone Project are tracked during their final year. In addition, the BSED also acts as a formative and summative assessment. Each supervisor over the course of four semesters evaluates the trainees on the BSED and continues to provide feedback for improvement. The progress over four semesters is tracked, culminating in the final BSED evaluation just prior to graduation. However, it is important to keep in mind that the BSED has certain limitations. The items on the BSED are not behaviorally and quantitatively defined (Nelson & Johnson, 1999). This increases the subjectivity in ratings by different supervisors, wherein, the same student at the same level of development may be rated differently by different supervisors. In addition, several skills are included together within each description of core dimensions which makes it difficult for supervisors to rate single skills as deficiencies (Perosa &Perosa, 2010). It can be challenging to show improvement over time using the BSED. One can show that the student met expectations at each time point, but the only thing that changes is the developmental and experience level. More research needs to be conducted to evaluate the BSED's value in evaluating students across time, across supervisors and across programs.

Leigh et al. (2007) identified four different categories in which assessment models used in health care professions can be grouped. These include (a) measures of knowledge, (b) measures of professional decision making, (c) measures of practice performance including professional attributes and, (d) integrated assessments of practice-based skills and tasks. The competency model in the MFT program incorporates all these assessment categories. Measures of knowledge include multiple-choice, essay and short answer questions which are included in

the University's individual course assessments as well as the Comprehensive Examination. Case-based oral examinations are used as a measure of professional decision making (Leigh et al., 2007). The Clinical Advancement Examination at the University is an example of a case-based oral examination. Assessments of performance during training are conducted on multiple occasions over time and help monitor and provide feedback to the supervisee. These assessments can be in the form of global rating scales and 360-degree evaluations. 360-degree evaluations involve receiving input from multiple raters such as different supervisors, clients, and self (Rodgers & Manifold, 2002). At the University's MFT program, supervisors evaluate their supervisees using the BSED at the end of each semester at the on-site clinic. The supervisees may have been evaluated by up to four different supervisors at the end of their year at the clinic. The supervisees are also evaluated by their clients at the end of every semester. These evaluations provide the supervisees feedback from multiple perspectives over time, which significantly helps with developing greater competence. In the future, it would also be helpful to have the supervisees evaluate themselves at the end of each semester and discuss their scores with their supervisor. Comparing their self-evaluation with the supervisor's evaluation and processing the discrepancies would be beneficial as they work to increase their level of competence. Integrated assessments of practice-based skills and tasks involve the use of clinical case situations and can include role-plays. Medical schools use Objective Structured Clinical Examinations (OSCEs) and Standardized Patients (SPs) for both formative and summative assessment of practice-based skills in medical students (Harden & Gleeson, 1979; Newble, 2004). OSCEs and SPs have been adapted for assessment of clinical competency in the field of MFT (Hodgson, Lamson & Feldhousen, 2007; Miller, 2010). Perosa and Perosa (2010) have provided a summary and critique of measures of trainee clinical skills used in

family therapy role-play simulations and sessions with clients. Roberts, Borden, Christiansen & Lopez (2005) suggest that in the mental health field, even though we have mechanisms to assess knowledge, there is a need to improve the methodology for the assessment of skills. As a profession it is important for us to continue to focus on mechanisms that will better assess clinical competency at the "shows how" level of Miller's pyramid. Experts in the field also agree that the assessment of competence should consider the developmental and incremental increase in the level of competence (Kaslow et al., 2007; Roberts et al., 2005). Different expectations for competence exist as a trainee develops. Therefore, different criterion levels are expected for the same competency at different developmental levels (Roberts et al., 2005). This corresponds with the approach used by Nelson and Lee (1999) as they developed the BSED. Nelson and Lee (1999) state that the scale be used at the experience level of the trainee. Therefore, the rating of "meets expectation" assigned to a trainee means in the supervisor's "experience compared with other trainees with this level of experience and training" (p. 23). They identify three developmental levels which include beginner, intermediate and advanced. In addition, it has also been noted in the literature that variation exists in the knowledge and skills of supervisees (Watkins, 2012). Supervision is likely to be most effective when individual differences are acknowledged, and supervision is tailored to the developmental needs of the supervisee. It is therefore important to meet supervisees where they are at (Watkins, 2012). The supervision model used in the MFT Program aligns with what has been suggested in the literature to be effective. The supervisors evaluate supervisees using the BESD at the end of each of the four semesters the supervisees are in the clinic. Since supervisees see clients in an on-site clinic, the supervisors can provide live as well as video supervision and are more easily able to track the developmental trajectory of supervisees. Also, since individual

supervision is provided in a setting where the supervisor meets with each supervisee individually, the supervisor is more easily able to tailor the supervision to the developmental needs of the supervisee. This may not be as easily possible if the supervisor met two supervisees together for individual supervision.

Roberts et al. (2005) raise an important consideration when assessing competence. The authors consider certain skills to be essential for achieving competence. They believe that if a student gets a low score on one of the essential skills, they should not be able to compensate with a high score on another skill domain. Therefore, if the student gets a high score on one domain, but does not pass another domain, the student should not pass the overall assessment. This applies to students who take the Clinical Advancement Examination in the MFT program at the University. If a student fails any one of the six domains, the student fails the Clinical Advancement Examination and is required to retake it.

Kaslow et al. (2007) also point out that when competence problems are identified through assessment, it is important to have strategies in place for their remediation and management. The MFT program competency model clearly outlines the remediation plan to be implemented if a student shows problems with competence when assessed through the Clinical Advancement Examination, Comprehensive Examination or the Capstone Project.

As the field shifted to outcome-based education, Nelson and Smock (2005) recommended that family therapy students must learn to collaborate with other systems and professionals that impact their clients' lives. The MFT students at this University receive this opportunity through participation in interdisciplinary programs during practicum collaborations.

The importance of the assessment of cultural competence has been highlighted by many authors (Kaslow et al., 2007; Roberts et al., 2005). Two of the milestone assessments (Clinical Advancement Examination and Capstone Project) in the MFT program have diversity components. Diversity related elements are infused in the questions of the third milestone assessment, the Comprehensive Examination.

With the passing of its alternative competency model requiring the completion of 300 direct client contact hours instead of 500 hours and renewal of accreditation, the MFT program at this University is paving the way for other MFT programs currently accredited or seeking future accreditation. It also provides the opportunity for programs to assess student competency and provides a model amidst changes in the field of MFT education, training and accreditation such as the publication of the COAMFTE Accreditation Standards Version 12.5.

Future Directions

In December 2020 COAMFTE published Accreditation Standards Version 12.5 which will go into effect in January 2022. There are several revisions that have been included that could significantly impact the path programs take towards demonstrating competency. These revisions give programs greater flexibility and freedom to determine the number of required direct client contact hours and how they choose to define competency. It is important that programs continue to maintain the same rigor as gatekeepers and ensure that graduates entering the field can practice as competent marriage and family therapists. With this added freedom there is also a need to get some agreement across states and programs on how to define and achieve competency. Currently there is a lack of research comparing competency resulting from the completion of 300 versus 500 direct client contact hours. It is important for future

studies to focus on comparing students' competencies based on different numbers of direct client contact hours.

A recent attempt has also been made to condense the AAMFT Core Competencies (Northey & Gehart, 2019). The authors suggest that, "the goal was not to substantially change the original 128, but to reorganize them in a way that would make them more usable to academic programs, supervisors and regulatory boards" (p.42). Northey and Gehart (2019) have condensed the current competencies down to 16 which makes them more manageable and measurable. The authors state that, "based on our consultation with COAMFTE, these 16 Condensed Core Competencies can be used as part of the accreditation process if the correlation to the original 128 competencies can be provided" (p.49). This article proposes a model for further condensing competencies that COAMFTE and MFT programs may consider for the future.

The turn of the century saw a shift from input-based to outcome-based education in MFT training. An attempt was also made to establish core competencies that practitioners of MFT should attain to provide effective client care. These developments had a significant impact on versions 11.0 and 12.0 of the COAMFTE Accreditation Standards. Since then, MFT educators have used these standards and guidelines to transition their programs to competency-based education and have had flexibility in carving out their path. The MFT program at this University was the first program to propose an alternative competency model requiring the completion of 300 direct client contact hours instead of 500 hours for all its graduating students when it went through the process of reaccreditation in 2019. The program was granted renewal of accreditation in May 2020. This article provides an overview of the competency model used by the MFT program at this University and can serve as an example for other MFT programs.

Competency-based education is continuing to gain momentum and there is no competing alternative on the horizon (Northey & Gehart, 2019). The new COAMFTE Accreditation Standards Version 12.5, the attempt to offer a condensed set of MFT core competencies (Northey & Gehart, 2019) and the constant need to develop more innovative ways to assess clinical skills and address the needs of the profession will continue to impact MFT educators as they strive to develop dynamic competency models.

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Figure 1

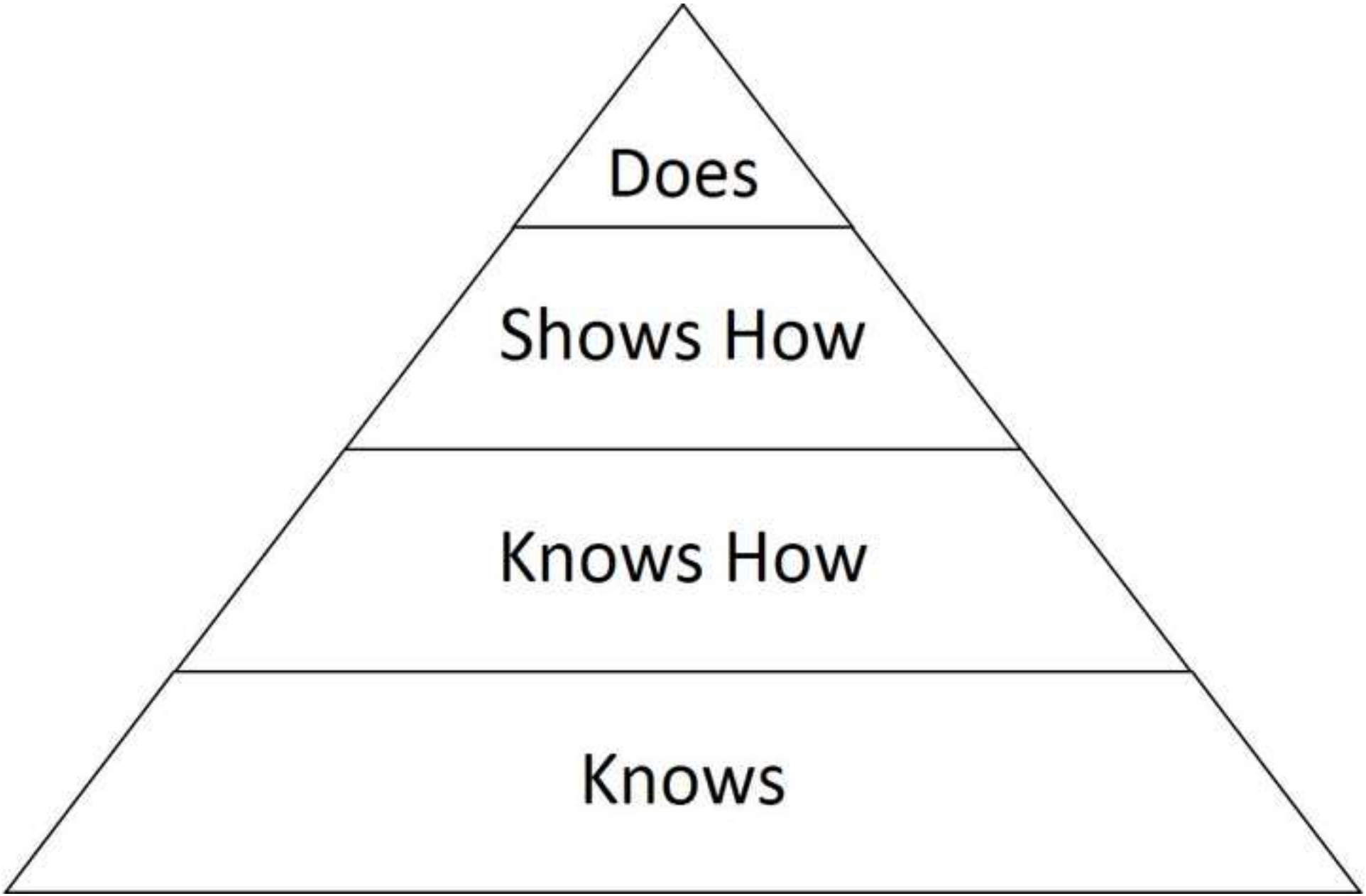

Figure 2

MISSION, GOALS AND OUTCOMES

The mission of Chapman University is to provide personalized education of distinction that leads to inquiring, ethical, and productive lives as global citizens.

The mission of the Marriage and Family Therapy Program is to provide students with the academic and professional training to become multiculturally competent, ethical and systems-oriented marriage and family therapists who are critical consumers of research in the field.

Program Goal 1
Teach a comprehensive curriculum emphasizing relational/systemic theories and techniques

SLO #1: Students will demonstrate knowledge of family systems theories by incorporating theory and technique when working with different treatment units.
Target/Benchmarks:
1) 80% of students will meet or exceed expectations on the Conceptual Skills section of the Basic Skills Evaluation Device.
2) 80% of students will score "Pass" on the Case Conceptualization/Treatment section of the Clinical Advancement Examination.
3) 80% of students will meet expectations on the Theory of Change portion of the Capstone Project.

Program Goal 2
Train and graduate students who are competent in the relational/systemic practice of marriage and family therapy

SLO #2: Students will graduate from the program within the advertised length of time.
Target/Benchmark:
70% of students will graduate from the program within three years.

SLO #6: Graduates will secure employment in the field of Marriage & Family Therapy.
Target/Benchmark:
70% of graduates will secure employment in the field of Marriage and Family Therapy within one year of graduation.

SLO #7: Graduates will pass MFT Licensing Exams.
Target/Benchmark:
70% of students will pass MFT licensing exams upon first attempt.

SLO #8: Students will be able to assess, hypothesize and intervene from a systemic perspective in their clinical practice.
Target/Benchmark:
80% of students will meet or exceed expectations on the Executives Skills section of the BSED.

Program Goal 3
Promote an environment of inclusion and respect for diversity in all its forms throughout curriculum offerings and clinical training

SLO #3: Students will demonstrate an awareness of and respect for diversity issues and their own social location in relation to their clinical experience.
Target/Benchmarks:
1) 80% of students will meet or exceed expectations on the Perceptual Skills section of the Basic Skills Evaluation Device.
2) 80% of students will meet or exceed expectations on the Social Location Paper in MFT 618 – Diversity Issues in Therapy.
3) 80% of students will score "Pass" in the Multicultural Considerations section of the Clinical Advancement Examination.
4) 80% of students will meet or exceed expectations on the Diversity Considerations section of the Comprehensive Written Case Report for the Capstone Project.

Program Goal 4
Teach students to critically evaluate research in the field and use it to inform and enhance clinical practice

SLO #4: Students will be successful consumers of research by demonstrating an understanding of basic research methods and integrating this knowledge into clinical practice
Target/Benchmarks:
1) 80% of students will get a score of 85% or higher on the "Research Proposal" assignment in the course, MFT 532 - Research and Bibliographic Methods.
2) 80% of students will meet or exceed expectations on the Research Based Interventions section of the Comprehensive Written Case Report for the Capstone Project.

Program Goal 5
Train students to apply MFT professional and ethical standards

SLO #5: Students will be knowledgeable of and successfully apply appropriate legal and ethical guidelines necessary for the competent practice of marriage and family therapy
Target/Benchmarks:
1) 80% of students will pass the Law/Ethics section of the Clinical Advancement Exam.
2) 80% of students will score at least 70% or higher on the Ethics portion of the MFT Comprehensive Examination.
3) 80% of students will meet or exceed expectations on the Professional Skills section of the Basic Skills Evaluation Device.
4) 80% of students will meet or exceed expectations on the Ethical and Legal Issues section of the Comprehensive Written Case Report for the Capstone Project.