THE OHIO STATE UNIVERSITY COUPLE AND FAMILY THERAPY PROGRAM

POLICIES
AND
PROCEDURES
MANUAL

Couple and Family Therapy Faculty:

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Program Mission:

To train excellent research clinicians for academic and research settings, who have sustainable programs of research in areas that move the CFT and Family Science fields forward.

PART 1: ACADEMIC TRAINING

A. Program Objectives

As part of our accreditation process the program has created educational objectives which consist of program goals, and student learning outcomes.

Program Goals:
1. CFT Students will develop research skills that will enable them to publish in top ranked peer reviewed journals, present at national conferences, and apply for grant funding.
2. CFT Students will solidify a theory of change that enables them to work with many different clients.
3. CFT Students will develop a philosophy of supervision and begin the process of becoming an approved supervisor.
4. Students will be well versed in the Couple and Family Therapy professional organizations and understand the context of the profession.

Student Learning Outcomes:
1. Identify ethical practices in human subjects research in order to conduct research
2. Apply qualitative and quantitative research designs that appropriately reflect research questions and hypotheses.
3. Develop skills in scientific writing for publication.
4. Develop grant proposal writing skills
5. Students will understand processes necessary for engaging diverse families in research.
6. Evaluate and critique current empirical research in Couple and Family Therapy effectiveness.
7. Synthesize conceptual and intervention skills within a solidified theory of change.
8. Know the literature available about diverse families and how diverse families access and engage in treatment.
9. Develop preliminary supervisor skills that focus on trainee’s theory development, intervention, and case management.
10. Present research at Couple and Family Therapy Organization Conferences
11. Participate in state and national level conferences of CFT organizations.

The educational objectives of the program emphasize research training and productivity for students and faculty. It is hoped that by the end of the program the student will have a sustainable program of research. Interspersed
with this major emphasis are also outcomes focused on clinical training. Our goal in this program is to train excellent researchers, excellent clinicians, and excellent beginning supervisors. Thus we are training those who will be training the next generation of family therapy researchers and clinicians.

B. Respect for Diversity Statement

The Ohio State University Couple and Family Therapy Program is committed to the value of all people regardless of race, color, creed, national origin, religion, sex, sexual orientation, age, disability, or Vietnam-era veteran status. We believe that our work as clinicians, researchers, and academicians, and students should reflect this core belief.

The Ohio State University Couple and Family Therapy Program respects and encourages the expression of the diversity of personal values and behaviors. As family therapists, we are aware we will encounter clients, colleagues, and trainees that will have values divergent from our own. We will endeavor to make the program a safe place in which trainees can explore their own values and biases in an effort to make them more aware of how these contribute or detract from their effectiveness as therapists.

As family therapists we are committed to The American Association for Marriage and Family Therapy’s Code of Ethics, in which it is considered unethical to deny family therapy services to anyone based on race, gender, religion, national origin, or sexual orientation. As personal values are explored through-out the program, trainees will be encouraged to confront their ability to uphold this ethical guideline and explore options when their own core beliefs may prevent them from being therapeutic with clients.

Mixed with these issues, however, is our belief that as family therapists, clients, colleagues, and trainees we are responsible for our behaviors and their consequences. Illegal behavior and behavior that endangers others will be dealt with appropriately. Trainees will be held accountable for their behaviors.

C. Admissions Policy

The CFT program requires students to meet the HDFS Program Admission Criteria (found at http://ehe.osu.edu/downloads/human-sciences/graduate/hdfs-graduate-handbook.pdf). To be admitted in to the CFT Ph.D. Program, students must hold a master’s degree. If coming from a masters in MFT program, students submit a research proposal when they are asked to interview with the program. If coming from a nonclinical master’s degree with a thesis, students are asked to conduct a mock therapy session at their interview for the faculty to review.

Above and beyond that, the CFT program requires an admissions interview in which the student meets with all CFT faculty. In this interview students will be asked to discuss their research and clinical interests, and experience and will be evaluated on their interpersonal skills. The CFT program uses a research clinician model. We place equal value on both academic/research experience and potential, and clinical training and experience. Furthermore, the CFT program is small which we hope will allow for an intensive, individual training experience.

D. Course Requirements

Students in this program are expected to meet the general requirements for the Ph.D. in the Human Development and Family Science Program area in Human Sciences as well as the CFT program requirements. The list of courses in each of these categories is presented in Appendix A.
E. Program Administration

The CFT program has two full-time faculty members, Suzanne Bartle-Haring, and Keeley Pratt; and one part-time clinical faculty member, Margaret “Charlie” Knerr. Suzanne Bartle-Haring and Keeley Pratt teach the majority of the couple and family therapy curriculum. All faculty provide supervision to the students in the program. There is a Program Director, Suzanne Bartle-Haring, who oversees the operation of the CFT program. Her job is to serve as a liaison with the Commission on Accreditation For Marriage and Family Therapy Education (COAMFTE), recruit prospective students, coordinate supervision assignments, oversee the evaluation processes within the program (Please see Evaluation Section F for further details).

The Clinical Director is Margaret “Charlie” Knerr. The clinical director oversees the activities of the Ohio State University Couple and Family Therapy Clinic, here on campus in Bevis Hall. She also oversees placement sites, and develops other programming to benefit students and the community.

Practicum Coordinator, Keeley Pratt, manages internship sites for the doctoral internship program and maintains the internship contracts for the program which can include clinical, teaching and research foci.

F. Evaluation

1. Student Evaluation

Since the program aims to produce both excellent researchers and clinicians, students will be evaluated in each area. These areas do not always go together. Some students exhibit excellent academic skills, but do not excel in clinical work. Others have excellent clinical skills and do not excel in academic work. Students’ academic performance will be evaluated throughout their training in the form of grades for course work completed. In addition, students will receive feedback from the CFT faculty at the end of each year concerning their academic progress. Appendix B contains the end of the year report that all students in the HDFS Program Area are required to submit. This includes an evaluation of the courses taken and grades obtained as well as progress on the dissertation project when applicable. If academic progress is not satisfactory students will be notified in writing and asked to meet with the CFT faculty and submit a plan for improved progress. If sufficient progress is not made the following academic year, individuals may be advised out of the CFT program or encouraged to take a leave of absence if extenuating circumstances exist.

Students will also be evaluated on the Student Learning Outcomes annually and receive that evaluation with their end of the year letter from the CFT faculty. This form can be found in Appendix C. The program uses this form to chart individual student progress and also aggregates the information annually by cohort (year of admission to the program) to evaluate the program.

Evaluation of clinical training takes place each semester. Students will also complete a clinical competency exam. Please see Evaluation sections in the Clinical Training part of this document.

2. Program Director Evaluation

The program director will be evaluated annually in May each year. The anonymous program director evaluation is conducted through the Qualtrics Survey System. The evaluation of the program director reflects the program goals and student learning outcomes. Please see Appendix U: Program Director Evaluation.
3. Student Support Services Evaluation

The Ohio State University offers many services to students including the Writing Center, library resources, statistical software, Counseling and Consultation Services, and The Office of Disability Services to name a few. Each year students will be asked to rate the services they have accessed at the university and asked if there are any gaps in the services offered. The CFT program faculty will use this information to make decisions about resources that the program may need to purchase, or seek other avenues for students to get their needs met within reason. If feedback about student services is consistently negative, the CFT Program Director will forward the deidentified feedback to the service so that the particular program will have the information to improve its services.

4. Alumni Evaluation

The program director keeps an ongoing list of OSU CFT alumni contact information that is updated annually each August. The program director is responsible for emailing alumni to inquire about employment, professional achievements (licensure, tenure, approved supervisor status, etc.), and other relevant professional information. The collected information is stored on an excel spreadsheet in the program director’s files (See Appendix U).

The program director will also contact employers of recent graduates at about one year of employment with a short satisfaction survey (See Appendix V). This data will be analyzed in aggregate form only and no names will be collected.

5. Overall Program Evaluation

Since we are accredited by the Commission on Accreditation for Marriage and Family Therapy Education, and the standards for accreditation are “outcome” based, rather than “input” based, we evaluate the program on an ongoing basis. The evaluations that we have listed above are our formal ways of evaluating student progress and overall program effectiveness. We also hope that students, supervisors, and faculty will provide feedback in informal ways. Program faculty will use both the formal feedback and informal feedback to continue to evaluate program effectiveness, make sure that we are reaching our benchmarks, and make changes to the program as needed. We examine aggregated data by cohort from our formal evaluations and our informal feedback annually to make these determinations.

G. Policy on the Disclosure of Personal Information

It should be noted that the CFT faculty meet regularly and discuss students’ clinical and academic progress. From time to time, students will share personal information during supervision or meetings with advisors etc. It is at the discretion of the supervisor or advisor to share that information with other CFT faculty. Students will be informed of this decision before the information is shared. All information shared will be for the good of the student and their progress in the program.

H. Committees and Dissertations

Upon admission to the program students are assigned to a faculty advisor. The selection is based on the faculty’s impression of their research interests. Students are, however, free to choose any member of the HDFS faculty to serve as advisor and/or as committee members. While we encourage students to have a CFT faculty
member serving as advisor, this is not mandatory. CFT students should, however, have a CFT faculty member as a member of their committee. Students are invited and encouraged to speak with all department faculty about their research interests to see if there is a better fit with them than with the assigned advisor. It is suggested that students do this fairly early in the program so that dissertation plans can be well underway before the candidacy examination. Please see the HDFS Graduate Student Handbook that outlines the deadlines for a plan of study submission and committee formation.

Students should inquire about scheduling their candidacy exams with their advisors. Students are advised to be careful about the timing of the candidacy, because there is a time limit for being a Ph.D. candidate (5 years). In addition, CFT students are required to have dissertation topics that are clinically relevant (i.e., outcome research, comparison of treatments, etc.). This requirement is a part of our association with COAMFTE. Students are encouraged to talk with an advisor well ahead of time so that a satisfactory fit between their interests and this requirement are satisfied.

I. Refund Policies

If a student pays fees and withdraws from all classes before the end of the term, or is academically dismissed, they may be required to repay or refund a portion of their aid. To initiate the refund process, students must obtain an OSU withdrawal form from the college office and bring a completed withdrawal form to the Office of University Registrar. The processed withdrawal form will be forwarded to the Office of Fees and Deposits, who will process and update the account to reflect the withdrawal.

Even if the term is not finished, students may still be charged for the portion of the term for which they registered. Consequently, the student account may reflect certain non-refundable charges such as pro-rated general and instructional fees, pro-rated room and board fees, and debits for cash or checks given previously for the credit balance. The Office of Student Financial Aid calculates the available refund according to federal, state and university regulations. This refund is used to repay financial aid programs in the order indicated below:

- Federal Direct Stafford Loan
- Federal Direct PLUS Loan
- Federal Perkins Loan
- Federal Pell Grant
- Federal Supplemental Educational Opportunity Grant (SEOG)
- Other federal, state, private, institutional funds
- Students (only if there is any refund left once all programs have been refunded)

If additional repayments are required, a notice from the Office of Fees and Deposits will be sent. The financial aid programs not refunded are retained in the student’s account and applied to nonrefundable charges. Repayments must be made before any additional financial aid can be provided, any further registration permitted, or any transcripts or their records released. A complete copy of the Refund Policy can be obtained from the Office of Student Financial Aid, or call (614) 292-0300.

J. Student Rights and Responsibilities

Students are subject to the provisions of the Code of Student Conduct, a compilation of rules of conduct and major policies and procedures affecting students. The Code is published by the Office of Student Life and is published annually at (http://studentlife.osu.edu/resources/). If a student believes that his/her rights have been violated or that the University has not responded to their needs they have several means of resolving the
complaint. The University's Office of Human Resources handles complaints of discrimination, and the Office of Student Life can advise students of their rights or help prepare judicial hearings. The Student Advocacy Center listens to, investigates, and seeks to mediate and resolve complaints about academic and administrative policies, practices and decisions.

K. Student Grievance Procedures within the Program

Students have the right to present grievances to CFT faculty and/or supervisors at any time. It is hoped that these grievances can be resolved without further intervention. However, if the student does not believe the issues have been resolved satisfactorily, they can submit their grievance in writing to the CFT Program Director, or the Department Chair if the CFT Program Director is the focus of the grievance. The CFT Faculty will then meet and decide on a course of action. The student will be notified of this decision within 30 days of their initial letter. If the student still feels the grievance has not been addressed satisfactorily, they can submit their grievance to the Department Chair, and then use the regular university channels as described above (Please see Section J) to reach a resolution.

L. Nondiscrimination Policy

The policy of The Ohio State University, both traditionally and currently, is that discrimination against any individual for reasons of race, color, creed, national origin, religion, sex, sexual orientation, age, disability, or Vietnam-era veteran status is specifically prohibited. Accordingly, equal access to employment opportunities, admissions, educational programs, and all other University activities is extended to all persons, and the University promotes equal opportunity through a positive and continuing affirmative action program.

The University's Office of Human Resources, Affirmative Action, 124 Archer House, 2130 Neil Avenue, Columbus, Ohio 43210-1175; (614) 292-4207, is responsible for the coordination of matters relating to equal opportunity and affirmative action.

M. Portability of Degree

Although the degree you receive from The Ohio State University is portable and accepted both in the US and abroad, whether or not you meet the Marriage and Family Therapy license requirements varies by state. Our program curriculum meets the accreditation standards for the Commission on Accreditation for Marriage and Family Therapy Education. The state of Ohio uses those standards for their educational requirements for licensure as well. Other states may require additional coursework, or additional client contact hours and supervision for you to be licensed in that state.

PART II: CLINICAL TRAINING

Clinical training includes both training at the on-campus Couple and Family Therapy Clinic and an internship experience. Each will be described below.

A. Criteria for Eligibility to see Clients in the Clinic

Once a student enters the program, they are placed at the Clinic in the Autumn Semester of the first year in the program. The CFT Clinical Director speaks with the student about his/her clinical experience and readiness to see clients. To ensure that the potential trainee is ready to begin the practicum experience, the following steps are taken: First, students read and review the CFT Program Policies and Procedures Manual to familiarize
him/herself with the goals of training and the requirements of training. This includes a review of the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics (Appendix D). All incoming students meet with the CFT Clinical Director or clinic staff to review the AAMFT Code of Ethics as well as the CFT Policies and Procedures that relate to working in the clinic such as record keeping, client charts, emergency procedures, and confidentiality issues.

Next, students who have a master’s degree from a COAMFTE Accredited program are considered ready to begin seeing clients in the clinic. Those without such a degree must meet individually with the Clinical Director or clinic staff for the semester to review the information provided, and discuss previous clinical experience. These meetings allow the faculty and student to determine the level of supervision required. If a student has little to no clinical experience, they will spend client contact hours behind the mirror observing other clinicians and being an active co-therapist. If a student has many years of clinical experience, but not necessarily family therapy experience, an appropriate training procedure will be put in place with a combination of observation of family work behind the mirror with the supervisor, co-therapy if necessary, and more live-supervision than required. Once these plans are in place, the supervisor will assign cases to students that are appropriate to their level of experience, their supervision needs, and their preferred client constellation.

B. Clinical Experience Requirements:

All students must obtain 1000 hours of direct client contact during their training in the CFT program. Typically, students obtain 500 of these hours at the on-site Couple and Family Therapy clinic and 500 during their internship. If a student has a master’s degree from an accredited CFT program, our program requires that they remain clinically active early in their program. Students with an accredited master’s degree will obtain at least 100 hours of client contact at the on-campus clinic before applying for internship. Students without an accredited master’s degree who have been supervised by an AAMFT approved supervisor may petition the faculty to count some or all of the hours previously accumulated. A letter from the previous supervisor stating the number of hours accrued with individuals, couples and families, and the number of hours of supervision (live, individual, and group) accrued is required. Please understand that just because the program accepts a student’s clinical work towards the 1000 requirement, this does not necessarily mean AAMFT or state licensure boards will also accept these hours. Conversely, the program is not required or obligated to accept clinical work that AAMFT has accepted towards a student’s 1000 hour requirement. Students should see the Program Director to obtain an agreement between him/her and the program concerning acceptance of clinical hours in writing.

Students who do not have a COAMFTE accredited master’s degree also begin their training in the CFT clinic on campus. They must complete at least one full year of work in the clinic and obtain 500 hours of client contact before obtaining an internship placement. Students can obtain an internship placement (30 hours a week) in their third year of training. The internship must meet the same requirements as described below (Please see Internship Section Part II, Section B).

To participate in the clinic, the student must register for 1 to 3 hours of HDFS 8189 (CFT Practicum) per semester. Students who are in their first year of clinical training, who do not have an accredited master’s degree should register for 3 semester hours of 8189 for three consecutive semesters. Students with an accredited master's degree or equivalent should register for 1 to 3 hours of 8189 their first semester depending on their agreed upon case load and number of hours needed.

C. Contact Hours Defined
Client contact hours are those spent in direct face-to-face contact with clients doing therapy. Phone time does not ordinarily count toward the total. Phone time that is primarily therapeutic in nature, for which one might bill the client in private practice, and is documented in the case notes may count. A supervisor must approve all electronic delivery of services other than phone contact before a therapist engages in these distance based services. There are many ethical, legal and technical issues involved in providing therapy other than in person face to face and students must be trained to handle these issues prior to receiving permission to provide electronic delivery of services.

1. Alternative Hours

   It is possible to use time behind the mirror as client contact hours. It is expected that such team work, to be equivalent to client contact time, will be intense and sustained. Team members should be considered co-therapists and not simply observers. This means that co-therapists behind the mirror should be active participants in treatment planning and follow through. Whenever possible, team members should join the case at or near the beginning of therapy and continue to termination or transfer. Up to 100 hours of client contact time may be accumulated through this exception, with the approval of the Clinical Director. Other forms of alternative hours may also be acceptable, please work with the Clinical Director on this issue.

D. Supervision

Students will be assigned a CFT faculty advisor and clinic supervisor upon admission to the program. Faculty advisors direct academic programs. Clinic supervisors are responsible for overseeing clinical work. Clinic supervisors are likely to change throughout the year and it is hoped that each student will have contact with each CFT faculty as a supervisor during the course of training at OSU. Since clinic supervisors may change each semester, information from supervision is shared among the CFT faculty supervisors (Please see Section G of Part I).

Students must receive 1 hour of face-to-face supervision for every 5 hours of face-to-face client contact. All students who work in the clinic will be expected to attend individual and group supervision. Individual supervision is held with no more than two students and one supervisor at a time. Group supervision sessions will consist of one supervisor and no more than 8 clinical students.

Supervision for clinic cases may be group and/or individual. Individual supervision must include at least 50 hours of face-to-face supervision from raw data, with observation behind a one-way mirror, or video.

All cases at the CFT Clinic must be supervised either through case consultation, video review, or live supervision. Practicum supervisors should be kept apprised of all case activity. Supervisors are responsible for signing off on each and every progress note. Remember that this is a training clinic and that accountability rests with the faculty. All concerns related to duty to warn issues such as abuse, violence, ethical or legal concerns, or any other tense or potentially dangerous situations should be discussed with a supervisor. Even when a therapist is sure they are handling a case appropriately, supervisors should be informed.

The practicum supervisor stands ready for consultation and assistance for all questions, including those unrelated to the issues identified above. The philosophy of our Clinic is concern for good therapy and good learning; faculty members are here to make sure we meet this goal. Therapists should never be concerned that questions are too trivial or that the faculty will not think well of the student for wanting to check something out. In this way, we can facilitate the best therapeutic and learning environment, maintain consistency in the way that we handle various situations, and be sure that we are operating legally and ethically. Students should always record supervision hours on the appropriate forms (See Part II, Section e).
1. Supervision Requirements Defined

a. Students must have at least **200** hours of face-to-face supervision to graduate from our accredited program. **50** of those hours must be “raw” data supervision (live or video). Definitions of the different forms of supervision are as follows:
   i. Individual supervision is that which occurs with one or two supervisees. It includes:
   ii. live supervision, when the student is the in-room therapist only, including its pre and post-time;
   iii. a team member when there is only one in-room therapist with a supervisor; and
   iv. supervision with the supervisor with no more than one other student.

b. Group supervision is that which occurs in a group of no more than eight students with one supervisor. Time spent during practicum with a supervisor may count as group time (if there are 8 or fewer students). To count as group time, observation must be active and include interaction with the supervisor. This means that passive observation of other students’ cases is not counted as group supervision. Also, this time can be documented as either clinical contact hours or as individual supervision, not both. Students should talk to their supervisor about active observation.

c. Live supervision is when a therapist conducts a session and is being observed by the supervisor.

d. Video supervision is when video is reviewed during supervision time and the video clip viewed is discussed during that time.

Supervision of clinic cases is to concentrate on live cases or video presentations. Case consultation from notes is to be kept to less than 50 hours of the first 100 hours required. Students should assist the supervisor by having video ready for supervision. Supervision hours are recorded on the Record of Client Contact and Supervision Hours form and (Please see Appendix E) should be given to the clinic staff at the end of each semester. This information is entered into the computer database and reports of accumulated totals will be available on an end of semester basis.

Note that the time spent in the therapy room during live supervision counts as both client contact and supervision time (e.g., 1 hour of therapy plus 15 minutes pre- and 15 minutes post-session counts as 1 hour of client contact time plus 1.5 hours individual live supervision time).

If therapists are being supervised by a senior student in the CFT program, record that time in the “other” supervision category on the form. This supervision can count toward the 1 to 5 ratio needed, but cannot be counted as part of the 200 hours of supervision from Approved Supervisors in the program.

Supervision of students by students: The CFT program encourages students to discuss their cases with other CFT students, however, the Commission on Accreditation regulations do not allow students to count student supervision of therapy toward the supervision hour requirements of the program. However, toward the end of the student’s time in the program he/she will take the Supervision in CFT course and the mentoring process for becoming an Approved Supervisor with AAMFT will commence. In order to fulfill the requirements of the Supervision course and mentoring process, students will be providing supervision to new CFT students in the program and being supervised in this process. Such experiences are helpful to the student being supervised and to the supervising student, broadening repertoires of interventions, building confidence, and giving each party...
an opportunity to learn more about therapy. However, these hours do not count toward the required 200 hours of supervision.

2. Recording of Therapy and Supervision Hours

Students should record supervision received hours on the Record of Client Contact and Supervision Hours form (Please see Appendix E). Accumulated supervision hours broken down by the various categories described in the Supervision Section are recorded each semester. The official reporting of supervision hours to COAMFTE are taken from these forms.

Therapists should record times in decimal (1.5) format. Therapists will receive an updated report of accumulated client contact and supervision hours once each semester. Contact hours should be checked over carefully and errors should be reported to the Program Director as soon as possible. Therapists are responsible for reporting errors themselves. Case notes should be pulled from the client file for documentation when requesting corrections. The original forms submitted to the practicum supervisor will remain on file in the CFT Program Director's Office.

E. Faculty Evaluation of Students

This evaluation consists of a written report form (Please see Appendix F) completed by the supervisor at the end of each semester. At the end of each semester, the supervisor completes a supervisee evaluation form that includes agreed upon goals and progress toward those goals (See Appendix F). The student does a self-evaluation and shares this with the supervisor. The supervisor shares his/her evaluation of the student at this time as well. Then they discuss strengths and areas for growth.

F. Clinical Competency Exam

All students in the program will complete a clinical competency exam. This will include a 10 minute video clip (or combination of clips up to 10 minutes) that illustrate the students philosophy of change, a case presentation, and a theory of change paper. That paper will be distributed to CFT faculty two weeks prior to the scheduled oral presentation. See Appendix G for outlines and requirements for the philosophy of change paper, and elements of the case presentation.

Students who do not have a CFT master’s degree will complete their clinical competency exam after completing their first 500 hours of client contact. Students with a CFT master’s degree will complete their clinical competency exam at the end of their first year in the program. Students will be evaluated on the written portion of the exam as well as the presentation, and the clinical work exhibited in the video. Students will be allowed one retake if they do not pass the first time. The second exam will be formulated by the CFT faculty to highlight the areas of weakness in the first exam (i.e. a second paper may be needed, or another video, and case presentation etc.). If the student does not pass the second exam, they will be advised out of the CFT program and asked to complete their Ph.D. in HDFS without the CFT specialization.

In addition, each year the CFT faculty convenes to complete a more comprehensive evaluation of each student. At that time, because the Ph.D. program in CFT is both a research and clinical degree, and the objectives for the program are to produce and support the growth of excellent research clinicians, students will be evaluated on both. See the evaluation section of the academic program above (Please see Part I, section F).
G. Policy for Remediating Clinical Deficiencies

There are times when therapist-trainees may be deficient in clinical skills. It may be that personal issues arise that would impair a therapist-trainee's ability to provide services to clients. Or it may be that a trainee may lack specific clinical skills (i.e. joining, tracking clients, etc.). In any circumstance in which the CFT faculty believes that a student lacks sufficient skills to provide professional services to clients, remediating procedures will be put into place. These procedures would be specific to the deficiency encountered and remediation plans will be developed on a case by case basis.

If a trainee becomes impaired in any way during clinical training due to personal circumstances, and personal therapy appears warranted, it will be suggested to the trainee that he/she reduce their case load while receiving services, and that all remaining sessions be observed by a supervisor. If both the supervisor and student are satisfied that the student has made progress, observation will return to its normal rate.

H. Co-therapy

COAMFTE regulations allow the CFT Program to count co-therapy for each therapist involved in the session. To have the session count as co-therapy, it is necessary that each therapist be in the room with the client(s) for the majority of the session period. Co-therapy can be especially useful in dealing with couples, families, and groups. Students are encouraged to engage in co-therapy when it is appropriate. To avoid confusion, one therapist must be declared the primary therapist; the other will be the co-therapist. The supervisor who supervises the primary therapist will provide supervision for the case.

It is also possible that the supervisor would suggest co-therapy. When this occurs, the student therapist is considered the primary therapist, and is responsible for the case and all accompanying paper work. When a student does co-therapy with a supervisor, the hour with the client counts as a client contact hour, any time spent discussing the case pre- and post- session counts as individual supervision.

I. Student Evaluation of Faculty:

Just as faculty evaluate students' academic and clinical work, students also have the opportunity to evaluate faculty as instructors and supervisors. At the end of each semester, students are offered an opportunity to evaluate each instructor. This is mandated by the university. In addition, at the end of each semester, students receiving supervision will complete an evaluation of their supervisors (Please see Appendix H). These instruments and evaluations are designed to offer feedback to faculty as they engage in the various roles in the program.

Part III. Couple and Family Therapy Internship Training

A. Criteria for Eligibility to begin Internship

To begin internship, several requirements must first be met:

1) The student must have completed all agreed upon client contact hours at the OSU Couple and Family Therapy Clinic. For those without a COAMFTE accredited master's degree or equivalent, this is 500 hours.
2) In addition to the accumulation of hours, the student must have received a satisfactory evaluation for all semesters in the Clinic and have the recommendation of all faculty supervisors before moving on to an internship placement.

3) The student must have completed the majority of their course work, this must include all but the supervision course within the CFT program. It is recommended that the student be finished with all but the supervision course and have passed their candidacy exams before moving to the internship experience.

4) The student must interview at designated internship sites.

5) Students have the option of participating in a research internship, teaching or a clinical internship or some combination of all.

B. Internship Experience Requirements

All doctoral students must complete 1,000 hours of direct client contact before graduation. In fulfilling the standard curriculum, students will have already completed at least 500 hours. Consequently, students must accumulate additional hours during the remainder of their program of study to total 1,000 hours. These additional hours can be accumulated in any combination between the student’s required clinical work at The Ohio State Couple and Family Therapy Clinic and an internship. The internship is a 30 hour a week experience. If the student opts for a clinical internship it should enable the student to accrue up to 500 hours of client contact and participate in the agency functioning including staff meetings and training opportunities. If the student opts for a research internship they can continue to accrue clinical hours at the Couple and Family Therapy Clinic. An internship agreement letter or contract (See Appendix I) is required for a clinical, teaching and research internship. During the internship, the student receives supervision on a regular basis from an internship supervisor who is clearly senior in experience. Students must hold the internship position for at least 9 consecutive months.

C. Supervision of Internship

During the internship, students must have a clinical supervisor who is actively involved in his/her training and readily available for consultation. Regular supervision sessions are recommended, however, the frequency of supervision is to be negotiated by the student intern and their supervisor. Internship supervisors must be clearly senior in experience to the intern(s) they are supervising. It is preferable that the supervision be provided by an AAMFT Approved Supervisor or the equivalent on-site. If such a person is not available, students must make arrangements for supervision by a program faculty member. In this case, the faculty supervisor would address clinical issues from the internship placement not addressed by the onsite supervisor.

D. Policy for the Transport, Storage, and Transmission of Confidential Media

In the event that a student is supervised by a CFT faculty member for their internship, the student must take precautions about transporting and storing video from the internship site. The video media must be stored in a locked box or briefcase that only the student has access to. This box or case should be in the possession of the student at all times, not left in a vehicle. Once the CFT faculty has viewed the media with the student, it should be immediately returned to the internship site and confidentially stored. No other form of transmission of media will be acceptable (i.e. via the internet).
**E. Evaluation**

In the same way that students are evaluated while working in the CFT clinic on campus, they are also evaluated at the end of their first three months and at the completion of their internship. This evaluation includes, the supervisor's (both onsite and OSU faculty if applicable) evaluation of the student, and the student's evaluation of the supervisor, as well as the internship site itself. (Please see Appendix J). If the student is performing unsatisfactorily at the internship site, the Program Director and the onsite supervisor along with the student will agree upon steps for improvement and the student's work will be monitored closely. If progress is not made the following semester, the Policy for Remediating Clinical Deficiencies will be implemented (Please see Part II, Section G).

**F. Recording Client Contact and Supervision Hours**

Students must record their client contact hours at their internship on the Record of Clinical and Supervision Hours at Internship form (Please see Appendix E). Students are required to submit these forms to the Director at the end of each semester during the internship.

**PART IV.: THE COUPLE AND FAMILY THERAPY CLINIC AT THE OHIO STATE UNIVERSITY. Policies and Procedures**

**A. Clinic Coordinator**

Each year a Ph.D. student may apply to be the clinic coordinator. This student will work at the clinic for 10 hours a week, assisting the Clinical Director, assigning cases, and supervising the work of the clinic assistant, and monitoring procedures and policies in the clinic for issues.

**B. Phones**

1. **Available Lines**

There is one phone line in the CFT Clinic. This line is located in the Clinic Office (100A) and is answered 24 hours per day by Skype for Business. The clinic number is (614) 292-3671. Student therapists may use the telephone for personal local calls within reasonable limits. In an emergency, clients may use the office phone for local calls, but only in the presence of a therapist. The therapist must insure that no confidential information is within view of the client.

2. **Long Distance Phone Call Policy**

The CFT Clinic phone line is part of The Ohio State University Skype for Business. Long distance calls are permitted for clinic business only.

**C. Voice Mail Policies and Procedures**

The purpose of the voice mail system is to allow our clients to have contact with the CFT Clinic when no one is available to answer the phone. The Clinic Staff monitor voice mail on week days. Students should call for messages regularly. CFT faculty serve as back up if therapists cannot be reached and for therapists in cases of
emergencies. A contact list, which includes all faculty and student therapists’ phone numbers, is kept next to the clinic phone.

Some procedures to consider:

Clients are informed during the intake interview and are reminded during the first session that the CFT Clinic has a voice mail system so that they can always have communication with Clinic personnel. (Therapists should, however remind them at other times also.)

The message on voice mail includes instructions for leaving name of client, time and date, name of therapist, the best time to call, instructions for emergency situations, and message. Voice mail answers the phone 24 hours per day, seven days per week and is monitored on week days.

CFT Clinic personnel should use the following procedures for communication of phone messages:

(1) Cancellation messages and requests for rescheduling appointments should be relayed to the relevant therapist as soon as possible. Each student therapist is provided a comprehensive roster of pertinent student and faculty numbers each academic year to facilitate this process.

(2) When new calls are retrieved, the Clinical Director is to be notified so that the client can be assigned. Either the Clinic Coordinator, clinic assistant or the assigned therapist will complete the intake form within 24 hours of the initial call.

(3) When taking a message from the voice mail system, save it and then leave a message for the therapist and the clinic staff that the message was relayed. The message to the therapist should be that there is a saved message for them on voice mail. If it is for a cancellation let the therapist know as soon as possible. If the message is for you, erase it once you have the information you need. This needs to be done promptly. Messages should be erased within 48 hours, if messages for a new intake are left longer than that it will be assumed the therapist cannot take the new case, and will be reassigned. If there are questions about whether to erase a message, the Clinic Coordinator should be consulted.

(4) Skype for Business records voicemails and sends them to a designated e-mail address as well. For clinic calls the e-mail address is cftclinic@osu.edu. You will be provided with the correct account in order to access this e-mail account. You can also access the voicemail system remotely by calling 614-515-4141 and follow the instructions. The pin is 919295.

D. Building Security

Keys

All new student therapists will be issued the four keys that are needed to open: (a) the side door of Bevis Hall, and (b) the clinic, (c) the clinic office, storage room, recording room, and (d) all other interior doors of the CFT Clinic.

Care should be taken not to lose them. A $40.00 fine will be levied to those students who lose their keys. Clinic keys are returned to the department staff at the end of the semester in which the therapist completes all clinical hour requirements in the clinic.
Safeguarding Building Security

For therapists’ own protection, the protection of others, and the security of confidential records and video equipment, therapists and staff should follow some simple guidelines. Therapists and supervisors need to be alert to security issues; it is unwise for therapists to be alone in the clinic in the late evening or on the weekend. As a general rule, therapists who must see clients at these times or who are concerned in any way about safety issues are responsible for arranging for another therapist or a supervisor to be available in the building during such appointments. In turn, CFT Clinic personnel need to be willing and flexible about providing such security services.

When not in use the door to the observation room, and the office should remain locked. All lights should be turned off in each room after usage. Therapists should never assume that someone else will lock up. This is especially important for the last therapist each evening. Therapists should always act as if they are the last one in the Clinic and lock up, and turn out the lights. Please refer to the closing procedure located on the back of the clinic door.

The outer door to the CFT Clinic suite (Suite 110) should be locked: (a) when no one is using the Clinic facilities, or (b) when a student is using Clinic facilities and is alone in the building. Only when clients are expected for appointments or research assistants are using the outer offices should the outer door to the CFT Clinic suite be unlocked. Make it your business to know who is in the building when you are there.

E. Mailboxes

All students have departmental mailboxes located in room 135 Campbell Hall on the Main Campus. Please check your box regularly for mail and important announcements. Every student will also have a clinic mailbox to be used for clinic business. Because of confidentiality considerations please do not use the department mailboxes for clinic business.

F. Waiting Area

The client waiting area is located in at the entrance of the 110 suite. Please remember to safeguard client confidentiality by not discussing cases in the waiting area or hallways. In addition, during the busier evening times, use caution when discussing cases in any of the clinic rooms. There is a white noise machine located outside the Clinic Office in the hallway of the 110 Suite. During the busier hours, especially when multiple rooms are in use, therapists are encouraged to turn on the white noise machine. When clients have children who may be unsupervised for part of a session, therapists are responsible for seeing that they do not disturb other therapy sessions. There are toys, drawing materials, and child appropriate magazines available to occupy children for short durations.

Therapists should clean up the waiting area and therapy rooms after appointments. The custodial personnel cannot clean up after use of these rooms because all the CFT Clinic facilities are off the master key system. If a therapist is made aware that their child client is ill (i.e., flu, stomach bug, cold, etc.) they should place the toys the child has been playing with in the clinic storage room and either clean the toys with the cleaning materials located in the supply cabinet in the storage room, or notify the Clinic Coordinator that they are there and need to be cleaned to prevent others from being infected.
G. Use of the CFT Clinic Office

The primary use of the clinic office is for maintaining client records and clinic data. CFT students may use the clinic computers for clinic business (i.e. entering case notes on TherapyNotes or writing letters to clients, etc). Therapists may use the clinic computers for personal use when they are available. When therapists have clinic business it takes precedence over personal use. If therapists are using the clinic computers for personal or academic nonclinical purposes, they are responsible for ensuring they do not save their work to the clinic computers at any time. The desktop and the documents folder of the clinic computers should only contain clinic-related documents.

H. Therapy Rooms

The CFT Clinic has seven therapy rooms. All rooms are equipped for live observation and supervision with cameras and microphones. The observation room has a digital recording system that connects to all rooms in the clinic. Rooms are available for the therapy sessions on a first-come, first-served basis. Students have access to the clinic calendar to schedule sessions and should do so as soon as they know they have a session.

Supervisors may need to reserve a particular therapy/observation suite for use during their supervision. Therapists should avoid scheduling cases in these rooms if they will conflict with a supervision group. It is assumed that therapists will be flexible in changing room assignments to meet the space needs of other therapists.

Each door to a therapy room has a “in use” sign. Be sure “in use” is showing when using a room. Faculty supervisors may, from time to time, wish to observe sessions. Other observers should always obtain permission for observation from both the clinic supervisor and the therapist.

Clean up the therapy room after finishing a session so that set-up for the next therapist is easier. Please check for tissues and replenish as needed. Tissues and cleaning supplies, such as window cleaner, are stored in the storage room or clinic office.

I. Building Maintenance and Service Requests

The University designates one person in each building to serve as the Building Coordinator. This individual acts as Bevis Hall’s liaison with the University’s Physical Facilities. Physical Facilities notifies this person about utility shut-offs, or fire alarm and fire extinguisher testing. He/she also communicates with the custodial personnel assigned to our building regarding our requests for lavatory supplies and special maintenance needs.

The CFT Clinic liaison with Bevis Hall’s Building Coordinator is the Clinic Coordinator or Clinical Director. Students should contact the Clinic Coordinator or Clinical Director when there are special requests for building improvements, building repair, light-bulb replacement, or security suggestions or issues. Students should not presume that someone else has already given the information or feedback that they may have in mind. Student input is needed on these matters.
J. Video Equipment

At the beginning of each Autumn Semester, the CFT Clinic Coordinator/Clinical Director will arrange for a training session in the use of the video equipment in our Clinic. While the sessions are directed to new therapists, continuing students and faculty members are welcome to attend the training. This training should help students in the use of the equipment and some information helpful in troubleshooting problems. Report problems immediately to the Clinic Coordinator or Clinical Director.

K. No Smoking Policy

No smoking is allowed in the CFT Clinic or anywhere on OSU’s campus. Therapists are responsible for making sure clients are aware of this policy and abide by it.

L. Community Resource File

The clinic maintains a list of referrals for clients in the clinic but also for those that need services sooner than we can accommodate or with particular needs that we cannot accommodate. Please use this resource as appropriate.

M. Toys

Toys are available and can be found in the storage room. Please return them after each session. Some “toys” are used strictly for therapy, however, and should not be given for general client access. If students have suggestions for quiet, colorful, and imaginative toys, please give them to the Clinic Coordinator.

Part V. CLIENT-RELATED POLICY AND PROCEDURES

A. Intake Process

Case assignments for the clinic will be handled through the Clinic Coordinator or Clinical Director. There are two ways that a therapist will be assigned a case:

a. The student will be informed that there is a call and the intake call will be handled by the assigned student therapist.

b. Clinic staff (i.e., undergraduate office assistant or Clinic Coordinator) will take the intake call, and pass on the intake information to the assigned therapist.

Regardless of who takes the intake call, as the conversation with the potential client or referral source proceeds, the intake person makes notes on an Intake form (Please see Appendix K), and records the date and time the call took place on the bottom of the Intake form. After establishing that the call is for therapy services, a tentative fee is set using the Fee Schedule (Please see, Appendix R), and the payment procedure is explained. The intake person then obtains the name, telephone number, and address of the caller. There is an inquiry about the nature of the assistance being sought from the Clinic and a (preliminary) problem definition is noted.
If someone other than the assigned therapist takes the call, they will inform the caller that the case will be assigned to a therapist who will call and schedule an appointment as soon as possible. Normally, the client will not schedule for the same day as the intake call. The therapist is responsible for contacting the client or other appropriate persons within 24 hours of receipt of the case in order to schedule the appointment.

If a potential client has called for information but does not want to schedule an appointment at the first call, the Clinic staff may call back in a week or two to follow-up on the telephone call.

In the event that there is a waitlist for clients to be seen at the clinic, callers will be notified that there is a waitlist, the approximate length of time before they may be seen (i.e., 2-3 weeks) and they will be asked if they would like to be placed on it at the current time. Waitlisted potential clients will be updated on an approximate 1-2 week basis about the status of length of time before they can be seen, and to inquire if they are still interested in services.

There is a record of all waitlisted clients located in the Phone Log binder in the Clinic Office.

**B. Case Assignments**

All cases are assigned by the Clinic Coordinator/Clinical Director. Decisions regarding case assignments will be based on the therapist’s caseload, her/his level of clinical expertise, and on Clinic needs. Therapists are encouraged to discuss with their individual supervisor and the Clinic Coordinator/Clinical Director, the number and type of cases (individual, couple or family) desired. This request assists the faculty/staff in making case assignments. Therapists are responsible for updating the dry erase board found on the clinic office which notates therapists name, number of active clients being seen at the clinic, and whether the therapist needs individual, couple or family clients at the current time. The white board assists the Clinic Coordinator with the assignment of cases. Once a case is assigned, the student therapist should take the following steps:

1. Contact the family immediately. If unable to contact a client within **24 hours** of assignment, therapists should give the case back to the Clinic Coordinator or supervisor so that it is available for assignment to someone else. Unnecessary delays for clients should be avoided.

2. Therapists should keep their supervisor notified of the status of the case, especially the date of the first session or a declined offer of therapy.

   (a) Once the initial appointment has been set by the therapist, the phone intake is returned to the Clinic staff who will place into a prepared case folder (found in cabinet in at the clinic office). The client folder will contain necessary forms to open the case and the original copy of the CFT Clinic Phone Intake Record. In addition, each folder will already be labeled only with the case number.

   (b) If the client declines the opportunity for therapy, the therapist gives the intake form to clinic staff to be placed in the Intakes Not Seen file.

3. Therapists should notify their supervisor when they terminate or otherwise close a case. The Termination Note in TherapyNotes is completed along with type of termination (ended with agreement, client no showed, or client left against therapist recommendation) and number of sessions attended. Once the supervisor signs off on the note, it is printed and the entire clinical file placed in the Clinic Assistant’s mailbox to be recorded and then stored, in case number order, in the CFT Clinic bank of inactive files.
4. Therapists should inform the Clinic Coordinator/Clinical Director if a formerly terminated client contacts him/her for additional therapy. Depending on the period of time elapsed since termination, the Coordinator/Director will decide: (a) whether he/she may immediately take the call, or (b) whether it will be added to the top or bottom of the waiting list to be assigned in order to the next therapist needing a case.

It is critical to keep track of Clinic activity and each therapist’s cooperation is essential and appreciated. If a client or caller requests a specific therapist by name, the assigning staff/faculty will make every effort to accommodate such requests. Needs of the clinic, however, take precedence over client requests. Guidelines for case assignments will vary depending on the time of year (beginning of Autumn Semester, holidays, etc.), available therapists, and Clinic needs.

C.. Intake calls and scheduling by a third party

When a caller wishes to schedule an appointment for a third party (e.g., a Child Protective Services Worker wanting to schedule an appointment for a parent), Clinic staff must ask if the caller intends to accompany the other person(s) to the appointment. If the caller does not plan on coming, the clinic staff requests the family to call the clinic directly in order to schedule an appointment.

Occasionally, referral sources or clients may want clinic personnel to inform an agency mandating the counseling that an appointment has been made. Under the rules of confidentiality of records, the Clinic personnel may not give such a confirmation without a release of information from all clients that the confirmation relates to (Please see Appendix M). The form may be mailed to the client or the client may come in to sign the release before the appointment. Upon receipt of the signed release of information, the therapists may then call and confirm the appointment with the appropriate representative of the agency.

D.. Scheduling

1. Assigned Therapist’s Initial Phone Call

The goal of the telephone call is to make contact with the individual, couple or family, complete the Intake Form if this has not been completed, and contract for the initial appointment. Make initial contact as soon as possible with the person who called the CFT Clinic, not his/her spouse or someone else. Consult a supervisor with questions about who should be involved in the assessment process and how to handle potential client concerns about who should attend therapy.

Arrange the date and time for the appointment and inquire about questions the client might have regarding the CFT Clinic or its location. Notify the supervisor that the appointment is scheduled. If the client has decided not to come to therapy, notify the supervisor as well.

The initial appointment should be scheduled for 1.5 to 2 hours to allow for paperwork completion, including any research questionnaires being used in the clinic at the time, and to permit initial information gathering. Thereafter, sessions are usually 1 hour in length.

If the client does not know the way to the CFT Clinic, the therapist gives directions. Possible driving routes to the CFT Clinic based on departure location (North, East, South, West) are located next to the phone in the Clinic Office. Sign up for a room for a scheduled session as soon as the client confirms their appointment.
The Clinic is intended to match the functioning of a public service agency. Therefore, appointments are scheduled year-round. Semester breaks, summer sessions, and regular school holidays should have a minimal effect on the operation of the Clinic. CFT students and practicum supervisors are expected to be available for new cases during semester breaks. Vacations for supervisors and students should be scheduled well in advance, and backup services should be arranged. Student therapists are expected to take ‘normal’ vacation periods with the permission of and coordination with their supervisor. Therapists should provide the clinic faculty and other therapists with an e-mail stating the days they will be gone, how they can be contacted, and who is covering their cases.

E. Referral sources

A substantial number of clients are referred to our clinic by agencies and other professionals. Consequently, it is essential that we maintain good communications between ourselves and our referral sources. Most referral sources have an investment in the clients they refer and will want to know if their client contacted the Clinic and attended the initial session. In some cases, a progress report may be requested. We cannot release such information until a Release of Information form (Please see Appendix M) is completed and signed by the client or parent/guardian and a witness. If there is any question about the procedure for releasing information to other agencies or other professionals, the therapist should consult with his/her supervisor.

We value referrals because they assure us of diversity and a number of cases for training purposes. We have a thank you letter to referral sources that is sent out by the clinic staff whenever a referred client calls for service. Even if individuals choose not to set up an appointment, it is imperative that therapists find out who referred them to the clinic. This should be noted on the intake form.

F. Initial Interview

At the end of the initial interview, the therapist should have:

1. a signed consent form (Please see Appendix N);
2. completed intake questionnaires from all participants;
3. a signed release of information form when applicable (Please see Appendix M for a copy of our standard two-way release form);
4. the collected fee for the first session and completed the receipt form; and,
5. an established time for the next appointment.

G. Procedures for Handling Money

When cash or checks are collected, they should be locked up before leaving the Clinic for the day. The Clinic Staff will provide further instruction for the storing of cash and checks. For each fee collected, a receipt form (Please see Appendix O) should be completed in triplicate. One copy goes with the client (pink), one stays with the money collected (white) and one is kept in the case file (yellow). Check numbers should be written on receipts.
H.. Case Management

1. Professional and Legal Duty to Confidentiality

The duty to safeguard client confidentiality is held in high regard by the faculty and students of the Couple and Family Therapy Clinic. As professionals, we adhere to the Ethical Principles for Family Therapists set forth by the American Association for Marriage and Family Therapy (AAMFT; see Appendix D). The duty to safeguard client confidentiality serves to strengthen the therapist’s ability to offer help to clients. Therapist behavior is organized by both professional requirements and legal obligations. Safeguarding clients’ privacy is balanced against the need to inform others when there is a clear and immediate danger to an individual or society.

Privacy and confidentiality issues are complex and become even more so when the unit of treatment is a family, a couple, or a relationship. The State of Ohio does not recognize the profession of Marriage and Family Therapy as having professional privilege, like the professions of physicians and clergy. This makes access to our testimony, case records, and videotapes easier to obtain. It is important that therapists at The Ohio State University develop guidelines for practice that safeguard the privacy of our clients, to the extent allowed by law. Practicum supervisors and HDFS 7770 (Professional Issues in Couple and Family Therapy) will provide opportunities for students to develop an understanding of these complex issues. Always contact the case supervisor when you have questions regarding confidentiality and professional ethics.

2. Informed Consent for Treatment

The informed consent form authorizes the video recording and live observation of therapy sessions (See Appendix N). Video may be kept for up to one semester without seeking further authorization. All people age 18 years and over who participate in therapy must sign the consent form. Sometimes, it is therapeutic to include children under 18 years of age in signing the consent form, this, however, is not mandatory.

3. Special Releases for Video

When video is used for purposes other than therapy supervision as outlined on the original consent form, students should consult the supervisor, compose an appropriate extension to the release form, and have it approved before requesting client signatures. Permission must be obtained from clients to use video of therapy sessions for purposes other than therapy supervision. All persons 18 years or older who appear in the video must sign the extension to the consent form(s).

4. Case Progress Notes

Case progress notes are required of all therapists seeing CFT Clinic clients. The clinic uses TherapyNotes for such purposes. Training for use of TherapyNotes will be provided by the Clinic Coordinator. After each session, the therapist enters a progress note. This note is electronically signed by the therapist, and the supervisor of the case. Unless there is a subpoena of the record, no notes will be printed for the case file.
These notes, along with other intake, assessment, consent and release form materials, constitute the official record of each case seen at the CFT Clinic. Information other than no-show notes or similar letters should be reviewed by the supervisor. **Any letters or correspondence going out on CFT stationary must have the specific approval of the supervisor, and a copy of it must be placed in the client's file.**

The client's file is an official record that is often targeted by subpoenas. Thus, notes must be recorded in a manner sensitive to the consequences of the release of such material to a court of law. The supervisor is a source of information on the proper manner by which to record your observations and reports of information relevant to treatment. Discussion of case material with supervisors, professional staff, and fellow student-therapists may occur, but this should be done with caution and attention paid to protecting the confidentiality of clients.

Case progress notes must be completed for each therapy session and for each phone call that is therapeutic in nature. In order to receive full credit for internal practicum hours (HDFS 8189) each semester these notes must be filed and all paperwork completed. If a therapist cannot, for some reason, fulfill this time constraint, contact the supervisor. If a therapist gets more than three weeks behind on case notes, he/she will be removed from the rotation for case assignment.

### 5. Referral and Other Professional Interaction

Therapists may find it valuable to contact a referral source or other professionals for information or consultation, or therapists may be contacted by another professional. Any time a therapist wishes to communicate with anyone other than the family, each client’s signature on a special release of information form must be obtained first. The family has a right to know and approve the release of any information related to treatment, including the fact that they are in therapy.

To obtain information from another agency/professional the Release of Information to the Couple and Family Therapy Clinic form (Please see Appendix M) must be completed by the therapist and signed by the client (or parent/guardian if the client is a minor). Therapists should be specific about the information to be sent to the Clinic—test results, diagnosis, prior therapy history, etc. In general, therapists should not request an entire case file. A cover letter, signed by the therapist and the supervisor, should accompany the completed form.

To release information to another professional or agency, The Release of Information by the Couple and Family Clinic (Please see Appendix M) must be completed by the therapist and signed by the client (parent/guardian if the client is a minor). Therapists should be specific about what information will be sent to the other agency/professional—a list of sessions attended, a general summary of progress in therapy, etc. In general, we do not release the client's case file in its entirety. In the event that such a request is made, therapists should see the supervisor for assistance.

It is not uncommon for the 'client' to be a couple or family. An appropriate release of information form must be obtained for each individual who is named in the record or whose presence can be inferred from the record (e.g., when 'father' is present but not named). A spouse cannot consent to the release of information regarding the other spouse's presence in therapy.

All client information is held confidential with certain exceptions required by law. Except when mandated by law, do not reveal client information unless a signed release of information form is obtained. The original should be sent to the person from whom information is being requested and a copy should be kept in the file. Client identification should be on all forms.
Client release is waived when the therapy is court-mandated (in writing), however, therapists should always contact a supervisor before responding to a subpoena. Most subpoenas are not court-ordered and need clarification to determine what information may be released. Client release may also be waived under conditions of mandatory reporting and duty-to-warn situations. Clients (except in rare circumstances approved by the supervisor) should be informed of reports and subpoenas. Therapists should explain the purposes and reason for the report or subpoena, explain likely procedures, and offer to help the family through the process. Always consult with the supervisor when any questions or concerns related to mandatory reporting or duty-to-warn arises.

6. Therapist’s Responsibility for Paperwork

All paperwork, including assessment material, case notes, etc., should be placed in the client files. Internship reports are filed with the Internship Coordinator. Internal practicum reports and supervision reports should be placed in file trays for the clinic staff in the CFT Clinic office. Therapists will receive a summary report at the end of each semester. Client files are available at all times, but must not be moved from the building. Return them to the client file cabinet and lock it before leaving the building.

a. Required Paperwork Time Frame

<table>
<thead>
<tr>
<th>Item</th>
<th>Submit</th>
<th>Submit to</th>
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</thead>
<tbody>
<tr>
<td>Informed consent</td>
<td>Immediately</td>
<td>Filed by therapist</td>
</tr>
<tr>
<td>Case notes</td>
<td>Immediately</td>
<td>Filed by therapist</td>
</tr>
<tr>
<td>Releases</td>
<td>Immediately</td>
<td>Filed by therapist</td>
</tr>
<tr>
<td>Transfer/termination</td>
<td>Within 2 weeks after</td>
<td>Supervisor</td>
</tr>
<tr>
<td>Summary</td>
<td>last session</td>
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</tr>
<tr>
<td>Supervision reports</td>
<td>At the end of each</td>
<td>Supervisor</td>
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<td></td>
<td>Semester</td>
<td></td>
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<tr>
<td>Client contact hour</td>
<td>At the end of each</td>
<td>Clinic staff</td>
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<td>reports</td>
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<tr>
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<td>Intern Coordinator</td>
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<td></td>
<td>Semester</td>
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</tbody>
</table>

Additional/Optional forms
7. Keeping Case Records
All CFT Clinic case records must be kept in the Clinic Office and on TherapyNotes. It is important that case record information be as accurate and complete as possible. The client's current address and telephone number, and place of employment, emergency contact numbers, and other personal information help the therapist and the CFT Clinic staff reach the client quickly, and allow staff to answer questions about general client load and services.

It is not unusual for the Clinic to receive legitimate inquiries from outside agencies and other professionals 2-3 years after services were delivered and the case closed. Without accurate records of sessions and case notes for each session, we have no way of supplying the information required. Similarly, if a client returns for additional services 2-3 years after initial round of therapy, it is unlikely that the original therapist will be seeing the client. It can be of immense value to the new therapist to have access to client information and complete case notes. The Clinic abides by legal and ethical standards for keeping case records. It is unethical not to have case notes for clients. If therapists continue to get behind in completing case notes, they will be considered to be practicing unethically and asked to leave the program. The Clinic keeps the full case record for 7 years after the last session. Then keeps an abbreviated file (intake, and case summary/termination form).

8. Case Transfers
Case transfers fall into one of two categories: in-house transfers and other agency transfers. If therapists cannot continue seeing a case that is not ready to terminate, they may arrange transfer to another CFT Clinic therapist in consultation with the supervisor. The family should be given a choice between continued therapy at the Clinic, referral to other community resources, or termination. If clients choose to be referred outside the CFT Clinic, at least three referrals should be provided. The Hands On Central Ohio website and a supervisor can assist with identifying other community resources.

Therapists should use the following procedures:

a. Discuss the case with the supervisor and explore options.

b. Inform the family in session of the change and outline options well in advance. Six to eight weeks is considered a minimum amount of time to initiate this process. The therapeutic relationship should be taken seriously; clients need time to adjust to such changes.

c. If the family decides to continue therapy at the Clinic, discuss potential therapists with the supervisor.
d. Once the supervisor has chosen a therapist, he/she will discuss the case with the potential
therapist. Be sure he/she knows about previous or potential violence or substance abuse. Cases
involving violence, abuse, or substance abuse should be considered at-risk and handled carefully.

e. Assist in the smooth transfer of the case. When possible introduce the family to the new therapist
during the session immediately prior to the final session. Be aware that this transition may be stressful
for the family.

f. Inform the clinic supervisor of the successful transfer.

g. Be sure that all paperwork is up-to-date. Complete a Transfer/Termination Summary form
(Please see Appendix L), including recommendations for further treatment.

h. Be sensitive to potential problems the family may have during the transition,
particularly if cases have involved abuse, substance abuse, or hospitalization.

i. Be sensitive to the fact that HDFS 8189-010 (as an official course) ends at the end
of the semester. It is expected, however, that client families will not be left in limbo. Clinicians are
expected to plan their transfers so that incoming therapists are involved in the cases prior to the
departure of the terminating therapists. It may also mean that the terminating therapists may have to
continue their clinical work for a week or so into the next term if the incoming therapists are new to the
clinic.

I. Video of Therapy Sessions

We are fortunate to be able to produce high quality video of our sessions. The Clinic provides the therapist with
a jump drive to download digital recordings of their sessions. The digital recording hard drive is deleted at the
end of each semester, so any client recording needed should be downloaded to the jump drive. Therapists
should take care to safeguard their jump drive by keeping them locked in the Clinic office. Therapists should
never allow friends, family, or non-CFT Clinic therapists to view video without appropriate releases. Further,
jump drives with client video should never be removed from the Clinic. Our consent form, which includes
permission for video recording, allows therapists to store video for short-term supervisory use. In general,
videos should be kept for only the semester and subsequently erased. When therapists wish to keep a video for
a longer period of time, he/she must add and process with the client an extension to the original consent form.
All persons 18 years or older who appear in a video must sign the release form(s). Therapists should discuss
extended use of client video with their supervisor before obtaining client consent.

Clients who are reluctant to sign informed consent forms should be given referrals elsewhere. It is clinic policy
not to do therapy with clients who are reluctant to be observed or video recorded since all therapy must be
available for supervision. From time to time, clients may request exemptions. Therapists should not implement
exemptions from the rule with clients unless the Clinic Coordinator or supervisor has been consulted first.

J. Observation of Therapy Sessions
Observation of therapy sessions is limited to CFT Clinic supervisors and CFT program participants. No one else is allowed to observe sessions without the approval of the therapist and the supervisor. Clients of the Clinic have a right to know when they are being observed. Therapists should always inform clients when they have a supervisor, observers, clinical team, or professionals present during a session. As a matter of confidentiality, therapists should not enter an observation room to observe another therapist’s session without approval from the therapist.

K. Confidentiality Issues

The Limits of Confidentiality as Defined by Law

1. Child Abuse

In order to provide protection for children, Ohio law requires that any person who suspects that a child has been abused or neglected by parents or other persons responsible for his or her care, report such information to Franklin County Children’s Services (464-4000) or the police. That is, therapists can be prosecuted if something happens to a child and this has not been reported (Please see Appendix P for Ohio State statute). The law establishes immunity from liability (for breaking client privilege to confidentiality) for those persons who, in good faith, report child abuse or neglect. Domestic violence in the home with the child present is considered a form of child abuse in Ohio. Therapists must consult the supervisor before reporting, if this becomes relevant. A therapist’s duty is to report suspected abuse, not substantiate it. Substantiation is the job of the Franklin County Children’s Services investigators. Therapists should document all actions in writing and have the supervisor read and sign off on the note immediately. All notes should be placed in the clients’ file.

2. Elder Abuse

In order to provide protection for adults over the age of 60 who have a physical or mental disability, Ohio law requires that any person who suspects that an elder has been abused or neglected by family members or other persons responsible for his or her care, report such information to the office of Adult Protective Services within Franklin County’s Department of Human Services (A-K at 462-4348 L-M at 462-4041). Therapists can be prosecuted if something happens to an elder and suspicions were not reported (Please see Appendix Q for the Ohio State statute). The law establishes immunity from liability (for breaking client privilege to confidentiality) for those persons who, in good faith, report elder abuse or neglect. Therapists must consult the supervisor before reporting, if this becomes relevant. Again, the therapists’ duty is to report suspected abuse, not to substantiate it. Substantiation is the job of the Franklin County Adult Protective Services investigators. Therapists should document all actions in writing with copies for the confidential client file and the supervisor.

3. Danger to Self and Others: Duty to Warn

It may become necessary to have a client hospitalized if the person is dangerous to self or others (in which case, warn the potential victim). In cases where there is the potential for suicide or violence to others, therapists should seek advice from the supervisor immediately. Duty to warn falls under the special situations in which it may become necessary to break client confidentiality, based on the AAMFT Code of Ethics. Most cases are not clear and require consultation. Duty to warn requires that we notify potential victims (or relatives in the case of self-harm) and appropriate authorities. Therapists should tell the client of the duty, establish a contract, and notify others as necessary.
If the client wishes or agrees to hospitalization, therapists may contact OSU/Harding at the University Hospitals (Admitting: 292-8655 or Emergency Services: 292-4520) The therapist should document all actions in writing with copies for the clients' file and the Clinic Coordinator. Ohio is one of the only states that does not have Duty to Warn legislation although it is upheld in case law. However, it is unclear whether or not therapists can be sued for breaking confidentiality if a potential victim is warned (which is our ethical duty). If this situation should arise, therapists need to be prepared for this eventuality. All notes should be kept up to date and all actions taken should be noted with all details and dates and signed by the supervisor.

4. Subpoena Related Procedures

If therapists receive a subpoena requesting testimony or parts of the CFT Clinic office case record, contact a supervisor. The supervisor will tell therapists how to proceed. Never give information until the subpoena has been clarified and everyone involved knows exactly what information is being requested and how to respond.

L. Special Situations

a. Absences from the Couple and Family Therapy Clinic
Therapists are expected to be available to their clients. Therapists often do not wish to give their personal phone numbers to clients and this is understandable. It is expected, however, that messages will be checked daily and that therapists (or a designated back-up) will be available at all times.

Vacation times, illnesses, attendance at professional meetings, and other absences from Clinic duty should be handled in a professional manner, in keeping with the similarity between the Clinic and other public service agencies. If possible, the therapist's supervisor should be notified of any absence well in advance, backup therapists should be available, and clients should be notified of the therapist's impending absence.

For any scheduled absences:

a. Obtain the supervisor's approval for the time away.
b. Make arrangements for one of the other students to cover cases for the period of the absence, including calling the answering service daily for messages for the absent therapist. Write an e-mail to all student therapists and CFT faculty. This should include the dates of the absence, the name of the therapist providing backup coverage, and telephone numbers where the therapist can be reached for emergency consultations.
c. Notify each active client of the expected absence, telling the client who will be providing backup coverage, and ensuring that each client has the Clinic number.
d. Before leaving, remind the backup therapists of the impending absence, making sure he/she also has emergency telephone numbers, and making sure the he/she and the supervisor are aware of any clients who may be calling in with emergencies.

If any cases have involved violence or other potentially dangerous circumstances, notify the supervisor of the case, the dates absent, and the backup therapist. Even if it seems to be no longer an issue, backup therapist need to be informed.
M. Alternative Communication with Clients

In the event that the client and/or the student-therapist may wish to communicate with their client via email, cell phone, text message, or home phone the following procedure will be followed. First and foremost, regardless of the method of communication in question (email, cell phone, text message, or home phone), so long that it is not the standard phone used in the clinic office, the student-therapist should talk with their supervisor.

a. Email: It is important that student-therapists relay to their clients that email communication is not confidential, and that unless requested by the client, therapists will reframe from using or pursuing email to communicate with their clients regarding progress in therapy, scheduling, or for any other means. If clients do request to schedule an appointment via email, the therapist will not use the clients full names, only abbreviations, and limit any identifying information disclosed in emails.

b. Cell Phone. If the student therapist, and his/her supervisor decide that it is appropriate for his/her cell phone number to be given to the client it is important that the following statements are disclosed. 1. The therapist’s cell phone is not to be used for emergency services. 2. Similar to the Clinic Office phone, there is no guarantee that the call will always be answered. 3. Therapists will call back clients who leave messages on their cell phone within 24 hours, unless calls are made on a weekend, in which case they will be returned the following Monday.

c. Home Phone. If the student therapist, and his/her supervisor decide that it is appropriate for his/her home phone number to be given to the client it is important that the following statements are disclosed. 1. The therapist’s home phone is not to be used for emergency services. 2. Similar to the Clinic Office phone, there is no guarantee that the call will always be answered. 3. Therapists will call back clients who leave messages on their home phone within 24 hours, unless calls are made on a weekend, in which case they will be returned the following Monday.

d. Text Message. If the student therapist, and his/her supervisor decide that it is appropriate for his/her client to communicate with the therapist via text message about scheduling an appointment the following statements are disclosed. 1. The therapist’s cell phone, and text message system is not to be used for emergency services. 2. Similar to the Clinic Office phone, there is no guarantee that the text will always be answered. 3. Therapists will call or text back clients who leave messages on their phone within 24 hours, unless calls or texts are made on a weekend, in which case they will be returned the following Monday. It is never appropriate for therapists to text message their clients about progress in therapy, or for any communication about the therapeutic process. Texting may only be used in the following circumstances: if the client needs to cancel an appointment last minute, state that they will be late or to reschedule and appointment. Anything else should be communicated via phone.

N. Fee payment

The Ohio State University provides partial underwriting of the cost of maintaining the Clinic. This allows the Clinic to provide services at reduced fees for clients who could not afford to pay full fee. Fees are set based on the current Clinic Fee Scale (Please see Appendix R). If a client indicates difficulty in meeting the established fee, therapists must consult their supervisor. Fee reductions and other alterations may be approved by the supervisor or Clinical Director. The final fee, negotiated by the client and the therapist with the approval of the supervisor, must be established at the time of the initial session.

Clients must pay for services at the time of their appointment, using check or cash. Checks are to be made payable to "The Ohio State University." The Receipt for Service is to be filled out in triplicate by the therapist (Please see Appendix O). The original copy (white) is to be paper-clipped to the check or cash and put with the rest of the fees. The second copy (yellow) is put into the client’s case folder. The third copy (pink) is given to
the client. Clients must be told explicitly that missing an appointment without notifying the therapist 24 hours in advance will result in the session fee being charged for the missed appointment. Waiving the fee for a missed appointment is the prerogative of the therapist and supervisor. If a client does not pay for a session, the missed fee must be collected prior to the following session.

Issues about fees and billing procedures should be explained to the client by the therapist during the first session. Research indicates that clients who are most likely to sue for malpractice or unprofessional behavior are those who have been allowed to run up considerable bills with the therapist. Therefore, it is a wise general policy to collect fees in a timely fashion. Exceptions should be cleared with the supervisor.

1. Fee Hardship Cases

The Ohio State University Couple and Family Therapy Clinic provides quality psycho-therapeutic services on a sliding fee scale (Please see Appendix R). The dollar amount of the fee for service is estimated for clients during the intake phone contact with the student therapists, and is finalized with the clients in the first session. Fees are expected to be collected at the time services are provided.

The fee hardship policy allows for four (4) additional sessions at a suspended charge to the clients. That is, clients must reimburse the Clinic at a future date. These four sessions may occur on a weekly basis or may occur over a protracted period of time. This decision is left up to the therapist and client. During these four sessions, clinicians are expected to provide basic information to clients about what options and services are available to deal with their financial emergency, as well as information about alternative locations for clinical services at reduced rates (such as Franklin County Children’s Services or Huckleberry House).

The process leading to the initiation of the fee hardship policy begins with the clinician gaining information from the client concerning their financial emergency. The clinician should seek to gain facts supporting the emergency nature of the client’s situation, and inform the client that a fee hardship policy may be put into effect only with approval from the Clinical Director.

When the four sessions with suspended payment have expired, clients may: (1) terminate therapy, (2) begin paying for sessions again, or (3) be put on the Clinic waiting list in hopes that they will be able to afford therapy at a later date. If clients return to non-emergency status at the end of the four hardship sessions and reinitiate payment for clinical services rendered, they are expected to work out an arrangement for the payment of those four sessions as soon as is financially possible. Clients who terminate at the end of the four hardship sessions are also expected to arrange for payment of those sessions as soon as possible. The original contracts will be put into the clients’ confidential files, and copies will be provided for the clients. Clinicians, however, are not expected to follow-up with these clients regarding payment.

O. Crisis Situations

1. Emergency situations should be handled as follows:

   a. Suicide or other risk of injury cases:

      * Attempt to notify the therapist.

   ""
* If this proves unsuccessful, notify the supervisor or the Clinical Director.

* Refer the client to a hospital emergency room, if the therapist and faculty are not available.

* The Clinical Director must be notified of the circumstances by the therapist once the emergency has been appropriately handled.

b. **Imminent hospitalization of other sorts:**

   same as (a.) Suicide.

c. **Protective services report:**

If a therapist believes that a client family needs to be reported to Child Protective Services because of suspected abuse, the therapist should first contact the supervisor. A process will be discussed that will involve the following:

- The therapist will be asked to have the client call and make the report and then immediately complete a note in TherapyNotes outlining the process followed and its results, which should be signed by both therapist and supervisor immediately.
- If the client refuses to make the call, the therapist will make the call in the presence of the client and follow the rest of the procedure.
- The therapist and supervisor may agree that having the client present to make the call is not in the clients’ and/or therapist’s best interest, and the therapist will make the call independent of the client, but inform the client that the call was made. Then follow the rest of the procedure.

d. **In-house Emergency**

If therapists need immediate assistance while in the CFT Clinic, call the University Police Department at either **911 or 292-2121**. If the emergency requires first aid or fire personnel, therapists should call Ohio State’s Department of Emergency Medical Service and Fire Prevention at **292-2525**. Therapists should familiarize themselves with the location of the fire extinguisher in Bevis Hall, as well as the location of fire alarms and emergency exits.

If therapists are seeing a client and they threaten harm to themselves or another and they refuse to contract to come to another session, or call at a particular time, and danger is imminent the therapist should call the police (911 or 292-2121). Once the police are called, the supervisor should also be called to inform them of what is happening. Once the police arrive or another individual who is willing to take the responsibility for ensuring the safety of the client or those threatened by the client, all are free to go. Before leaving the clinic the therapist should write a note detailing all actions and decision making processes and be sure to have the supervisor sign off on the note within 24 hours.

If the client refuses to stay, therapists should not try to restrain them physically, or go after them. Once they have left, therapists should call the police and inform them of the situation. Also the therapists should call the supervisor and inform them of the emergency. As always the therapist should keep detailed notes of all actions taken and decision making process, and have the supervisor sign off on the note.

e. **Domestic Violence**
For therapists who are seeing previously violent couples, they must have them sign a No Violence Contract (Please see Appendix S), available in the clinic, in order to continue seeing them conjointly.

No Violence Contract: It is the policy of the Clinic not to see couples conjointly when there is ongoing violence. If current violence is suspected or past violence has been reported, it is good practice to institute a No Violence Contract. There is a form (Appendix S) for this contract available in the clinic. The No Violence Contract outlines the clinic’s stance on violence and requires that each partner have a safety plan if violence is imminent. If clients are unwilling or unable to sign the No Violence Contract, they should be seen separately. As always, the therapist should consult with the supervisor in making these treatment decisions.

CHOICES, a shelter for battered women and their children, is a 24-hour service. It offers temporary, secure housing, basic needs provision, crisis counseling, advocacy, and referral to other community services. The program is designed primarily for victims of domestic violence. The numbers for CHOICES are 224-4663 (crisis line) and 258-6080 (business office).

Parents who need to protect their children from abuse or neglect by their spouses or other individuals may call either Franklin County Children’s Services (464-4000) or the Columbus Police Department (dial “0” and ask the operator to connect you to the police radio room) for immediate assistance. Teenagers who wish to escape from an immediately abusive environment may contact Huckleberry House (294-5553) for temporary shelter and family crisis counseling services.

f. Notification of Supervisor

Whenever therapists encounter a case-related emergency, it is important to notify the supervisor. Also, the therapist should be sure to document all actions taken in responses to the emergency. These notes should become part of the official case record.

P. Liability Insurance

a. Malpractice Coverage

All student therapists are covered by the University malpractice insurance policy when they are seeing CFT Clinic clients, and are enrolled in HDFS 8189. Students are not covered personally, but are covered by virtue of faculty supervision. Faculty are indemnified by the University. Therapists will be notified of this coverage during the first semester in the Clinic at The Ohio State University. For liability purposes, therapists must be registered for practicum credit whenever they are seeing clients and are to make sure their supervisor is aware and updated on all active cases. In addition, as of September 2001, all students will be required to purchase a personal liability policy. Becoming an AAMFT student member provides free liability insurance.

When therapists are at an internship with another agency, that agency’s insurance should be assessed. Students are not covered by liability insurance by virtue of registering for external practicum credit. Most agencies or hospitals will cover students without cost. It is the intern’s responsibility to find out about malpractice coverage. If malpractice coverage is not available, it is essential that students get their own coverage (i.e. become a student member of AAMFT).
b. Need for Faculty Supervision

All student therapists seeing CFT Clinic clients must receive ongoing case supervision. Thus, even if seeing only one client, interns must receive supervision with a CFT supervisor. All cases must be supervised via case report, video, or live supervision.

c. Practicum Credit

Therapists must be registered for Practicum if seeing any clients. This is required for liability purposes. In order to register for HDFS 8189, permission must be obtained from the practicum supervisor for submission to the Graduate School (247 University Hall) prior to registering for the course. If planning to see only 1 client, students should register for 1 credit hour of 8189-010. If you students are planning on seeing 2 clients, they should register for 2 credit hours of 8189-010. If students are planning on seeing 3 or more clients, register for 3 credit hours of 8189-010.

It is expected that all cases will be transferred or terminated at the end of the semester when students will not be continuing to see clients in the clinic. On occasion, cases may need just a few (2 or 3) sessions into a new semester before termination or may need a few sessions spaced out in the following semester for follow-up. Unless special permission of the supervisor is obtained, students will be expected to finish with all cases within 4 weeks of the beginning of the semester. Under such circumstances, students may register for 1 credit hour of practicum. A maximum of 2 cases will be allowed. If any of these cases appear to need regular, ongoing therapy for more than 2 or 3 sessions, the therapist should effect a transfer.

d. Private Clients

The CFT Clinic may not be used to see private clients.

Q. Professional Consultation

a. Evaluations (Psychiatric, Psychological)

In general, the clinic refers to outside therapists or psychiatric agencies in cases of extreme need for psychiatric care. Please consult with the faculty supervisor for judgments regarding these types of referrals.

b. Legal

The University attorney is available to answer legal questions that may arise during treatment of CFT Clinic clients. Therapists should give questions in writing to the Clinical Director who will then initiate a formal request for information. Therapists should record the consultation in the case notes. The Program’s association with AAMFT also provides us with access to the AAMFT attorney through the legal consultation plan. Therapists should contact the Clinical Director with any questions.
R. Licensure Requirements

Students are encouraged to review the licensure requirements for MFT in the state of Ohio or any state that they believe they will be moving to. See Appendix T for Ohio’s Licensure Requirements. If students currently have a masters in MFT they are encouraged to apply for licensure while they are in the program. If students do not have a masters in MFT but have met the educational requirements and have the number of client contact hours required with supervision, they are encouraged to apply for licensure as well. Remember that in Ohio, hours post licensure count toward the independent license, and hours post license also count toward the AAMFT Approved Supervisor Designation.
NOTE: You have “two masters” so to speak. **You must meet all departmental requirements** (please refer to the department graduate guide) and all program requirements.

### AREA I: Theoretical Foundations (Must have 6 semester hours)

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<th>Credits</th>
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OSU MFT Program Course Title:

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<th>Course Title</th>
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<tr>
<td>5200: Foundations in Marital and Family Therapy</td>
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<td>8824: General Systems Theory*</td>
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* Departmental requirement for all graduate students.

### AREA II: Clinical Practice (Must have 12 semester hours)

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<td>8875: Family Therapy Theory II</td>
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<td>8876: Marital Therapy Theory</td>
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<td>8870: Family Systems Assessment</td>
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<td>8860: Diagnosis in Family Therapy</td>
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### AREA III: Individual Development and Family Relations (Must Have 9 semester hours)

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or approved Human Sexuality class from master’s program

And any two HDFS or related courses:

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### AREA IV: Professional Identity and Ethics (Must have 3 semester hours)

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OSU MFT Program Course Title:
7770: Professional and Ethical Issues in Marriage and Family Therapy
3

AREA V: Research (Must have 3 semester hours)

Course Title from Master’s Program (Attach Syllabi)  Credits
OSU MFT Program Course Title:
6782: Research Methods\(^a\) 5
or
8881: Research in Marital and Family Therapy\(^*\) 3

\(^*\) 8881 is required for all students in the CFT Ph.D. program. It can be counted here, or counted for research methods and stats on the doctoral curriculum, but it cannot be counted for both Area V and Area XI.

\(^a\) This is required for straight through Ph.D. students only.

AREA VI: Additional Learning (Must have 3 semester hours)

Course title from Master’s Program (Attach Syllabus)  Credits

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Clinical Experiences

Document up to
500 Hours Client Contact from Master’s Program

<table>
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<tr>
<th>CLIENT CONTACT</th>
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OSU MFT Clinic Client Contact Hours

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<th># OF HOURS</th>
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DOCTORAL CURRICULUM REQUIREMENTS

AREA VIII:  Clinical Practice (Must have 6 credits)

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<thead>
<tr>
<th>Course Title</th>
<th>Credits</th>
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<tbody>
<tr>
<td>8824: General Systems Theory*</td>
<td>3</td>
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<tr>
<td>8860: Seminars in Marriage and Family Therapy</td>
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<tr>
<td>8860.02: Diversity in Families and Family Therapy</td>
<td>3</td>
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<td>8860.03: Critical Incidents in Family Therapy</td>
<td>3</td>
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<tr>
<td>8860: Adolescents in Family Therapy</td>
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<tr>
<td>8860: Other</td>
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* Departmental Requirement: For those without a masters in MFT, this course cannot be “double counted.” If you used it for the Standard Curriculum you will need to take an additional 8880 seminar to complete this requirement.

AREA IX:  Individual Development and Family Relations
These are Departmental Requirements.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Credits</th>
<th>DATE COMPLETED</th>
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<tbody>
<tr>
<td>6780, 6890, 6892: Proseminars</td>
<td>6</td>
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<tr>
<td>7350: Adolescence and Emerging Adulthood</td>
<td>3</td>
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<tr>
<td>Or 7765: Advanced Child Development</td>
<td>3</td>
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<td>8820: Perspectives on the Family</td>
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AREA X:  Clinical Supervision

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<tr>
<th>Course Title</th>
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<tr>
<td>8878: Family Therapy Supervision</td>
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AREA XI:  Research (Must have 15 semester credits per department requirements)

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<tr>
<td>8881: Research in Marital and Family Therapy (required)</td>
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Courses in methods and statistics from the university adding up to an additional 12 credits which may include:

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<th>Course Title</th>
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<tbody>
<tr>
<td>8880: Causal Modeling for Marriage and Family Therapy Research</td>
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AREA XII: Additional Courses

This can include anything that doesn’t fit in the previous areas

Course Title:

Course #

CLINICAL EXPERIENCE

<table>
<thead>
<tr>
<th>Internship Site:</th>
<th>Supervisors Name</th>
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End of Academic Year Report Form

Please note that failure to complete and turn in this report by the deadline will result in an automatic “unsatisfactory progress” report.

Name: ________________________ Major Advisor: ______________________
Date: ________________________
Degree Sought: MS/Ph.D.
Year you began in the program: ________________

In reviewing the last academic year (summer, autumn, winter and spring quarters), please report on the following:

Courses Taken and Grade (use course number, title and grade by quarter)

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<tr>
<th>Course Number</th>
<th>Title</th>
<th>Autumn</th>
<th>Grade/Status</th>
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**General Examination:**
Committee Formed: Yes/No  
Scheduled: Yes/No  Date:  
Completed: Yes/No  Date:

**Masters Examination**
Committee Formed: Yes/No  
Scheduled: Yes/No  Date:  
Completed: Yes/No  Date:

**Progress on Dissertation/Thesis:**
Proposal Approved: yes/no  date:  
IRB Approval for project with human subjects: yes/no  date:

Number of subjects planned:  (use n/a if not applicable)  
Number of subjects accrued:  (use n/a if not applicable)

**Publications:** published, in press, and in preparation (use APA citation style)

**Presentations at local, state or national meetings:**

**Conferences Attended:**

**For GTA’s Only:**  
Au Wi Sp

**Courses Taught:**
**Number Enrolled:**
**Average SEI’s:**
CFT Students Only:
   Number of client contact hours accrued to date: __________
   Number of client contact hours accrued over the last 2 semesters: __________
   Number of Supervision hours accrued to date: __________

Service: Please list any service to the department (i.e. active in GSO), college of university, as well as any local or state presentations made that were not part of a conference.

Student’s Narrative Evaluation of progress for the academic year:
Advisor’s Rating:

Satisfactory progress  Unsatisfactory Progress

Actions Needed:

_____ make a plan to improve progress with student
_____ make a plan to improve progress and submit to Graduate Studies Committee
_____ notify Graduate School of unsatisfactory progress

Advisor’s Narrative (optional):

Advisors Signature: _________________________________

Graduate Studies Chair Rating:

Satisfactory Progress  Unsatisfactory Progress

Actions taken:

______ advisor and student informed of unsatisfactory progress
______ plan to improve progress is requested
______ Graduate School notified of unsatisfactory progress

Graduate Studies Chair Signature: _________________
PREAMBLE
The Board of Directors of the American Association for Marriage and Family Therapy (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.01.3 of the Association’s Bylaws, the Revised AAMFT Code of Ethics, effective January 1, 2015.

Honoring Public Trust
The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee.

Commitment to Service, Advocacy and Public Participation
Marriage and family therapists are defined by an enduring dedication to professional and ethical excellence, as well as the commitment to service, advocacy, and public participation. The areas of service, advocacy, and public participation are recognized as responsibilities to the profession equal in importance to all other aspects. Marriage and family therapists embody these aspirations by participating in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return. Additionally, marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest. Marriage and family therapists also encourage public participation in the design and delivery of professional services and in the regulation of practitioners. Professional competence in these areas is essential to the character of the field, and to the well-being of clients and their communities.

Seeking Consultation
The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.
Ethical Decision-Making
Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

Marriage and family therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and take reasonable steps to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics.

Binding Expectations
The AAMFT Code of Ethics is binding on members of AAMFT in all membership categories, all AAMFT Approved Supervisors and all applicants for membership or the Approved Supervisor designation. AAMFT members have an obligation to be familiar with the AAMFT Code of Ethics and its application to their professional services. Lack of awareness or misunderstanding of an ethical standard is not a defense to a charge of unethical conduct.

Resolving Complaints
The process for filing, investigating, and resolving complaints of unethical conduct is described in the current AAMFT Procedures for Handling Ethical Matters. Persons accused are considered innocent by the Ethics Committee until proven guilty, except as otherwise provided, and are entitled to due process. If an AAMFT member resigns in anticipation of, or during the course of, an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the Association will include the fact that the member attempted to resign during the investigation.

Aspirational Core Values
The following core values speak generally to the membership of AAMFT as a professional association, yet they also inform all the varieties of practice and service in which marriage and family therapists engage. These core values are aspirational in nature, and are distinct from ethical standards. These values are intended to provide an aspirational framework within which marriage and family therapists may pursue the highest goals of practice.

The core values of AAMFT embody:
1. Acceptance, appreciation, and inclusion of a diverse membership.
2. Distinctiveness and excellence in training of marriage and family therapists and those desiring to advance their skills, knowledge and expertise in systemic and relational therapies.
3. Responsiveness and excellence in service to members.
4. Diversity, equity and excellence in clinical practice, research, education and administration.
5. Integrity evidenced by a high threshold of ethical and honest behavior within Association governance and by members.
6. Innovation and the advancement of knowledge of systemic and relational therapies.

Ethical Standards
Ethical standards, by contrast, are rules of practice upon which the marriage and family therapist is obliged and judged. The introductory paragraph to each standard in the AAMFT Code of Ethics is an aspirational/explanatory orientation to the enforceable standards that follow.
STANDARD I

RESPONSIBILITY TO CLIENTS
Marriage and family therapists advance the welfare of families and individuals and make reasonable efforts to find the appropriate balance between conflicting goals within the family system.

1.1 Non-Discrimination. Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status.

1.2 Informed Consent. Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented.

1.3 Multiple Relationships. Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken.

1.4 Sexual Intimacy with Current Clients and Others. Sexual intimacy with current clients or with known members of the client's family system is prohibited.

1.5 Sexual Intimacy with Former Clients and Others. Sexual intimacy with former clients or with known members of the client's family system is prohibited.

1.6 Reports of Unethical Conduct. Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct.

1.7 Abuse of the Therapeutic Relationship. Marriage and family therapists do not abuse their power in therapeutic relationships.

1.8 Client Autonomy in Decision Making. Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise clients that clients have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

1.9 Relationship Beneficial to Client. Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.

1.10 Referrals. Marriage and family therapists respectfully assist persons in obtaining appropriate therapeutic services if the therapist is unable or unwilling to provide professional help.

1.11 Non-Abandonment. Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment.
1.12 Written Consent to Record. Marriage and family therapists obtain written informed consent from clients before recording any images or audio or permitting third-party observation.

1.13 Relationships with Third Parties. Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality.

STANDARD II

CONFIDENTIALITY

Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

2.1 Disclosing Limits of Confidentiality. Marriage and family therapists disclose to clients and other interested parties at the outset of services the nature of confidentiality and possible limitations of the clients’ right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.

2.2 Written Authorization to Release Client Information. Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual.

2.3 Client Access to Records. Marriage and family therapists provide clients with reasonable access to records concerning the clients. When providing couple, family, or group treatment, the therapist does not provide access to records without a written authorization from each individual competent to execute a waiver. Marriage and family therapists limit client's access to their records only in exceptional circumstances when they are concerned, based on compelling evidence, that such access could cause serious harm to the client. The client's request and the rationale for withholding some or all of the record should be documented in the client's file. Marriage and family therapists take steps to protect the confidentiality of other individuals identified in client records.

2.4 Confidentiality in Non-Clinical Activities. Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with Standard 2.2, or when appropriate steps have been taken to protect client identity and confidentiality.

2.5 Protection of Records. Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.

2.6 Preparation for Practice Changes. In preparation for moving a practice, closing a practice, or death, marriage and family therapists arrange for the storage, transfer, or disposal of client records in conformance with applicable laws and in ways that maintain confidentiality and safeguard the welfare of clients.

2.7 Confidentiality in Consultations. Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.
STANDARD III

PROFESSIONAL COMPETENCE AND INTEGRITY

Marriage and family therapists maintain high standards of professional competence and integrity.

3.1 Maintenance of Competency. Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience.

3.2 Knowledge of Regulatory Standards. Marriage and family therapists pursue appropriate consultation and training to ensure adequate knowledge of and adherence to applicable laws, ethics, and professional standards.

3.3 Seek Assistance. Marriage and family therapists seek appropriate professional assistance for issues that may impair work performance or clinical judgment.

3.4 Conflicts of Interest. Marriage and family therapists do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

3.5 Maintenance of Records. Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law.

3.6 Development of New Skills. While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, and/or supervised experience.

3.7 Harassment. Marriage and family therapists do not engage in sexual or other forms of harassment of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.8 Exploitation. Marriage and family therapists do not engage in the exploitation of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.9 Gifts. Marriage and family therapists attend to cultural norms when considering whether to accept gifts from or give gifts to clients. Marriage and family therapists consider the potential effects that receiving or giving gifts may have on clients and on the integrity and efficacy of the therapeutic relationship.

3.10 Scope of Competence. Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies.

3.11 Public Statements. Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements.

3.12 Professional Misconduct. Marriage and family therapists may be in violation of this Code and subject to termination of membership or other appropriate action if they: (a) are convicted of any felony; (b) are convicted of a misdemeanor related to their qualifications or functions; (c) engage in conduct which could lead to conviction of a felony, or a misdemeanor related to their qualifications or functions; (d) are expelled from or disciplined by other professional organizations; (e) have their licenses or certificates suspended or revoked or are otherwise disciplined by regulatory bodies; (f) continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances; or (g) fail to cooperate with the Association at any point from the inception of an ethical complaint through the completion of all proceedings regarding that complaint.
STANDARD IV

RESPONSIBILITY TO STUDENTS AND SUPERVISEES

Marriage and family therapists do not exploit the trust and dependency of students and supervisees.

4.1 Exploitation. Marriage and family therapists who are in a supervisory role are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

4.2 Therapy with Students or Supervisees. Marriage and family therapists do not provide therapy to current students or supervisees.

4.3 Sexual Intimacy with Students or Supervisees. Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee.

4.4 Oversight of Supervisee Competence. Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.

4.5 Oversight of Supervisee Professionalism. Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional.

4.6 Existing Relationship with Students or Supervisees. Marriage and family therapists are aware of their influential positions with respect to supervisees, and they avoid exploiting the trust and dependency of such persons. Supervisors, therefore, make every effort to avoid conditions and multiple relationships with supervisees that could impair professional judgment or increase the risk of exploitation. Examples of such relationships include, but are not limited to, business or close personal relationships with supervisees or the supervisee's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, supervisors document the appropriate precautions taken.

4.7 Confidentiality with Supervisees. Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for training of the supervisee. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law.

4.8 Payment for Supervision. Marriage and family therapists providing clinical supervision shall not enter into financial arrangements with supervisees through deceptive or exploitative practices, nor shall marriage and family therapists providing clinical supervision exert undue influence over supervisees when establishing supervision fees. Marriage and family therapists shall also not engage in other exploitative practices of supervisees.

STANDARD V

RESEARCH AND PUBLICATION

Marriage and family therapists respect the dignity and protect the welfare of research participants, and are aware of applicable laws, regulations, and professional standards governing the conduct of research.

5.1 Institutional Approval. When institutional approval is required, marriage and family therapists submit accurate information about their research proposals and obtain appropriate approval prior to conducting the research.
5.2 Protection of Research Participants. Marriage and family therapists are responsible for making careful examinations of ethical acceptability in planning research. To the extent that services to research participants may be compromised by participation in research, marriage and family therapists seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.

5.3 Informed Consent to Research. Marriage and family therapists inform participants about the purpose of the research, expected length, and research procedures. They also inform participants of the aspects of the research that might reasonably be expected to influence willingness to participate such as potential risks, discomforts, or adverse effects. Marriage and family therapists are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, or have impairments which limit understanding and/or communication, or when participants are children. Marriage and family therapists inform participants about any potential research benefits, the limits of confidentiality, and whom to contact concerning questions about the research and their rights as research participants.

5.4 Right to Decline or Withdraw Participation. Marriage and family therapists respect each participant's freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid multiple relationships with research participants that could impair professional judgment or increase the risk of exploitation. When offering inducements for research participation, marriage and family therapists make reasonable efforts to avoid offering inappropriate or excessive inducements when such inducements are likely to coerce participation.

5.5 Confidentiality of Research Data. Information obtained about a research participant during the course of an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that others, including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

5.6 Publication. Marriage and family therapists do not fabricate research results. Marriage and family therapists disclose potential conflicts of interest and take authorship credit only for work they have performed or to which they have contributed. Publication credits accurately reflect the relative contributions of the individual involved.

5.7 Authorship of Student Work. Marriage and family therapists do not accept or require authorship credit for a publication based from student's research, unless the marriage and family therapist made a substantial contribution beyond being a faculty advisor or research committee member. Co-authorship on student research should be determined in accordance with principles of fairness and justice.

5.8 Plagiarism. Marriage and family therapists who are the authors of books or other materials that are published or distributed do not plagiarize or fail to cite persons to whom credit for original ideas or work is due.

5.9 Accuracy in Publication. Marriage and family therapists who are authors of books or other materials published or distributed by an organization take reasonable precautions to ensure that the published materials are accurate and factual.

STANDARD VI

TECHNOLOGY-ASSISTED PROFESSIONAL SERVICES

Therapy, supervision, and other professional services engaged in by marriage and family therapists take place over an increasing number of technological platforms. There are great benefits and responsibilities inherent in both the traditional therapeutic and supervision contexts, as well as in the utilization of technologically-assisted professional services. This standard addresses basic ethical requirements of offering therapy, supervision, and related professional services using electronic means.
6.1 Technology Assisted Services. Prior to commencing therapy or supervision services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that technologically-assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology.

6.2 Consent to Treat or Supervise. Clients and supervisees, whether contracting for services as individuals, dyads, families, or groups, must be made aware of the risks and responsibilities associated with technology-assisted services. Therapists are to advise clients and supervisees in writing of these risks, and of both the therapist’s and clients’/supervisees’ responsibilities for minimizing such risks.

6.3 Confidentiality and Professional Responsibilities. It is the therapist’s or supervisor’s responsibility to choose technological platforms that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist’s or supervisor’s technology.

6.4 Technology and Documentation. Therapists and supervisors are to ensure that all documentation containing identifying or otherwise sensitive information which is electronically stored and/or transferred is done using technology that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist’s or supervisor’s technology.

6.5 Location of Services and Practice. Therapists and supervisors follow all applicable laws regarding location of practice and services, and do not use technologically-assisted means for practicing outside of their allowed jurisdictions.

6.6 Training and Use of Current Technology. Marriage and family therapists ensure that they are well trained and competent in the use of all chosen technology-assisted professional services. Careful choices of audio, video, and other options are made in order to optimize quality and security of services, and to adhere to standards of best practices for technology-assisted services. Furthermore, such choices of technology are to be suitably advanced and current so as to best serve the professional needs of clients and supervisees.

STANDARD VII

PROFESSIONAL EVALUATIONS

Marriage and family therapists aspire to the highest of standards in providing testimony in various contexts within the legal system.

7.1 Performance of Forensic Services. Marriage and family therapists may perform forensic services which may include interviews, consultations, evaluations, reports, and assessments both formal and informal, in keeping with applicable laws and competencies.

7.2 Testimony in Legal Proceedings. Marriage and family therapists who provide expert or fact witness testimony in legal proceedings avoid misleading judgments, base conclusions and opinions on appropriate data, and avoid inaccuracies insofar as possible. When offering testimony, as marriage and family therapy experts, they shall strive to be accurate, objective, fair, and independent.

7.3 Competence. Marriage and family therapists demonstrate competence via education and experience in providing testimony in legal systems.
7.4 Informed Consent. Marriage and family therapists provide written notice and make reasonable efforts to obtain written consents of persons who are the subject(s) of evaluations and inform clients about the evaluation process, use of information and recommendations, financial arrangements, and the role of the therapist within the legal system.

7.5 Avoiding Conflicts. Clear distinctions are made between therapy and evaluations. Marriage and family therapists avoid conflict in roles in legal proceedings wherever possible and disclose potential conflicts. As therapy begins, marriage and family therapists clarify roles and the extent of confidentiality when legal systems are involved.

7.6 Avoiding Dual Roles. Marriage and family therapists avoid providing therapy to clients for whom the therapist has provided a forensic evaluation and avoid providing evaluations for those who are clients, unless otherwise mandated by legal systems.

7.7 Separation of Custody Evaluation from Therapy. Marriage and family therapists avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by not performing evaluations for custody, residence, or visitation of the minor. Marriage and family therapists who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist's perspective as a treating marriage and family therapist, so long as the marriage and family therapist obtains appropriate consents to release information.

7.8 Professional Opinions. Marriage and family therapists who provide forensic evaluations avoid offering professional opinions about persons they have not directly interviewed. Marriage and family therapists declare the limits of their competencies and information.

7.9 Changes in Service. Clients are informed if changes in the role of provision of services of marriage and family therapy occur and/or are mandated by a legal system.

7.10 Familiarity with Rules. Marriage and family therapists who provide forensic evaluations are familiar with judicial and/or administrative rules prescribing their roles.

STANDARD VIII

FINANCIAL ARRANGEMENTS

Marriage and family therapists make financial arrangements with clients, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.

8.1 Financial Integrity. Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals. Fee-for-service arrangements are not prohibited.

8.2 Disclosure of Financial Policies. Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related to professional services, including charges for canceled or missed appointments; (b) the use of collection agencies or legal measures for nonpayment; and (c) the procedure for obtaining payment from the client, to the extent allowed by law, if payment is denied by the third-party payor. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges.

8.3 Notice of Payment Recovery Procedures. Marriage and family therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information.

8.4 Truthful Representation of Services. Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered.
8.5 Bartering. Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted; and (d) a clear written contract is established.

8.6 Withholding Records for Non-Payment. Marriage and family therapists may not withhold records under their immediate control that are requested and needed for a client's treatment solely because payment has not been received for past services, except as otherwise provided by law.

STANDARD IX

ADVERTISING

Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.

9.1 Accurate Professional Representation. Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy in accordance with applicable law.

9.2 Promotional Materials. Marriage and family therapists ensure that advertisements and publications in any media are true, accurate, and in accordance with applicable law.

9.3 Professional Affiliations. Marriage and family therapists do not hold themselves out as being partners or associates of a firm if they are not.

9.4 Professional Identification. Marriage and family therapists do not use any professional identification (such as a business card, office sign, letterhead, Internet, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive.

9.5 Educational Credentials. Marriage and family therapists claim degrees for their clinical services only if those degrees demonstrate training and education in marriage and family therapy or related fields.

9.6 Employee or Supervisee Qualifications. Marriage and family therapists make certain that the qualifications of their employees and supervisees are represented in a manner that is true, accurate, and in accordance with applicable law.

9.7 Specialization. Marriage and family therapists represent themselves as providing specialized services only after taking reasonable steps to ensure the competence of their work and to protect clients, supervisees, and others from harm.

9.8 Correction of Misinformation. Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products.
APPENDIX D
RECORD OF CLIENT CONTACT AND SUPERVISION HOURS
## Weekly Summary of Client Contact & Supervision

<table>
<thead>
<tr>
<th>WEEK OF:</th>
<th>Total Hours</th>
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<tbody>
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### CLIENT CONTACT

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<tbody>
<tr>
<td>Individual Therapy</td>
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<tr>
<td>Couples Therapy</td>
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<tr>
<td>Family Therapy</td>
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<tr>
<td>Group Therapy</td>
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### ALTERNATIVE HOURS

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<td>Individual</td>
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<td>Couples Therapy</td>
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<tr>
<td>Family Therapy</td>
<td></td>
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<tr>
<td>Group Therapy</td>
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### TOTAL PER WEEK:

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### SUPERVISION - INDIVIDUAL

<p>| | |</p>
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<tbody>
<tr>
<td>Live</td>
<td></td>
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<tr>
<td>Videotape</td>
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<tr>
<td>Audiotape</td>
<td></td>
</tr>
<tr>
<td>Case Report</td>
<td></td>
</tr>
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</table>

### SUPERVISION – GROUP

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<tbody>
<tr>
<td>Live</td>
<td></td>
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<tr>
<td>Videotape</td>
<td></td>
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<tr>
<td>Audiotape</td>
<td></td>
</tr>
<tr>
<td>Case Report</td>
<td></td>
</tr>
</tbody>
</table>

### TOTAL PER WEEK:

<p>| | |</p>
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</table>

| Signature of Supervisor |             |
AAMFT has set a 5 client contact to 1 supervision hour ratio per week during training. You must receive supervision every week, one hour for 1 to 5 client contact hours, and two hours for over five hours of client contact up to 10 and so forth. AAMFT also has set a standard for number of relational vs. Individual hours for training. You need to accrue at least 50% of your client contact hours with couples and families.

**CLIENT CONTACT HOURS:**

These are face to face hours with clients. You may count telephone conversations in certain circumstances. The call must be "therapeutic" in nature, not just to schedule an appointment.

**Individual:** When one person is in the room with the therapist. (Even if the person is discussing relationship or family issues, it still counts as individual hours).

**Couple:** When two adults are in the room with the therapist discussing relationship issues.

**Family:** When two or more people are in the room with the therapist discussing family/relational issues.

**SUPERVISION HOURS:**

**Individual:** when one or two students are being supervised by one supervisor

**Group:** when three to 6 students are being supervised by one supervisor

**Live:** when the supervisor is observing behind a one-way mirror or via a live video connection.

**Videotape:** when the therapist and supervisor view a tape of previous therapy and discuss it.

**Audiotape:** when the therapist and supervisor listen to a tape of previous therapy and discuss it.

**Case Report:** when the therapist and supervisor discuss a case via the therapist verbal report of the session.
APPENDIX E
END OF SEMESTER CLINICAL EVALUATION FORM
Supervisee Evaluation Form

Therapist trainee: ___________  Quarter/Year: ___________
Experience: >500 client contact hours______  First 500 hours______
Time in PhD program: 1st year____  2nd year____  3rd year____  4th year____  5th year____

Supervisor:

Please indicate therapist’s skill/performance levels in all areas, using the following rating scale.

- N = No opportunity to observe
- 0 = Does not meet criteria for student’s stage in program
- 1 = Competence level inconsistent with student’s stage in program
- 2 = Competence level consistent with student’s stage in program
- 3 = Competence level exceeds student’s stage in program
- 4 = Competence and conceptual understanding exceeds student’s stage in program

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Rating</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative (i.e., attendance, record-keeping, etc.)</td>
<td>N</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Structuring (i.e., setting boundaries, controlling interactions during session, etc.)</td>
<td>N</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Conceptualization (i.e., hypothesizing, content v. process, use of theory, systemic understanding clear, etc.)</td>
<td>N</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Therapeutic skills and abilities (i.e., creating a safe environment, active listening, assessment, joining, planning and implementing systemic interventions, termination, etc.)</td>
<td>N</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Use of supervision (i.e., seeking supervision when appropriate, ability to receive and utilize feedback, appropriate supervision goal-setting, etc.)</td>
<td>N</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Understanding of self (i.e., understands self-of-therapist, is aware of his/her own belief systems and their impact on clinical work, can assess his/her part in the system, etc.)</td>
<td>N</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Use of self in session (i.e. is able to use self in session as a tool to build therapeutic alliance, attend to therapy process, and highlight interpersonal interaction)</td>
<td>N</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Personal and professional responsibility (i.e., operates consistent with AAMFT ethical principles, adheres to deadlines and policies, prompt and professional, etc.)</td>
<td>N</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Competence (i.e., recognizing limits, recognizing and correcting deficiencies, demonstrating cultural competence, etc.)</td>
<td>N</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>Therapist characteristics (i.e., demonstrating self-control, being fair, honest, and respectful, refraining from engaging in triangulation to resolve issues, etc.)</td>
<td>N</td>
<td>0</td>
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</tr>
<tr>
<td>Integrity (i.e., avoiding dual relationships, refraining from making deceptive claims, respects cultural, individual, and role differences, respecting individual rights, etc.)</td>
<td>N</td>
<td>0</td>
</tr>
</tbody>
</table>
Describe this therapist’s strengths.

Describe this therapist’s growth edges.

Site Supervisor Signature: ____________________________ Date: ___________________
Clinical Competency Exam

Prerequisite: 500 hours of client contact, completion of foundational components of the curriculum.

Format:
1. Case presentation providing information about the client system (ages, race/ethnicity, gender, sexual orientation etc), presenting concerns, interventions used, number of sessions attended, progress.
2. 10 minute video clip (or combination of clips) demonstrating therapist’s use of their theory change.
3. Theory of Change Paper:
   I. The Big Picture (if the theory has one)
      a. how do families operate?
      b. how do families develop?
   II. Symptoms
      a. what is different about families without symptoms, and families that develop symptoms?
      b. how do symptoms develop?
   III. Interventions
      a. Given the theoretical conceptualization from the first two sections, how can you intervene to change the way the family operates?
      b. What is the focus of these interventions, i.e. insight, feelings, interaction patterns, behavior, cognition? Use examples.
   IV. Research and Critique
      a. provide any research evidence of the effectiveness of this treatment model. If there is little research explain why.
      b. discuss the model’s applicability to diverse clients, would any part of it need to be revised for it to be acceptable to all clients?
      c. discuss any shortcomings of the model that have been suggested in the literature and any shortcomings that you believe exist.
APPENDIX G
SUPERVISOR EVALUATION FORM
Evaluation of Individual Supervision

Semester:________________

Supervisor:_____________________________  Site:_________________________

1. How often, per week, did you meet with your supervisor:_____________________________

2. How frequently did you use the following type of supervision:
   a. Videotapes             Never       Sometimes       Often       Always
   b. Case discussion (no tape)  Never       Sometimes       Often       Always
   c. Live                   Never       Sometimes       Often       Always
   d. Conjoint therapy session Never       Sometimes       Often       Always
   e. Other, please specify: Never       Sometimes       Often       Always

3. Using the following scale, please rate your supervisor’s ability to:

<table>
<thead>
<tr>
<th>Area</th>
<th>Excellent (5)</th>
<th>Very good (4)</th>
<th>Good (3)</th>
<th>Fair (2)</th>
<th>Poor (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist me in meeting my goals</td>
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<tr>
<td>Assist me theoretically</td>
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<tr>
<td>Help me develop good technical clinical skills</td>
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<tr>
<td>Identify difficulties with my clinical skills</td>
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<tr>
<td>Help me develop good clinical judgement.</td>
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</table>
APPENDIX G
SAMPLE INTERSHIP CONTRACT
SAMPLE INTERNSHIP AGREEMENT LETTER

(date)
(supervisor)
(agency name)
(address)
(address)

Dear (supervisor),

Thank you for agreeing to provide an internship placement for (student). This placement serves to satisfy the requirements for FM & HU DV 989, Field Experience in Family Therapy. As you know, before (student) can begin (his/her) placement certain conditions of both the agency and the experience must be met. These conditions assure each of our students receives an equally high quality clinical experience.

It is understood that the (agency name):

1. Is chartered or licensed by the appropriate state authority (if applicable).
2. Has been in operation for at least 2 full years.
3. Has a governing board that includes representation reflecting the public interest.
4. Has adequate facilities and equipment for the intern to carry out their responsibilities.
5. Has published procedures for handling grievances.
6. Has published policies prohibiting discrimination on the basis of race, ethnicity, religion, and gender.

It is further understood that the experience for the intern will include:

1. A continuous 9 month experience in marriage and family therapy.
2. A case load that will be sufficient to provide the intern with a minimum of 500 direct client contact hours. At least half of these (250 hours) will be with couples and families.
3. A minimum of 100 hours of supervision with an AAMFT Supervisor, a licensed supervisor, or the equivalent. These hours will be provided at a rate of 1 hour of supervision for every 5 hours of client contact. If the facility does not have such a supervisor, it is agreed that supervision will
be conducted by the clinical faculty of The Ohio State University. This does not preclude additional supervision being done on site.

4. Appropriate releases of information so that client materials may be shared with the clinical faculty at The Ohio State University.

5. An evaluation of the intern’s performance at your setting and the opportunity for the intern to evaluate their experience with you and the placement site.

6. Orientation to the policies and procedures of the internship site.

If the conditions of this agreement are acceptable and can be provided please indicate this by filling out the requested information below and signing the agreement. Please have this form returned to the Internship Coordinator so that a copy can be made for your records. If you should have any questions about this agreement, please do not hesitate to contact: (name and number).

Sincerely,

(Supervisor)

I agree that the above conditions have been or can be met by this internship site:

Signed:__________________________ Printed name:__________________________

Title:____________________________ Date:_____________________

Name of Placement:__________________________________________________________
The Ohio State University
Couple and Family Therapy Program

Evaluation of Internship

Semester:________________  Supervisor:_____________________________
Site:_________________________

1. How often, per week, did you meet with your supervisor:_____________________________

2. How frequently did you use the following type of supervision:
   a. Videotapes   Never  Sometimes  Often  Always
   b. Case discussion  (no tape)  Never  Sometimes  Often  Always
   c. Live  Never  Sometimes  Often  Always
   d. Conjoint therapy session  Never  Sometimes  Often  Always
   e. Other, please specify: Never  Sometimes  Often  Always

3. Using the following scale, please rate your supervisor’s ability to:

<table>
<thead>
<tr>
<th>Area</th>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assist me in meeting my goals</td>
<td>(5)</td>
<td>(4)</td>
<td>(3)</td>
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<td>(1)</td>
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<tr>
<td>2. Assist me theoretically</td>
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<tr>
<td>3. Help me develop good technical clinical skills</td>
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<td>4. Identify difficulties with my clinical skills</td>
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<td>5. Help me develop good clinical judgement</td>
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<td>6. Identify my anxieties</td>
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<tr>
<td>7. Assist me in developing good professional skills</td>
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4. What was most helpful about this supervisory experience:
5. How might your supervisor have been of more help to you:

6. How often were you able to attend team meetings/staff meetings and/or group supervision?
   Weekly  Every Other Week  Monthly  Less Often

7. How many client contact hours were you able to accrue each week?
   4 or less  5 -7  8-10  11 or more

8. Of the client contact hours you were able to accrue what percentage were with couples and/or families?
   Less than 10  11-15  16-20  21-25  26-30  31-35  36-40  41-45  46-50  51 or more

9. If you were also involved in research, how many hours per week were you involved in the research process (proposal writing, data entry, data analysis, publication preparation etc.)?

10. How was your supervisor useful to you in your development as a research clinician?

11. What would you have liked to have had more experience with in terms of your research experience at this site?
APPENDIX I
INTAKE FORM
### Date:  | Time:  | Initials:  
---|---|---

How did you hear about the clinic?

### Person Calling the Clinic:

<table>
<thead>
<tr>
<th>Contact Information:</th>
<th>Ok to leave messages?</th>
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<tbody>
<tr>
<td>(H)</td>
<td>Yes</td>
</tr>
<tr>
<td>(W)</td>
<td>Yes</td>
</tr>
<tr>
<td>(Cell)</td>
<td>Yes</td>
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### Address:

### Client Information:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Race</th>
<th>Work @ OSU</th>
<th>Student @ OSU</th>
<th>Relationship</th>
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### Family Income:

<table>
<thead>
<tr>
<th>$</th>
<th># of Dependents:</th>
<th>Fee:</th>
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</table>

### Days Available:

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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</table>

### Time Available:

### Presenting Issue:

### Type of Therapy:

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<thead>
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<th>Individual</th>
<th>Couple</th>
<th>Family</th>
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<tbody>
<tr>
<td>Single</td>
<td>Dating</td>
<td>Cohabiting</td>
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### Relationship Status:

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<th>Divorced</th>
<th>Remarried</th>
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</table>

### Length of Relationship:
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>What occurred?</th>
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**Date of First Session:**
APPENDIX J
TERMINATION/TRANSFER FORM
TERMINATION OR TRANSFER SUMMARY FORM

Client #: ___________________ Date of this report: ________________

Relationship and Age of family members attending therapy
sessions: ____________________________________________________________

______________________________________________________________

Date of Initial Contact: __________________________________________

Time span of treatment (beginning and end dates): ______________________

Total number of sessions: ________________________________

Therapist: ___________________ Supervisor(s): __________________________

______________________________________________________________

Problem(s) presented by
family: __________________________________________________________

______________________________________________________________

Goals of treatment: ______________________________________________

______________________________________________________________

Treatment outcome at ___ transfer (or) termination:

___ The goals of therapy were successfully met/problems resolved.
___ Some positive changes have occurred regarding the presenting problems.
___ No positive changes occurred regarding the presenting problem(s).
___ The presenting problem(s) become worse.

Reason for Termination (Check one):

___ Therapy ended by therapist and client agreement.
___ Client terminated against therapist recommendation.
___ Clients no-showed and never returned (dropped out of therapy).
___ Was necessary to refer out of Clinic to

_______________________________________________
Other.

Briefly describe the events of therapy:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If case has been transferred, to whom: __________________________________________

____________________________________
Therapist's Signature

____________________________________
Supervisor's Signature
APPENDIX K
TWO-WAY RELEASE OF INFORMATION
TWO-WAY RELEASE OF INFORMATION
The Ohio State Couple and Family Therapy Clinic

The Couple and Family Therapy Clinic of The Ohio State University is hereby granted permission:

____ to release to
____ to exchange with
____ to request from

Name or title: __________________________________________________________________

Address: __________________________________________________________________________
________________________________________________________________________

From the record of: ____________________________________________________________

Clients name: __________________________________________________________________

Purpose: ______________________________________________________________________
________________________________________________________________________

EXTENT OR NATURE OF INFORMATION TO BE RELEASED:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Records and information which are not to be released are:_________________________
________________________________________________________________________
________________________________________________________________________

I (we) understand that all such information is confidential and that I (we) may rescind this authorization at any time with written notices to all parties. This authorization, unless expressly revoked earlier, expires 180 days from the date signed below. I understand that all family members involved in therapy at The Ohio State University Family Therapy Clinic have signed below.

______________________    Date:___________________
(Signature of client or person authorized to consent)

______________________    Date:___________________
(Signature of client or person authorized to consent)

______________________    Date:___________________
(Signature of client or person authorized to consent)
(Signature of client or person authorized to consent)

______________________    Date:___________________
(Signature of client or person authorized to consent)

______________________    Date:___________________
(Signature of client or person authorized to consent)

______________________    Date:___________________
(Signature of client or person authorized to consent)

Witnessed:   __________________________________

If there are any questions or concerns about the release of information, please contact:

Suzanne Bartle-Haring, Ph.D. Couple and Family Therapy Program Director,
Human Development and Family Science; The Ohio State University; 135 Campbell Hall; 1787 Neil Avenue, Columbus, Ohio 43210-1295
APPENDIX L
CONSENT FOR TREATMENT
CONSENT FORM
TO RECEIVE SERVICES AT
THE OHIO STATE UNIVERSITY
COUPLE AND FAMILY THERAPY CLINIC

The Ohio State Couple and Family Therapy Clinic is a training and research facility. Our goal is to provide consistent and professionally competent services for our clients.

By signing below, you are agreeing to the following:

I understand that treatment at the Ohio State University Couple and Family Therapy Clinic may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with relationships. I am aware of alternative treatment facilities available to me.

My Rights as a client:

1. I have the right and am encouraged to ask questions about the method, procedure or approach to therapy at any time.

2. I have the right to end therapy at any time. I would then be provided with names and numbers of other professionals whose services I might prefer.

3. I have the right to end therapy at any time without moral, legal, or financial obligations other than those already accrued.

4. If I should desire, any part of my record in the files can be released to any person or agency I designate. My therapist will be glad to give me advice, at the time, whether or not releasing the information in question to that person or agency might be harmful in any way.

5. I have the right to confidentiality, however, this right has stipulations attached. There are situations in which my therapist is required by law to reveal information obtained in therapy to other persons or agencies without my permission. These situations are as follows:

   a) If I threaten bodily harm or death to myself or another person.
   b) If a court of law issues a legitimate subpoena.
   c) If I reveal information relative to child abuse or neglect.
   d) If I am in therapy or being tested by order of a court of law, the results of the treatment or tests ordered must be revealed to the court.

Rules of Therapy

Benefitting from therapy requires one to have a clear head, therefore, I will not be under the influence of any substances. Substances include alcohol, drugs, or other mind altering
substances. If I come to therapy under the influence, the session will be canceled and I will be responsible for full payment.

My therapist has answered all my questions about treatment at the Couple and Family Therapy Clinic satisfactorily. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave therapy at any time, although I have been informed that this is best accomplished by consulting with my therapist first.

I understand that at the Couple and Family Therapy Clinic that a) doctoral students in family therapy conducts therapy under close supervision of family therapy faculty, and b) therapy sessions are routinely videoed and/or observed by other clinic therapists and supervisors. The videos are erased at the end of my treatment at the Clinic.

My therapist has explained the sliding fee scale, and I agree to pay ________ per session.

Signed by all participating members in therapy over age 11:

Signatures: Date:

____________________   ___________________
____________________   ___________________
____________________   ___________________
____________________   ___________________

Witness (OSU MFT CLINIC THERAPIST)
_____________________________
APPENDIX M
RECEIPT FOR SERVICE
Couples and Family Therapy Clinic  
012 Mount Hall  
1030 Carmack Road  
Columbus, OH 43210  
(614) 292-2171

CASH: _______  DATE: ___/____/____

NAME: _______  _______  _______  _______  _______  _______  _______  _______

SERVICE/FEE: _______  THERAPIST: _______  _______  _______  _______  _______

YOUR NEXT APPOINTMENT IS FOR:

DATE: ___/____/____  TIME: ______

MON  TUES  WED  THURS  FRI

(24 HOURS OF CANCELLATION REQUIRED)

METHOD OF PAYMENT

CASH: _______  CHECK#: _______

PREVIOUS BALANCE: _______  CURRENT DUE: _______

CURRENT PAYMENT: _______  BALANCE: _______

CLINICANS

THERAPIST: _______  _______  _______  _______  _______  _______  _______  _______

CO-THERAPIST: _______  _______  _______  _______  _______  _______  _______  _______

SUPERVISOR: _______  _______  _______  _______  _______  _______  _______  _______

TYPE:

FAMILY: _______  _______  _______  _______  _______  _______  _______  _______

COUPLE: _______  _______  _______  _______  _______  _______  _______  _______

INDIVIDUAL: _______  _______  _______  _______  _______  _______  _______  _______

GROUP: _______  _______  _______  _______  _______  _______  _______  _______
APPENDIX N
THE STATE OF OHIO MANDATORY REPORTING STATUTE (CHILDREN)
Ohio Revised Code

2151.421 Reporting child abuse or neglect.

(A)(1)(a) No person described in division (A)(1)(b) of this section who is acting in an official or professional capacity and knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in a similar position to suspect, that a child under eighteen years of age or a mentally retarded, developmentally disabled, or physically impaired child under twenty-one years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child shall fail to immediately report that knowledge or reasonable cause to suspect to the entity or persons specified in this division. Except as provided in section 5120.173 of the Revised Code, the person making the report shall make it to the public children services agency or a municipal or county peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred. In the circumstances described in section 5120.173 of the Revised Code, the person making the report shall make it to the entity specified in that section.

(b) Division (A)(1)(a) of this section applies to any person who is an attorney; physician, including a hospital intern or resident; dentist; podiatrist; practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised Code; registered nurse; licensed practical nurse; visiting nurse; other health care professional; licensed psychologist; licensed school psychologist; independent marriage and family therapist or marriage and family therapist; speech pathologist or audiologist; coroner; administrator or employee of a child day-care center; administrator or employee of a residential camp or child day camp; administrator or employee of a certified child care agency or other public or private children services agency; school teacher; school employee; school authority; person engaged in social work or the practice of professional counseling; agent of a county humane society; person, other than a cleric, rendering spiritual treatment through prayer in accordance with the tenets of a well-recognized religion; employee of a county department of job and family services who is a professional and who works with children and families; superintendent, board member, or employee of a county board of developmental disabilities; investigative agent contracted with by a county board of developmental disabilities; employee of the department of developmental disabilities; employee of a facility or home that provides respite care in accordance with section 5123.171 of the Revised Code; employee of a home health agency; employee of an entity that provides homemaker services; a person performing the duties of an assessor pursuant to Chapter 3107. or 5103. of the Revised Code; or third party employed by a public children services agency to assist in providing child or family related services.

(2) Except as provided in division (A)(3) of this section, an attorney or a physician is not required to make a report pursuant to division (A)(1) of this section concerning any communication the attorney or physician receives from a client or patient in an attorney-client or physician-patient relationship, if, in accordance with division (A) or (B) of section 2317.02 of the Revised Code, the attorney or physician could not testify with respect to that communication in a civil or criminal proceeding.

(3) The client or patient in an attorney-client or physician-patient relationship described in division (A)(2) of this section is deemed to have waived any testimonial privilege under division (A) or (B) of section 2317.02 of the Revised Code with respect to any communication the attorney or physician receives from the client or patient in that attorney-client or physician-
patient relationship, and the attorney or physician shall make a report pursuant to division (A)(1) of this section with respect to that communication, if all of the following apply:

(a) The client or patient, at the time of the communication, is either a child under eighteen years of age or a mentally retarded, developmentally disabled, or physically impaired person under twenty-one years of age.

(b) The attorney or physician knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in similar position to suspect, as a result of the communication or any observations made during that communication, that the client or patient has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the client or patient.

(c) The abuse or neglect does not arise out of the client’s or patient’s attempt to have an abortion without the notification of her parents, guardian, or custodian in accordance with section 2151.85 of the Revised Code.

(4)(a) No cleric and no person, other than a volunteer, designated by any church, religious society, or faith acting as a leader, official, or delegate on behalf of the church, religious society, or faith who is acting in an official or professional capacity, who knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, that a child under eighteen years of age or a mentally retarded, developmentally disabled, or physically impaired child under twenty-one years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, and who knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, that another cleric or another person, other than a volunteer, designated by a church, religious society, or faith acting as a leader, official, or delegate on behalf of the church, religious society, or faith caused, or poses the threat of causing, the wound, injury, disability, or condition that reasonably indicates abuse or neglect shall fail to immediately report that knowledge or reasonable cause to believe to the entity or persons specified in this division. Except as provided in section 5120.173 of the Revised Code, the person making the report shall make it to the public children services agency or a municipal or county peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred. In the circumstances described in section 5120.173 of the Revised Code, the person making the report shall make it to the entity specified in that section.

(b) Except as provided in division (A)(4)(c) of this section, a cleric is not required to make a report pursuant to division (A)(4)(a) of this section concerning any communication the cleric receives from a penitent in a cleric-penitent relationship, if, in accordance with division© of section 2317.02 of the Revised Code, the cleric could not testify with respect to that communication in a civil or criminal proceeding.

(c) The penitent in a cleric-penitent relationship described in division (A)(4)(b) of this section is deemed to have waived any testimonial privilege under division© of section 2317.02 of the Revised Code with respect to any communication the cleric receives from the penitent in that cleric-penitent relationship, and the cleric shall make a report pursuant to division (A)(4)(a) of this section with respect to that communication, if all of the following apply:

(i) The penitent, at the time of the communication, is either a child under eighteen years of age or a mentally retarded, developmentally disabled, or physically impaired person under twenty-one years of age.
(ii) The cleric knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, as a result of the communication or any observations made during that communication, the penitent has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the penitent.

(iii) The abuse or neglect does not arise out of the penitent’s attempt to have an abortion performed upon a child under eighteen years of age or upon a mentally retarded, developmentally disabled, or physically impaired person under twenty-one years of age without the notification of her parents, guardian, or custodian in accordance with section 2151.85 of the Revised Code.

(d) Divisions (A)(4)(a) and© of this section do not apply in a cleric-penitent relationship when the disclosure of any communication the cleric receives from the penitent is in violation of the sacred trust.

(e) As used in divisions (A)(1) and (4) of this section, “cleric” and “sacred trust” have the same meanings as in section 2317.02 of the Revised Code.

(B) Anyone who knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in similar circumstances to suspect, that a child under eighteen years of age or a mentally retarded, developmentally disabled, or physically impaired person under twenty-one years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or other condition of a nature that reasonably indicates abuse or neglect of the child may report or cause reports to be made of that knowledge or reasonable cause to suspect to the entity or persons specified in this division. Except as provided in section 5120.173 of the Revised Code, a person making a report or causing a report to be made under this division shall make it or cause it to be made to the public children services agency or to a municipal or county peace officer. In the circumstances described in section 5120.173 of the Revised Code, a person making a report or causing a report to be made under this division shall make it or cause it to be made to the entity specified in that section.

(C) Any report made pursuant to division (A) or (B) of this section shall be made forthwith either by telephone or in person and shall be followed by a written report, if requested by the receiving agency or officer. The written report shall contain:

(1) The names and addresses of the child and the child’s parents or the person or persons having custody of the child, if known;

(2) The child’s age and the nature and extent of the child’s injuries, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to have occurred or of the threat of injury, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to exist, including any evidence of previous injuries, abuse, or neglect;

(3) Any other information that might be helpful in establishing the cause of the injury, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to have occurred or of the threat of injury, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to exist.

Any person, who is required by division (A) of this section to report child abuse or child neglect that is known or reasonably suspected or believed to have occurred, may take or cause to be taken color photographs of areas of trauma visible on a child and, if medically indicated, cause to be performed radiological examinations of the child.
(D) As used in this division, “children’s advocacy center” and “sexual abuse of a child” have the same meanings as in section 2151.425 of the Revised Code.

(1) When a municipal or county peace officer receives a report concerning the possible abuse or neglect of a child or the possible threat of abuse or neglect of a child, upon receipt of the report, the municipal or county peace officer who receives the report shall refer the report to the appropriate public children services agency.

(2) When a public children services agency receives a report pursuant to this division or division (A) or (B) of this section, upon receipt of the report, the public children services agency shall do both of the following:

(a) Comply with section 2151.422 of the Revised Code;

(b) If the county served by the agency is also served by a children’s advocacy center and the report alleges sexual abuse of a child or another type of abuse of a child that is specified in the memorandum of understanding that creates the center as being within the center’s jurisdiction, comply regarding the report with the protocol and procedures for referrals and investigations, with the coordinating activities, and with the authority or responsibility for performing or providing functions, activities, and services stipulated in the interagency agreement entered into under section 2151.428 of the Revised Code relative to that center.

(E) No township, municipal, or county peace officer shall remove a child about whom a report is made pursuant to this section from the child’s parents, stepparents, or guardian or any other persons having custody of the child without consultation with the public children services agency, unless, in the judgment of the officer, and, if the report was made by physician, the physician, immediate removal is considered essential to protect the child from further abuse or neglect. The agency that must be consulted shall be the agency conducting the investigation of the report as determined pursuant to section 2151.422 of the Revised Code.

(F)(1) Except as provided in section 2151.422 of the Revised Code or in an interagency agreement entered into under section 2151.428 of the Revised Code that applies to the particular report, the public children services agency shall investigate, within twenty-four hours, each report of child abuse or child neglect that is known or reasonably suspected or believed to have occurred and of a threat of child abuse or child neglect that is known or reasonably suspected or believed to exist that is referred to it under this section to determine the circumstances surrounding the injuries, abuse, or neglect or the threat of injury, abuse, or neglect, the cause of the injuries, abuse, neglect, or threat, and the person or persons responsible. The investigation shall be made in cooperation with the law enforcement agency and in accordance with the memorandum of understanding prepared under division (J) of this section. A representative of the public children services agency shall, at the time of initial contact with the person subject to the investigation, inform the person of the specific complaints or allegations made against the person. The information shall be given in a manner that is consistent with division (H)(1) of this section and protects the rights of the person making the report under this section.

A failure to make the investigation in accordance with the memorandum is not grounds for, and shall not result in, the dismissal of any charges or complaint arising from the report or the suppression of any evidence obtained as a result of the report and does not give, and shall not be construed as giving, any rights or any grounds for appeal or post-conviction relief to any person. The public children services agency shall report each case to the uniform statewide automated child welfare information system that the department of job and family services shall maintain in accordance with section 5101.13 of the Revised Code. The public children services agency shall submit a report of its investigation, in writing, to the law enforcement agency.
(2) The public children services agency shall make any recommendations to the county prosecuting attorney or city director of law that it considers necessary to protect any children that are brought to its attention.

(G)(1)(a) Except as provided in division (H)(3) of this section, anyone or any hospital, institution, school, health department, or agency participating in the making of reports under division (A) of this section, anyone or any hospital, institution, school, health department, or agency participating in good faith in the making of reports under division (B) of this section, and anyone participating in good faith in a judicial proceeding resulting from the reports, shall be immune from any civil or criminal liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of the making of the reports or the participation in the judicial proceeding.

(b) Notwithstanding section 4731.22 of the Revised Code, the physician-patient privilege shall not be a ground for excluding evidence regarding a child’s injuries, abuse, or neglect, or the cause of the injuries, abuse, or neglect in any judicial proceeding resulting from a report submitted pursuant to this section.

(2) In any civil or criminal action or proceeding in which it is alleged and proved that participation in the making of a report under this section was not in good faith or participation in a judicial proceeding resulting from a report made under this section was not in good faith, the court shall award the prevailing party reasonable attorney’s fees and costs and, if a civil action or proceeding is voluntarily dismissed, may award reasonable attorney’s fees and costs to the party against whom the civil action or proceeding is brought.

(H)(1) Except as provided in divisions (H)(4) and (N) of this section, a report made under this section is confidential. The information provided in a report made pursuant to this section and the name of the person who made the report shall not be released for use, and shall not be used, as evidence in any civil action or proceeding brought against the person who made the report. Nothing in this division shall preclude the use of reports of other incidents of known or suspected abuse or neglect in a civil action or proceeding brought pursuant to division (M) of this section against a person who is alleged to have violated division (A)(1) of this section, provided that any information in a report that would identify the child who is the subject of the report or the maker of the report, if the maker of the report is not the defendant or an agent or employee of the defendant, has been redacted. In a criminal proceeding, the report is admissible in evidence in accordance with the Rules of Evidence and is subject to discovery in accordance with the Rules of Criminal Procedure.

(2) No person shall permit or encourage the unauthorized dissemination of the contents of any report made under this section.

(3) A person who knowingly makes or causes another person to make a false report under division (B) of this section that alleges that any person has committed an act or omission that resulted in a child being an abused child or a neglected child is guilty of a violation of section 2921.14 of the Revised Code.

(4) If a report is made pursuant to division (A) or (B) of this section and the child who is the subject of the report dies for any reason at any time after the report is made, but before the child attains eighteen years of age, the public children services agency or municipal or county peace officer to which the report was made or referred, on the request of the child fatality review board, shall submit a summary sheet of information providing a summary of the report to the review board of the county in which the deceased child resided at the time of death. On the request of the review board, the agency or peace officer may, at its discretion, make the report available to the review board. If the county served by the public children services agency is also
served by a children’s advocacy center and the report of alleged sexual abuse of a child or another type of abuse of a child is specified in the memorandum of understanding that creates the center as being within the center’s jurisdiction, the agency or center shall perform the duties and functions specified in this division in accordance with the interagency agreement entered into under section 2151.428 of the Revised Code relative to that advocacy center.

(5) A public children services agency shall advise a person alleged to have inflicted abuse or neglect on a child who is the subject of a report made pursuant to this section, including a report alleging sexual abuse of a child or another type of abuse of a child referred to a children’s advocacy center pursuant to an interagency agreement entered into under section 2151.428 of the Revised Code, in writing of the disposition of the investigation. The agency shall not provide to the person any information that identifies the person who made the report, statements of witnesses, or police or other investigative reports.

(I) Any report that is required by this section, other than a report that is made to the state highway patrol as described in section 5120.173 of the Revised Code, shall result in protective services and emergency supportive services being made available by the public children services agency on behalf of the children about whom the report is made, in an effort to prevent further neglect or abuse, to enhance their welfare, and, whenever possible, to preserve the family unit intact. The agency required to provide the services shall be the agency conducting the investigation of the report pursuant to section 2151.422 of the Revised Code.

(J)(1) Each public children services agency shall prepare a memorandum of understanding that is signed by all of the following:

(a) If there is only one juvenile judge in the county, the juvenile judge of the county or the juvenile judge’s representative;

(b) If there is more than one juvenile judge in the county, a juvenile judge or the juvenile judges’ representative selected by the juvenile judges or, if they are unable to do so for any reason, the juvenile judge who is senior in point of service or the senior juvenile judge’s representative;

(c) The county peace officer;

(d) All chief municipal peace officers within the county;

(e) Other law enforcement officers handling child abuse and neglect cases in the county;

(f) The prosecuting attorney of the county;

(g) If the public children services agency is not the county department of job and family services, the county department of job and family services;

(h) The county humane society;

(i) If the public children services agency participated in the execution of a memorandum of understanding under section 2151.426 of the Revised Code establishing a children’s advocacy center, each participating member of the children’s advocacy center established by the memorandum.

(2) A memorandum of understanding shall set forth the normal operating procedure to be employed by all concerned officials in the execution of their respective responsibilities under this
section and division© of section 2919.21, division (B)(1) of section 2919.22, division (B) of section 2919.23, and section 2919.24 of the Revised Code and shall have as two of its primary goals the elimination of all unnecessary interviews of children who are the subject of reports made pursuant to division (A) or (B) of this section and, when feasible, providing for only one interview of a child who is the subject of any report made pursuant to division (A) or (B) of this section. A failure to follow the procedure set forth in the memorandum by the concerned officials is not grounds for, and shall not result in, the dismissal of any charges or complaint arising from any reported case of abuse or neglect or the suppression of any evidence obtained as a result of any reported child abuse or child neglect and does not give, and shall not be construed as giving, any rights or any grounds for appeal or post-conviction relief to any person.

(3) A memorandum of understanding shall include all of the following:

(a) The roles and responsibilities for handling emergency and nonemergency cases of abuse and neglect;

(b) Standards and procedures to be used in handling and coordinating investigations of reported cases of child abuse and reported cases of child neglect, methods to be used in interviewing the child who is the subject of the report and who allegedly was abused or neglected, and standards and procedures addressing the categories of persons who may interview the child who is the subject of the report and who allegedly was abused or neglected.

(4) If a public children services agency participated in the execution of a memorandum of understanding under section 2151.426 of the Revised Code establishing a children's advocacy center, the agency shall incorporate the contents of that memorandum in the memorandum prepared pursuant to this section.

(5) The clerk of the court of common pleas in the county may sign the memorandum of understanding prepared under division (J)(1) of this section. If the clerk signs the memorandum of understanding, the clerk shall execute all relevant responsibilities as required of officials specified in the memorandum.

(K)(1) Except as provided in division (K)(4) of this section, a person who is required to make a report pursuant to division (A) of this section may make a reasonable number of requests of the public children services agency that receives or is referred the report, or of the children's advocacy center that is referred the report if the report is referred to a children's advocacy center pursuant to an interagency agreement entered into under section 2151.428 of the Revised Code, to be provided with the following information:

(a) Whether the agency or center has initiated an investigation of the report;

(b) Whether the agency or center is continuing to investigate the report;

(c) Whether the agency or center is otherwise involved with the child who is the subject of the report;

(d) The general status of the health and safety of the child who is the subject of the report;

(e) Whether the report has resulted in the filing of a complaint in juvenile court or of criminal charges in another court.
(2) A person may request the information specified in division (K)(1) of this section only if, at the
time the report is made, the person’s name, address, and telephone number are provided to the
person who receives the report.

When a municipal or county peace officer or employee of a public children services agency
receives a report pursuant to division (A) or (B) of this section the recipient of the report shall
inform the person of the right to request the information described in division (K)(1) of this
section. The recipient of the report shall include in the initial child abuse or child neglect report
that the person making the report was so informed and, if provided at the time of the making of
the report, shall include the person’s name, address, and telephone number in the report.

Each request is subject to verification of the identity of the person making the report. If that
person’s identity is verified, the agency shall provide the person with the information described
in division (K)(1) of this section a reasonable number of times, except that the agency shall not
disclose any confidential information regarding the child who is the subject of the report other
than the information described in those divisions.

(3) A request made pursuant to division (K)(1) of this section is not a substitute for any report
required to be made pursuant to division (A) of this section.

(4) If an agency other than the agency that received or was referred the report is conducting the
investigation of the report pursuant to section 2151.422 of the Revised Code, the agency
conducting the investigation shall comply with the requirements of division (K) of this section.

(L) The director of job and family services shall adopt rules in accordance with Chapter 119. of
the Revised Code to implement this section. The department of job and family services may
enter into a plan of cooperation with any other governmental entity to aid in ensuring that
children are protected from abuse and neglect. The department shall make recommendations to
the attorney general that the department determines are necessary to protect children from child
abuse and child neglect.

(M) Whoever violates division (A) of this section is liable for compensatory and exemplary
damages to the child who would have been the subject of the report that was not made. A
person who brings a civil action or proceeding pursuant to this division against a person who is
alleged to have violated division (A)(1) of this section may use in the action or proceeding
reports of other incidents of known or suspected abuse or neglect, provided that any information
in a report that would identify the child who is the subject of the report or the maker of the
report, if the maker is not the defendant or an agent or employee of the defendant, has been
redacted.

(N)(1) As used in this division:

(a) “Out-of-home care” includes a nonchartered nonpublic school if the alleged child abuse or
child neglect, or alleged threat of child abuse or child neglect, described in a report received by a
public children services agency allegedly occurred in or involved the nonchartered nonpublic
school and the alleged perpetrator named in the report holds a certificate, permit, or license
issued by the state board of education under section 3301.071 or Chapter 3319. of the Revised
Code.

(b) “Administrator, director, or other chief administrative officer” means the superintendent of
the school district if the out-of-home care entity subject to a report made pursuant to this
section is a school operated by the district.
(2) No later than the end of the day following the day on which a public children services agency receives a report of alleged child abuse or child neglect, or a report of an alleged threat of child abuse or child neglect, that allegedly occurred in or involved an out-of-home care entity, the agency shall provide written notice of the allegations contained in and the person named as the alleged perpetrator in the report to the administrator, director, or other chief administrative officer of the out-of-home care entity that is the subject of the report unless the administrator, director, or other chief administrative officer is named as an alleged perpetrator in the report. If the administrator, director, or other chief administrative officer of an out-of-home care entity is named as an alleged perpetrator in a report of alleged child abuse or child neglect, or a report of an alleged threat of child abuse or child neglect, that allegedly occurred in or involved the out-of-home care entity, the agency shall provide the written notice to the owner or governing board of the out-of-home care entity that is the subject of the report. The agency shall not provide witness statements or police or other investigative reports.

(3) No later than three days after the day on which a public children services agency that conducted the investigation as determined pursuant to section 2151.422 of the Revised Code makes a disposition of an investigation involving a report of alleged child abuse or child neglect, or a report of an alleged threat of child abuse or child neglect, that allegedly occurred in or involved an out-of-home care entity, the agency shall send written notice of the disposition of the investigation to the administrator, director, or other chief administrative officer and the owner or governing board of the out-of-home care entity. The agency shall not provide witness statements or police or other investigative reports.

(O) As used in this section, “investigation” means the public children services agency’s response to an accepted report of child abuse or neglect through either an alternative response or a traditional response.

Amended by 129th General Assembly File No. 28, HB 153, § 101.01, eff. 9/29/2011.

Amended by 128th General Assembly ch. 7, SB 79, § 1, eff. 10/6/2009.

Effective Date: 01-30-2004; 09-16-2004; 04-11-2005; 05-06-2005; 08-03-2006; 09-21-2006; 2008 HB314 06-20-2008; 2008 SB163 08-14-2008; 2008 HB280 04-07-200
APPENDIX O
THE STATE OF OHIO MANDATORY REPORTING STATUE (ELDERS)
Elder Abuse and Ohio Adult Protective Services

1. What Is Elder Abuse?

Adult Protective Services (APS) is responsible for investigating reports of suspected abuse, neglect, or exploitation of Ohioans aged 60 and older. APS is part of each Ohio County Department of Job & Family Services (CDJFS). The Ohio Revised Code defines “abuse” as infliction upon an adult by self or others of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain, or mental anguish. “Neglect” is defined as the failure of an adult to provide for self the goods or services necessary to avoid physical harm, mental anguish, or mental illness or the failure of a caretaker to provide such goods or services. “Exploitation” means the unlawful or improper act of a caretaker using an adult or an adult’s resources for their monetary or personal benefit, profit or gain.

2. What Are The Indicators Of Abuse Or Exploitation?

Indicators of physical abuse are bodily injuries such as fractures, lacerations abrasions and burns. Sexual abuse indicators are sexually transmitted diseases or pain, itching, bleeding or bruising in the genital area. Psychological abuse indicators are low self-esteem, very anxious or withdrawn, depression or confusion. Financial abuse or exploitation involves the theft or conversation of money or property. Indications of neglect include malnutrition, poor personal hygiene, over-medication and under-medication and when the elder is left alone, deprived of stimulation or affection.

3. What Causes Elder Abuse?

Societal changes may contribute to the predisposition of some individuals to become abusive towards the elderly. In previous generations extended family members could share the responsibility of caring for the aging. However, increased mobility, strained economic times and a smaller nuclear family have limited familial resources. Most often the responsibility of elder care falls on a select few and is more likely fraught with emotional and economic stress. Another major contributor of abuse may be the declining health of the older person and age-related diseases and medications that may alter the older person’s behavior. A variety of these indicators and their intensity may in some cases trigger elderly abuse.

4. Is There A Typical Victim Or Abuser?

No. Abusers and elder abuse victims fall within all demographic categories. Because older victims usually have fewer support systems and reserves – physical, psychological and economic – the impact of abuse is magnified, and a single incident
is more likely to trigger a downward spiral leading to loss of independence, serious illness and even death. Recent statistics show the average elderly abuse victim is aged 75 or older and more than likely dependent on others for food, medication and personal care. Women (67%) are more likely to be abused than men (32%). Of alleged perpetrators, 33% are adult children, 22% are other family members, 16% are strangers and 11% are spouses or intimate partners. More than half of these perpetrators (53%) are women.

5. What Can Older Persons And Caregivers Do To Prevent Abuse?

Both the older person and the caregiver should plan and encourage time away from each other. The older person should not rely on the caregiver solely for emotional support and care, but try to maintain a network of family, friends and community relationships. Likewise, the caregiver should plan to spend some of their free time away from the older person. Respite care (temporary help) is vitally important to promote an abusive-free environment. To prevent financial abuse or exploitation, the older person should familiarize themselves with their finances whenever possible. Know what you have and where it is. If not possible, the older person should grant a trusted individual a durable power of attorney to monitor and handle her financial obligations.

6. When And How Should APS Be Contacted?

If you have reasonable cause to suspect that an older person is being abused, call or write the County APS office. To report abuse in Hamilton County, call 421-LIFE (513-421-5433), the community 24-hour hotline. For a list of the CDJFS in other counties call: 614-466-6282 or see http://jfs.ohio.gov/County/cntydir.stm. Your report should include the name, address and approximate age of the adult, the name and address of the adult's caregiver, the nature and extent of the suspected abuse, neglect, or exploitation, and what makes you believe it has occurred.

Additionally, the following categories of professionals are required to report suspected abuse: any attorney, physician, osteopath, podiatrist, chiropractor, dentist, psychologist, any employee of a hospital, any nurse, any employee of an ambulatory health facility, any employee of a home health agency, an adult care facility, a community alternative home, a nursing home, residential care facility, or home for the aging, any senior service provider, any peace officer, coroner, clergyman, any employee of a community mental health facility, and any person engaged in social work or counseling having reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation shall immediately report such belief to the CDJFS. If suspected abuse is reported in good faith, you are immune from civil or criminal liability and your employer cannot retaliate against you.

7. What Must APS Do After Being Contacted?
APS must investigate “emergency” reports within 24 hours and all other reports within three working days. An emergency report is one in which there is a substantial risk of immediate physical harm to an individual or others. The investigator must meet face to face with the abused adult, who is given written notice of the investigation and, when possible, also consult with the person reporting abuse. The investigation results in a written report, which either confirms or denies the need for protective services.

8. What Protective Services May Be Available Through APS?

If available, APS services may include, but are not limited to, the provision of casework services, medical care, mental health services, legal services, fiscal management, home health care, homemaker services, housing-related services, guardianship services and placement services. They also may include the provision of food, clothing and shelter.

9. What If The Adult Or Someone Else Denies Or Obstructs Access To The Residence Of The Adult, Or Otherwise Refuses APS Services?

APS can petition Probate Court for a temporary restraining order to prevent interference or obstruction of its investigation by any person, including the abused adult. The court must find (a) that there is reasonable cause to believe the adult is being or has been abused, neglected, or exploited, and (b) that access to the adult's residence has been obstructed. APS can also petition the court to approve a service plan providing involuntary services. The adult must receive a notice describing his or her rights and the consequences of a court order at least five working days before a hearing on the petition. An indigent adult has the right to a court-appointed attorney. Notice of the hearing must also be sent to the adult's guardian, attorney, caretaker and spouse.

The court must find by clear and convincing evidence that (a) the adult has been abused, neglected, or exploited; (b) the adult is in need of protective services; (c) the adult is incapacitated; and (d) no other person authorized by law is available to give consent. If the court so finds, it must issue an order requiring protective services for up to six months, but can be re-authorized for up to a year.

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Pro Seniors, Inc. www.proseniors.org Page 4

This pamphlet provides general information and not legal advice.
### Annual Income vs. Number of Dependents

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APPENDIX Q
NO VIOLENCE CONTRACT
NO VIOLENCE CONTRACT

NON- VIOLENCE PLEDGE

I pledge never to allow my anger to go to the point that I use violence with my partner or other family member, no matter how justified I feel in doing so.

Violence is defined as:
- Slapping, kicking, punching, or using another object to hit or strike a person.
- Holding forcefully, throwing a person into a wall or other object.
- Pulling hair, biting or otherwise harming another person physically.
- Additional behaviors_____________________________________________

Instead, I pledge to use a timeout procedure and/or to cooperate whenever my partner or another family member initiates a timeout.

The timeout procedure consists of: (please list specific details)
___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________

My agreement with the details set forth here and the binding nature of this pledge are demonstrated by my signature below:

Name_____________________________________           Date:___________

Name_____________________________________           Date:___________
The Practice of Marriage and Family Therapy in Ohio

The practice of marriage and family therapy is defined in division (G) & (H) of section 4757.01 of the Revised Code:

(G) “Marriage and family therapy” means the diagnosis, evaluation, assessment, counseling, management and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems, through the professional application of marriage and family therapies and techniques.

(H) “Practice of marriage and family therapy” means the diagnosis, treatment, evaluation, assessment, counseling, and management, of mental and emotional disorders, whether cognitive, affective or behavioral, within the context of marriage and family systems, to individuals, couples, and families, singly or in groups, whether those services are offered directly to the general public or through public or private organizations, for a fee, salary or other consideration through the professional application of marriage and family theories, therapies, and techniques, including, but not limited to psychotherapeutic theories, therapies and techniques that marriage and family therapists are educated and trained to perform.

The practice is further defined in division (E) & (G) of section 4757.30 of the Revised Code:

(E) A marriage and family therapist may diagnose and treat mental and emotional disorders only under the supervision of a psychologist, psychiatrist, professional clinical counselor, independent social worker, or independent marriage and family therapist. An independent marriage and family therapist may diagnose and treat mental and emotional disorders without supervision.

(G) An independent marriage and family therapist or a marriage and family therapist may not diagnose, treat, or advise on conditions outside the recognized boundaries of the marriage and family therapist's competency. An independent marriage and family therapist shall make appropriate and timely referrals when a client's needs exceed the marriage and family therapist's competence level.

Information about educational requirements and how to apply for a license can be found at: http://www.cswmft.ohio.gov/FormsM.stm#1
CFT Program Director Evaluation

Q1 The general quality of the Program Director’s leadership?
- Very Dissatisfied (1)
- Dissatisfied (2)
- Neutral (3)
- Satisfied (4)
- Very Satisfied (5)

Q2 The courtesy and friendliness of the Program Director?
- Very Dissatisfied (1)
- Dissatisfied (2)
- Neutral (3)
- Satisfied (4)
- Very Satisfied (5)

Q3 The thoroughness of the Program Director in gathering important information regarding your problem/concern/request?
- Very Dissatisfied (1)
- Dissatisfied (2)
- Neutral (3)
- Satisfied (4)
- Very Satisfied (5)

Q4 The Program Director’s warmth and interest in your professional growth?
- Very Dissatisfied (1)
- Dissatisfied (2)
- Neutral (3)
- Satisfied (4)
- Very Satisfied (5)

Q5 The amount of respect that is shown to you by the Program Director?
- Very Dissatisfied (1)
- Dissatisfied (2)
- Neutral (3)
- Satisfied (4)
- Very Satisfied (5)

Q6 The Program Director, Suzanne Bartle-Haring, is readily available to me.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q7 The Program Director handles clinic related concerns appropriately.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)
Q8 The Program Director addresses the strengths and challenges of the CFT program.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q9 The Program Director successfully mentors/advises graduate students.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q10 The Program Director promotes the needs of CFTs to higher administration (e.g., Chair or Dean).
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q11 The Program Director facilitates a meaningful orientation for students.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q12 The Program Director effectively facilitates the accreditation process.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q13 I feel that I receive the services I need from the Program Director.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q14 The Program Director created appropriate Student Learning Outcomes (SLOs) to assess student development.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)
Q15 The Program Director collected data in an appropriate manner to evaluate the relevance of the SLOs.
  - Strongly Disagree (1)
  - Disagree (2)
  - Neither Agree nor Disagree (3)
  - Agree (4)
  - Strongly Agree (5)

Q19 The Program Director used the evaluations to follow up on the relevance of the SLOs for the faculty, students, and program.
  - Strongly Disagree (1)
  - Disagree (2)
  - Neither Agree nor Disagree (3)
  - Agree (4)
  - Strongly Agree (5)

Q16 The Program Director created appropriate Faculty Outcomes (FOs) to assess faculty professional development.
  - Strongly Disagree (1)
  - Disagree (2)
  - Neither Agree nor Disagree (3)
  - Agree (4)
  - Strongly Agree (5)

Q17 The Program Director collected data in an appropriate manner to evaluate the relevance of the FOs.
  - Strongly Disagree (1)
  - Disagree (2)
  - Neither Agree nor Disagree (3)
  - Agree (4)
  - Strongly Agree (5)

Q18 The Program Director used the evaluations to follow up on the relevance of the FOs for the faculty, students, and program.
  - Strongly Disagree (1)
  - Disagree (2)
  - Neither Agree nor Disagree (3)
  - Agree (4)
  - Strongly Agree (5)

Q20 The Program Director created appropriate Program Outcomes (POs) to assess the program's development and performance.
  - Strongly Disagree (1)
  - Disagree (2)
  - Neither Agree nor Disagree (3)
  - Agree (4)
  - Strongly Agree (5)

Q21 The Program Director collected data in an appropriate manner to evaluate the relevance of the POs.
  - Strongly Disagree (1)
  - Disagree (2)
  - Neither Agree nor Disagree (3)
  - Agree (4)
  - Strongly Agree (5)
Q22 The Program Director used the evaluations to follow up on the relevance of the POs for the students, faculty, and program.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q23 The Program Director promotes discussions about diversity with students, faculty, and in the program.
- Very Dissatisfied (1)
- Dissatisfied (2)
- Neutral (3)
- Satisfied (4)
- Very Satisfied (5)

Q24 The Program Director is respectful of diversity.
- Very Dissatisfied (1)
- Dissatisfied (2)
- Neutral (3)
- Satisfied (4)
- Very Satisfied (5)

Q25 I am given the opportunity to have a personal meeting at the start of each academic year with the Program Director.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q26 I am given the opportunity to give important feedback to the Program Director about my experiences in the program.
- Strongly Disagree (1)
- Disagree (2)
- Neither Agree nor Disagree (3)
- Agree (4)
- Strongly Agree (5)

Q29 The next section asks for your experiences with the university sponsored support services that are provided by The Ohio State University. Have you ever used

<table>
<thead>
<tr>
<th>Support Service</th>
<th>Yes (1)</th>
<th>No (2)</th>
<th>I was unaware that such services were available to me. (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Center for the Advancement of Teaching (UCAT) (4)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Counseling and Consultation Services (CCS) (5)</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Office for Disability Services (ODS) (6)</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Writing Center (7)</td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
</tbody>
</table>
Q31 Please provide a few sentences regarding your satisfaction with the services provided by University Center for the Advancement of Teaching (UCAT).

Q32 Please provide a few sentences regarding your satisfaction with the services provided by Counseling & Consultation Services (CCS).

Q33 Please provide a few sentences regarding your satisfaction with the services provided by the Office for Disability Services (ODS).

Q28 Please provide a few sentences regarding your satisfaction with the services provided by the Writing Center.

Q35 Are there other services you wish were available to you? If so, please describe what those might be:
CFT Graduates Survey

Q1 Dear OSU CFT Ph.D. Program Graduate;

The following set of questions are designed for the program to gather information about you since you graduated from the program. Your participation in this survey is completely voluntary and your choice in participating will in no way change your relationship to the program, the department or The Ohio State University. We are collecting this information to help us with program improvement and to see how we, as a program, are doing when it comes to our stated goals and objectives. We appreciate your participation. The survey is brief and will take you no more than 15 minutes to complete.

Q2 Please tell us what year you graduated with your Ph.D.

Q3 Please tell us your sex
   ☐ Male
   ☐ Female
   ☐ Other ____________________

Q4 Please tell us your race
   ☐ White/Caucasian
   ☐ Black/African American
   ☐ International

Q5 Please Tell us your ethnicity

Q6 Upon graduation what was the first position you held?

Q7 How would you categorize this position?
   ☐ Academic
   ☐ Postdoc Research
   ☐ Postdoc Clinical
   ☐ Clinical
   ☐ Other ____________________

Q8 Have you gotten another position since the first one?
   ☐ Yes
   ☐ No

Q10 How would you categorize this position?
   ☐ Academic
   ☐ Postdoc Research
   ☐ Postdoc Clinical
   ☐ Clinical
   ☐ Other ____________________

Q9 Have you passed the national license exam?
   ☐ Yes
   ☐ No

Q11 Are you currently licensed as an MFT
   ☐ Yes
   ☐ No
Q12 In what state are you licensed?

Q13 Now that you have been out of the program for some time, how would you rate your training, in terms of your preparation for the positions that you have held and currently hold. Using the following stars to rate your satisfaction with your training in the program, with 1 star indicating "not satisfied at all" to 5 stars indicating "completely satisfied." did your training in the program prepare you for
______ Doing Clinical Work?
______ Doing Research in the Field of MFT and other areas?
______ Publishing in peer reviewed journals?
______ Writing grant proposal to procure funding for your research?
______ Supervising MFT Trainees?
______ Teaching Courses in MFT?
______ Holding a tenure track position in academia?

Q14 Have you published in peer reviewed journals since your graduation?
☑ Yes
☑ No

Q15 Have you procured funding for research since your graduation?
☑ Yes
☑ No

Q16 Have you supervised MFT trainees since your graduation?
☑ Yes
☑ No

Q17 How many hours of supervision have you provided since graduation (an estimate will do)?

Q18 How many hours of supervision have you obtained since graduation?

Q19 Are you eligible to become an Approved Supervisor for AAMFT?
☑ Yes
☑ No

Q20 Have you become an Approved Supervisor for AAMFT?
☑ Yes
☑ No

Q21 <P>Thank you so much for your responses. If you have questions or just want to catch up with the program please feel free to </P> <P>e-mail me at <A href="mailto:haring.19@osu.edu">haring.19@osu.edu</A>. Suzanne Bartle-Haring, Ph.D., CFT Program Director </P>

Appendix V
Employer Satisfaction
Employer/Internship Site Satisfaction

Q1 Over the past year you have had under your employ a graduate of The Ohio State University Couple and Family Therapy Ph.D. program. As part of our ongoing evaluation of our program we like to have data about how our graduates are doing as employees in their first position upon graduation. The information you provide will not be shared with the graduate in anyway, and will only be reported in aggregate form as part of our annual review of the program and as part of our self-study for accreditation. Your name will not be collected nor any other identifying information. Since this is an electronic survey there is always a remote chance that an unauthorized person will get access to this information. Since your name, nor the name of our graduate will be collected, we believe the information shared in this survey presents minimal risk to you and our graduate. I thank you in advance for providing this information for us. This should take you no longer than 10 minutes to complete. Suzanne Bartle-Haring, Ph.D. Professor, CFT Program Director Human Development and Family Science Program Area Department of Human Sciences The Ohio State University

Q2 First, please tell us your setting:
- University (1)
- Clinical Setting (2)
- Research Institute (3)
- Other Setting, please specify (4) ____________________

Q3 Given the duties assigned to the CFT Program Graduate that you currently employ, how satisfied are you with the graduate's performance of these duties?
- Very Dissatisfied (1)
- Dissatisfied (2)
- Somewhat Dissatisfied (3)
- Neutral (4)
- Somewhat Satisfied (5)
- Satisfied (6)
- Very Satisfied (7)

Q4 From your experience with the CFT Program Graduate, how satisfied are you with the training they received from The Ohio State University Couple and Family Therapy Program?
- Very Dissatisfied (1)
- Dissatisfied (2)
- Somewhat Dissatisfied (3)
- Neutral (4)
- Somewhat Satisfied (5)
- Satisfied (6)
- Very Satisfied (7)

Q5 Finally, if you are in a university and/or research setting, how satisfied are you with the research training that the CFT Program Graduate received?
- Very Dissatisfied (1)
- Dissatisfied (2)
- Somewhat Dissatisfied (3)
- Neutral (4)
- Somewhat Satisfied (5)
- Satisfied (6)
- Very Satisfied (7)