BEHAVIORAL SCIENCES REGULATORY BOARD
MARRIAGE AND FAMILY THERAPY ADVISORY COMMITTEE
Thursday, June 16, 2022
Agenda

Due to COVID-19, the Board office is practicing social distancing. The office space does not allow for a meeting while practicing social distancing, therefore, the meeting will be conducted virtually on the Zoom platform.

You may view the meeting here: https://youtu.be/mY0Epz-FS34

To join the meeting by conference call: 877-278-8686 (Pin: 327072)

If there are any technical issues during the meeting, you may call the Board office at, 785-296-3240.

The Behavioral Sciences Regulatory Board may take items out of order as necessary to accommodate the time restrictions of Board members and visitors. All times and items are subject to change

Thursday, June 16, 2022, 10:00 a.m.

I. **Call to Order and Roll Call**

II. **Agenda Approval**

III. **Review and Approval of Minutes from Previous Meeting on April 8, 2022**

IV. **Executive Director's Report**

V. **Old Business**
   - A. **Advisory Committee Membership**
   - B. **Continued Discussion of Unprofessional Conduct Regulations**
   - C. **Subcommittee for Clinical Supervision Manual**

VI. **New Business**
   - A. **Examination of Licensure Requirements and the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) Accreditation Standards**

VII. **Special Recognition of Joyce Baptist and Rebecca Culver-Turner Reaching Maximum Length of Service**

VIII. **Next Meeting: Friday August 12, 2022, at 10am?**

IX. **Adjournment**

BEHAVIORAL SCIENCES REGULATORY BOARD
MARRIAGE AND FAMILY THERAPY ADVISORY COMMITTEE
Friday, June 24, 2022
Agenda

Due to COVID-19, the Board office is practicing social distancing. The office space does not allow for a meeting while practicing social distancing, therefore, the meeting will be conducted virtually on the Zoom platform.

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Friday, June 24, 2022, 1:30 p.m.

I. **Call to Order and Roll Call**

II. **Agenda Approval**

III. **Review and Approval of Minutes from Previous Meeting on April 8, 2022**

IV. **Executive Director's Report**

V. **Old Business**
   - A. **Advisory Committee Membership**
   - B. **Continued Discussion of Unprofessional Conduct Regulations**
   - C. **Subcommittee for Clinical Supervision Manual**

VI. **New Business**
   - A. **Examination of Licensure Requirements and the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) Accreditation Standards**

VII. **Special Recognition of Joyce Baptist and Rebecca Culver-Turner Reaching Maximum Length of Service**

VIII. **Next Meeting: Friday August 12, 2022, at 10am?**

IX. **Adjournment**

Behavioral Sciences Regulatory Board
Marriage and Family Advisory Committee Meeting
April 8, 2022
Draft Minutes

I. Call to Order. Mary Jones, Chair of the Advisory Committee, called the meeting to order at 10 a.m.

Committee Members: Advisory Committee members present by Zoom were Mary Jones, Leslie Sewester, Joyce Baptist, Jurdene Coleman, and Rebecca Culver-Turner.

Staff: BSRB staff present by Zoom were David Fye and Leslie Allen.

II. Approval of Agenda: Jurdene Coleman moved to approve the agenda. Joyce Baptist seconded. The motion carried.

III. Approval of Minutes: Joyce Baptist moved to approve the minutes from the Advisory Committee meeting on February 11, 2022. Jurdene Coleman seconded. The motion passed.

IV. Executive Director's Report. David Fye, Executive Director for the BSRB, reported on the following items:

A. BSRB Staff Update. The BSRB is still under most of the Governor's pandemic directions, including the limit on in-person meetings, so the agency is unable to hold Board or Advisory Committee meetings in person currently. Most staff are working in the office full-time, though the two investigators are using a telework hybrid model, working in the office three days each week and utilizing the BSRB Telework Pilot two days each week.

B. 2022 Legislative Session. The Executive Director provided a brief summary of the legislative process to enact a bill, including legislative deadlines. The Legislature is currently on a three-week break, before returning and wrapping up most items during the legislative Omnibus period. The appropriations bill (House Substitute for Substitute for Senate Bill (SB) 267) was passed by the Legislature and is pending review and action by the Governor. The bill requested by the BSRB was passed within SB 453. The final bill included Board recommendations for the addiction counselor profession and the social work profession, but did not include the Board's recommendation concerning continuing education changes for the Licensed Psychology profession. Another bill relevant to the BSRB is House Bill (HB) 2087, which was passed with the previous contents of Substitute for SB 34. HB 2087 requires all agencies to submit a report to the Joint Committee on Rules and Regulations, for all agency regulations, explaining if each regulation is necessary for the implementation of state law. There are over 120 regulations for the BSRB, so creation of this report will necessitate the agency diverting staff time from regular

duties and will likely cause licensing delays or lead the agency to hire additional part-time staff.

C. **March Board Meeting.** The Executive Director provided updates from the Board meeting on March 14, 2022. Most full Board meetings will begin at 9am, at least while meetings are held remotely. The Board is reviewing the Investigation Policy for the Board, which was last updated in 2009. The Executive Director will be presenting a report to the Board with proposed changes to the Policy at the May Board meeting. Certain statutes and regulations state authority for actions as "the Board," but some of these tasks have been delegated over the years to the BSRB, the Executive Director, the Complaint Review Committee, etc. The Executive Director noted he will bring sections of statutes and regulations before the Board to clarify delegation authority and possibly have the Board vote to renew some of these delegations. The Board discussed Board-approved supervisor training and if there are adequate opportunities for supervisor trainings. The Executive Director noted that a majority of current members of the Behavior Analyst Advisory Committee started serving on the Advisory Committee in 2015. While the Advisory Committee did not meet every year since that time, the maximum period for membership on the Advisory Committee is 8 years, so several Advisory Committee members will reach their maximum service at the end of June 2023. In future meetings, the Board intends to discuss impaired provider programs, telehealth standards, and other topics.

D. **Conferences.** The Executive Director will be attending upcoming conferences for the Association of State and Provincial Psychology Boards (ASPPB) and the Association of Social Work Boards (ASWB) later this month and will provide a report on any items relevant to the Advisory Committee.

Advisory Committee members requested an update on the current status of the Advisory Committee recommended changes to the approved supervisor regulations and application. Leslie Allen, Assistant Director and Licensing Manager for the BSRB, stated that the change to the application had already been made. The recommended changes to the regulations would be provided to the Board for the Board's consideration at the next Board meeting in May 2022.

V. New Business

A. **Advisory Committee Membership.** The Executive Director summarized the Advisory Committee Policy, including that non-Board members on the Advisory Committee may serve up to four 2-year terms, for a maximum length of service of 8 years. Current Advisory Committee Members Joyce Baptist and Rebecca Culver-Turner will reach the maximum length of service length at the end of June 2022. At the last Advisory Committee meeting, the Advisory Committee asked the Executive Director to send a message to all licensees, requesting interested parties submit a resume and letter of interest for review. Eight individuals submitted materials for consideration. The Executive Director verified that all applicants hold a permanent license under the BSRB. The Advisory Committee members discussed the applicants.

Joyce Baptist moved to recommend Chris Habben, Marcie Lechtenberg, and Nicole Eitzen be added to the Advisory Committee. Rebecca Culver-Turner seconded. The motion passed.

B. Unprofessional Conduct Regulations. Advisory Committees were asked to review the unprofessional conduct regulations for their professions and identify possible updates or other changes. Advisory Committee members discussed the following areas for potential changes to the unprofessional conduct regulation in K.A.R. 102-5-12:

- Review of unprofessional conduct on recordkeeping regulation, K.A.R. 102-5-16, for quality standards, comprehensiveness, and timeliness. The Advisory Committee requested clarification of the reason these two regulations were separate and expressed support for moving the contents of the unprofessional conduct regulation on recordkeeping within the general unprofessional conduct regulation, so long as a compelling reason for keeping them separate is not discovered when examining the history of the regulations;
- Examination of K.A.R. 102-5-12(b)(26), which prohibits making sexual advances towards or engaging in physical intimacies with someone who has been one's client within the past 24 months. Advisory Committee member discussed why this item includes both sexual advances and undue influences and questioned whether these two topics should be separated. Similarities between items (26) and (25) were noted, and the Advisory Committee expressed interest in revisiting these two regulations for further examination and discussion;
- Examination of K.A.R. 102-5-12(b)(12), to include additional topics to be consistent with the Association of Marital and Family Therapy (AAMFT) standards;
- Examination of electronic means of communications, social media, and interactions with clients over social media. Advisory Committee members expressed interest in obtaining information on how other groups are handling this topic. Leslie Allen, Assistant Director and Licensing Manager for the BSRB, noted the a past Professional Counselor Advisory Committee considered changes to their unprofessional conduct regulation related to this topic and the BSRB will provide that draft language. Advisory Committee members noted AAMFT provided teletherapy guidelines, which include language on social media. That information will be provided to Advisory Committee members; and
- Advisory Committee members expressed support for regulatory language that practitioners should not speak poorly of other professionals.

C. BSRB Social Work Clinical Supervision Manual. Advisory Committee members discussed the Social Work Clinical Supervision Manual and expressed support for creating a similar document for the marriage and family therapy profession. The Executive Director noted the Social Work Supervision Manual was the product of a Social Work Advisory Committee that met for about a year to complete that document. The Board is currently considering possible changes to regulations that would affect some of the supervision requirements for the profession, so Advisory Committee members stated it would be helpful to wait until those discussions have

concluded prior to creating this manual. The Advisory Committee decided to have a subcommittee work on this project, but to table that work until at least the August meeting, when new members had been added to the Advisory Committee.

D. Pre-approved Providers for Continuing Education. The BSRB currently offers optional pre-approved status for continuing education providers and continuing education programs for the social work profession (social work was the profession that had requested this ability previously). The Executive Director discussed the benefits and drawbacks involved in this process, for the providers and for the staff of the BSRB. At the last Board meeting, Advisory Committees were asked to discuss whether the BSRB should pursue similar language for their professions. The Assistant Director and Licensing Manager clarified the BSRB standard for pre-approval of continuing education. Advisory Committee members expressed support for adding pre-approved providers and pre-approved courses for the marriage and family therapy profession and requested draft language be created and brought back to the next meeting for review, so members could have time to consider the topic and ask additional questions during the next Advisory Committee meeting.

E. Training for Advisory Committee Members. Due to the Advisory Committee recommending new members be added to the Advisory Committee, the Advisory Committee decided to move the annual training for Advisory Committee members and Board members to the August 2022 meeting, after new members have been appointed to the Advisory Committee.

VI. Other Business. None.

VII. Next Meeting. Due to conflicts, the Executive Director stated he would poll the members following the meeting, for their availability for the next meeting. (After the meeting, the date for the next meeting was determined to be Thursday, June 16, 2022.)

VIII. Adjournment. Joyce Baptist moved to adjourn the meeting. Jurdene Coleman seconded. The motion carried.

102-5-12. Unprofessional conduct.

(a) Any license may be suspended, limited, conditioned, qualified, restricted, revoked, not issued, or not renewed upon a finding by the board that unprofessional conduct has occurred.

(b) Any of the following acts by either a marriage and family therapy licensee or a marriage and family therapy licensure applicant shall constitute unprofessional conduct:

(1) Obtaining or attempting to obtain a license or registration for oneself or another by engaging in fraud, bribery, deceit, misrepresentation, or by concealing a material fact;

(2) except when the information has been obtained in the context of confidentiality, failing to notify the board, within a reasonable period of time, that the licensee or applicant or any other person regulated by the board or applying for licensure or registration has met any of these conditions:

(A) Has had a professional license, certificate, permit, registration, certification, or professional membership granted by any jurisdiction, professional association, or professional organization that has been limited, conditioned, qualified, restricted, suspended, revoked, refused, voluntarily surrendered, or allowed to expire in lieu of or during investigatory or disciplinary proceedings;

(B) has been subject to any other disciplinary action by any credentialing board, professional association, or professional organization;

(C) has been demoted, terminated, suspended, reassigned, or asked to resign from employment, or has resigned from employment, for some form of misfeasance, malfeasance, or nonfeasance;

(D) has been convicted of a crime; or

(E) has practiced the licensee's or registrant's profession in violation of the laws or regulations that regulate the profession;

(3) knowingly allowing another person to use one's license or registration;

(4) impersonating another person holding a license or registration issued by this or any other board;

(5) having been convicted of a crime resulting from or relating to one's professional practice of marriage and family therapy;

(6) furthering the licensure or registration application of another person who is known or reasonably believed to be unqualified with respect to character, education, or other relevant eligibility requirements;

(7) knowingly aiding or abetting any individual who is not credentialed by the board to represent that individual as a person who was or is credentialed by the board;

(8) failing to recognize, seek intervention, and otherwise appropriately respond when one's own personal problems, psychosocial distress, or mental health difficulties interfere with or negatively impact professional judgment, professional performance and functioning, or the ability to act in the client's best interests;

(9) failing or refusing to cooperate in a timely manner with any request from the board for a response, information, or assistance with respect to the board's investigation of any report of an alleged violation filed against oneself or any other applicant or professional who is required to be licensed or registered by the board. Any person taking longer than 30 days to provide the requested response, information, or assistance shall have the burden of demonstrating that the person has acted in a timely manner;

(10) offering to perform or performing services clearly inconsistent or incommensurate

with one's training, education, or experience or with accepted professional standards;
(11) treating any client, student, or supervisee in a cruel manner;
(12) discriminating against any client, student, or supervisee on the basis of color, race, gender, religion, national origin, or disability;
(13) failing to advise and explain to each client the respective rights, responsibilities, and duties involved in the marriage and family therapy relationship;
(14) failing to provide each client with a description of what the client can expect in the way of services, consultation, reports, fees, billing, therapeutic regimen, or schedule, or failing to reasonably comply with that description;
(15) failing to provide each client with a description of the possible effects of the proposed treatment when the treatment is experimental or when there are clear and known risks to the client;
(16) failing to inform each client, student, or supervisee of any financial interests that might accrue to the licensee or applicant if the licensee or applicant refers a client, student, or supervisee to any other service or if the licensee or applicant uses any tests, books, or apparatus;
(17) failing to inform each client that the client is entitled to the same services from a public agency if one is employed by that public agency and also offers services privately;
(18) failing to inform each client, student, or supervisee of the limits of client confidentiality, the purposes for which the information is obtained, and the manner in which the information may be used;
(19) revealing information, a confidence, or secret of any client, or failing to protect the confidences, secrets, or information contained in a client's records, except when at least one of these conditions is met:
(A) Disclosure is required or permitted by law;
(B) failure to disclose the information presents a clear and present danger to the health or safety of an individual or the public;
(C) the licensee or applicant is a party to a civil, criminal, or disciplinary investigation or action arising from the practice of marriage and family therapy, in which case disclosure is limited to that action; or
(D) the criteria provided by K.S.A. 65-6410, and amendments thereto, are met;
(20) failing to obtain written, informed consent from each client, or the client's legal representative or representatives, before performing any of these actions:
(A) Electronically recording sessions with that client;
(B) permitting a third-party observation of their activities; or
(C) releasing information concerning a client to a third person, except as required or permitted by law;
(21) failing to protect the confidences of, secrets of, or information concerning other persons when providing a client with access to that client's records;
(22) failing to exercise due diligence in protecting the information regarding and the confidences and secrets of the client from disclosure by other persons in one's work or practice setting;
(23) engaging in professional activities, including billing practices and advertising, involving dishonesty, fraud, deceit, or misrepresentation;
(24) using alcohol or illegally using any controlled substance while performing the duties or services of a marriage and family therapist;

(25) making sexual advances toward or engaging in physical intimacies or sexual activities with one's client, student, or supervisee;
(26) making sexual advances toward, engaging in physical intimacies or sexual activities with, or exercising undue influence over any person who, within the past 24 months, has been one's client;
(27) exercising undue influence over any client, student, or supervisee, including promoting sales of services or goods, in a manner that will exploit the client, student, or supervisee for the financial gain, personal gratification, or advantage of oneself or a third party;
(28) directly or indirectly offering or giving to a third party or soliciting, receiving, or agreeing to receive from a third party any fee or other consideration for referring the client or in connection with performing professional services;
(29) permitting any person to share in the fees for professional services, other than a partner, an employee, an associate in a professional firm, or a consultant authorized to practice marriage and family therapy;
(30) soliciting or assuming professional responsibility for clients of another agency or colleague without attempting to coordinate the continued provision of client services by that agency or colleague;
(31) making claims of professional superiority that one cannot substantiate;
(32) guaranteeing that satisfaction or a cure will result from performing or providing any professional service;
(33) claiming or using any secret or special method of treatment or techniques that one refuses to disclose to the board;
(34) continuing or ordering tests, procedures, or treatments or using treatment facilities or services not warranted by the client's condition, best interests, or preferences;
(35) taking credit for work not personally performed, whether by giving inaccurate or misleading information or by failing to disclose accurate or material information;
(36) if engaged in research, failing to fulfill these requirements:
(A) Consider carefully the possible consequences for human beings participating in the research;
(B) protect each participant from unwarranted physical and mental harm;
(C) ascertain that each participant's consent is voluntary and informed; and
(D) preserve the privacy and protect the anonymity of each subject of the research within the terms of informed consent;
(37) making or filing a report that one knows to be false, distorted, erroneous, incomplete, or misleading;
(38) failing to notify the client promptly when one anticipates terminating or interrupting service to the client;
(39) failing to seek continuation of service, or abandoning or neglecting a client under or in need of professional care, without making reasonable arrangements for that care;
(40) abandoning employment under circumstances that seriously impair the delivery of professional care to clients and without providing reasonable notice to the employer;
(41) failing to terminate marriage and family therapy services when it is apparent that the relationship no longer serves the client's needs or best interests;
(42) supervising in a negligent manner anyone for whom one has supervisory responsibility;

(43) when applicable, failing to inform a client that marriage and family therapy services are provided or delivered under supervision;
(44) engaging in a dual relationship with a client, student, or supervisee;
(45) failing to inform the proper authorities as required by K.S.A. 38-2223, and amendments thereto, that one knows or has reason to believe that a client has been involved in harming or has harmed a child, whether by physical, mental, or emotional abuse or neglect or by sexual abuse;
(46) failing to inform the proper authorities as required by K.S.A. 39-1402, and amendments thereto, that one knows or has reason to believe that any of the following circumstances apply to a resident, as defined by K.S.A. 39-1401(a) and amendments thereto:
(A) Has been or is being abused, neglected, or exploited;
(B) is in a condition that resulted from abuse, neglect, or exploitation; or
(C) needs protective services;
(47) failing to inform the proper authorities as required by K.S.A. 39-1431, and amendments thereto, that one knows or has reason to believe that any of the following circumstances apply to an adult, as defined in K.S.A. 39-1430 and amendments thereto:
(A) Is being or has been abused, neglected, or exploited;
(B) is in a condition that is the result of abuse, neglect, or exploitation; or
(C) needs protective services;
(48) intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing another person from filing a report or record that is required by state or federal law, or inducing another person to take any of these actions;
(49) offering to perform or performing any service, procedure, or therapy that, by the accepted standards of marriage and family therapy practice in the community, would constitute experimentation on human subjects without first obtaining the full, informed, and voluntary written consent of the client or the client's legal representative or representatives;
(50) practicing marriage and family therapy in an incompetent manner;
(51) practicing marriage and family therapy after one's license expires;
(52) using without a license or continuing to use after a license has expired any title or abbreviation prescribed by law to be used solely by persons who currently hold that type or class of license; or
(53) violating any provision of this act or any regulation adopted under the act.
(Authorized by K.S.A. 65-6408 and K.S.A. 2007 Supp. 74-7507; implementing K.S.A. 65-6408; effective March 29, 1993; amended Dec. 19, 1997; amended July 11, 2003; amended Jan. 9, 2004; amended Aug. 8, 2008.)

102-5-16. Unprofessional conduct regarding recordkeeping.

(a) The failure of a marriage and family therapist licensee or clinical marriage and family therapist licensee to comply with the recordkeeping requirements established in this regulation shall constitute unprofessional conduct.

(b) Content of marriage and family therapy or clinical marriage and family therapy records. Each licensed marriage and family therapist or clinical marriage and family therapist shall maintain a record for each client or client system that accurately reflects the licensee's contact with the client or client system and the results of the marriage and family therapy or clinical marriage and family therapy services provided. Each licensee shall have ultimate responsibility for the content of the licensee's records and the records of those persons under the licensee's supervision. These records may be maintained in a variety of media, if reasonable steps are taken to maintain confidentiality, accessibility, and durability. Each record shall be completed in a timely manner and shall include the following information for each client or client system:

(1) Adequate identifying data;

(2) the date or dates of services that the licensee or the licensee's supervisee provided;

(3) the type or types of services that the licensee or the licensee's supervisee provided;

(4) the initial assessment, conclusions, and recommendations;

(5) a plan for service delivery or case disposition;

(6) the clinical notes from each session; and

(7) sufficient detail to permit planning for continuity that would enable another marriage and family therapist or clinical marriage and family therapist to take over the delivery of services.

(c) Retention of records. If a licensee is the owner or custodian of client or client system records, the licensee shall retain a complete record for the following time periods, unless otherwise provided by law:

(1) At least six years after the date of termination of one or more contacts with an adult; and

(2) for a client who is a minor on the date of termination of the contact or contacts, at least until the later of the following two dates:

(A) Two years past the date on which the client reaches the age of majority; or

(B) six years after the date of termination of the contact or contacts with the minor.

(Authorized by K.S.A. 65-6408 and 74-7507; implementing K.S.A. 65-6408; effective July 11, 2003.)

102-3-12a. Unprofessional conduct. (a) Any license may be suspended, limited, conditioned, qualified, restricted, revoked, not issued, or not renewed upon a finding of unprofessional conduct.

(b) Any of the following acts by a licensed professional counselor, a licensed clinical professional counselor, or an applicant for a professional counselor license or a clinical professional counselor license shall constitute unprofessional conduct:

(1) Obtaining or attempting to obtain a license or registration for oneself or another by means of fraud, bribery, deceit, misrepresentation, or concealment of a material fact;

(2) except when the information has been obtained in the context of confidentiality, failing to notify the board, within a reasonable period of time, that any of the following circumstances apply to any person regulated by the board or applying for a license or registration, including oneself:

(A) Had a professional license, certificate, permit, registration, certification, or professional membership granted by any jurisdiction, professional association, or professional organization that has been limited, conditioned, qualified, restricted, suspended, revoked, refused, voluntarily surrendered, or allowed to expire in lieu of or during investigatory or disciplinary proceedings;

(B) has been subject to any other disciplinary action by any credentialing board, professional association, or professional organization;

(C) has been demoted, terminated, suspended, reassigned, or asked to resign from employment, or has resigned from employment, for some form of misfeasance, malfeasance, or nonfeasance;

(D) has been convicted of a crime; or

(E) has practiced the licensee's or registrant's profession in violation of the laws or regulations regulating the profession;

(3) knowingly allowing another person to use one's license or registration;

(4) impersonating another person holding a license or registration issued by this or any other board;

(5) having been convicted of a crime resulting from or relating to the licensee's professional practice of professional counseling or clinical professional counseling;

(6) furthering the licensure or registration application of another person who is known or reasonably believed to be unqualified with respect to character, education, or other relevant eligibility requirements;

(7) knowingly aiding or abetting any individual who is not credentialed by the board to represent that individual as a person who is credentialed by the board;

(8) failing to recognize, seek intervention, and otherwise appropriately respond when one's own personal problems, psychosocial distress, or mental health difficulties interfere with or negatively impact professional judgment,

professional performance and functioning, or the ability to act in the client's best interests;

(9) failing or refusing to cooperate in a timely manner with any request from the board for a response, information, or assistance with respect to the board's investigation of any report of an alleged violation filed against oneself or any other applicant or professional who is required to be licensed or registered by the board. Any person taking longer than 30 days to provide the requested response, information, or assistance shall have the burden of demonstrating that the person has acted in a timely manner;

(10) offering to perform or performing professional counseling, assessments, consultations, or referrals clearly inconsistent or incommensurate with one's training, education or experience or with accepted professional standards;

(11) treating any client, student, directee, or supervisee in a cruel manner;

(12) discriminating against any client, student, directee, or supervisee on the basis of color, race, gender, religion, national origin, or disability;

(13) failing to advise and explain to each client the respective rights, responsibilities, and duties involved in the professional counseling relationship;

(14) failing to provide each client with a description of what the client can expect in the way of services, consultation, reports, fees, billing, and therapeutic regimen or schedule, or failing to reasonably comply with the description;

(15) failing to provide each client with a description of the possible effects of the proposed treatment when the treatment is experimental or when there are clear and known risks to the client;

(16) failing to inform each client, student, directee, or supervisee of any financial interests that might accrue to the professional counselor or clinical professional counselor from a referral to any other service or from using any tests, books, or apparatus;

(17) failing to inform each client that the client is entitled to the same services from a public agency if the professional counselor or clinical professional counselor is employed by that public agency and also offers services privately;

(18) failing to inform each client, student, directee, or supervisee of the limits of client confidentiality, the purposes for which the information is obtained, and the manner in which the information may be used;

(19) revealing information, a confidence, or a secret of any client, or failing to protect the confidences, secrets, or information contained in a client's records, except when at least one of these conditions is met:

(A) Disclosure is required or permitted by law;

(B) failure to disclose the information presents a clear and present danger to the health or safety of an individual or the public; or

(C) the professional counselor or clinical professional counselor is a party to a civil, criminal, or disciplinary investigation or action arising from the practice

of professional counseling or clinical professional counseling, in which case disclosure is limited to that action;

(20) failing to obtain written, informed consent from each client, or the client's legal representative or representatives, before performing any of these actions:

(A) Electronically recording sessions with that client;

(B) permitting a third-party observation of their activities; or

(C) releasing information concerning a client to a third person, except as required or permitted by law;

(21) failing to protect confidences of, secrets of, or information concerning other persons when providing a client with access to that client's records;

(22) failing to exercise due diligence in protecting the information regarding and the confidences and secrets of the client from disclosure by other persons in one's work or practice setting;

(23) engaging in professional activities, including billing practices and advertising, involving dishonesty, fraud, deceit, or misrepresentation;

(24) ~~using alcohol or illegally using a controlled substance~~ Being under the influence of any substance that impairs professional judgement while performing the duties or services of a professional counselor or clinical professional counselor;

(25) engaging in sexual behavior including sexual harassment, making sexual advances toward, ~~or~~ engaging in physical intimacies or engaging in

sexual activities with one's active client, active student, directee, or supervisee or anyone with whom they have power or authority;

(26) engaging in sexual behavior including sexual harassment, making sexual advances toward, engaging in physical intimacies or sexual activities with, or exercising undue influence over any person who, within the past ~~24~~ 60 months, has been one's client, client's romantic partners, or the client's family member, or anyone with whom they have power or authority;

(27) exercising undue influence over any client, student, directee, or supervisee, including promoting sales of services or goods, in a manner that will exploit the client, student, directee, or supervisee for the financial gain, personal gratification, or advantage of oneself or a third party;

(28) directly or indirectly offering or giving to a third party or soliciting, receiving, or agreeing to receive from a third party any fee or other consideration for the referral of the client or in connection with performing professional counselor or clinical professional counselor services;

(29) permitting any person to share in the fees for professional services, other than a partner, employee, associate in a professional firm, or consultant authorized to practice as a professional counselor or clinical professional counselor;

(30) soliciting or assuming professional responsibility for clients of another agency or colleague without attempting to coordinate continuity of client services with that agency or colleague;

(31) making claims of professional superiority that one cannot substantiate;

(32) guaranteeing that satisfaction or a cure will result from the performance of professional services;

(33) claiming or using any secret or special method of treatment or techniques that one refuses to disclose to the board;

(34) continuing or ordering tests, procedures, or treatments or using treatment facilities or services not warranted by the condition, best interests, or preferences of the client;

(35) failing to maintain a record for each client that conforms to the following minimal requirements:

(A) Contains adequate identification of the client;

(B) indicates the client's initial reason for seeking the services of the professional counselor or clinical professional counselor;

(C) contains pertinent and significant information concerning the client's condition;

(D) summarizes the interventions, treatments, tests, procedures, and services that were obtained, performed, ordered, or recommended and the findings and results of each;

(E) documents the client's progress during the course of intervention or treatment provided by the professional counselor;

(F) is legible;

(G) contains only those terms and abbreviations that are comprehensible to similar professional practitioners;

(H) indicates the date and nature of any professional service that was provided; and

(I) describes the manner and process by which the professional counseling or clinical professional counseling relationship terminated;

(36) taking credit for work not personally performed, whether by giving inaccurate or misleading information or failing to disclose accurate or material information;

(37) ~~if engaged in research, failing to fulfill these requirements:~~ Failing to consider the possible consequences on participants, failing to take all reasonable precautions on behalf of participants' welfare, or causing emotional, physical, or social harm to participants throughout the research process, according to all current state and federal laws and statutes for conducting research

~~(A) Consider carefully the possible consequences for human beings participating in the research;~~

~~(B) protect each participant from unwarranted physical and mental harm;~~

~~(C) ascertain that the consent of each participant is voluntary and informed; and~~

~~(D) preserve the privacy and protect the anonymity of each subject of the research within the terms of informed consent~~;

(38) making or filing a report that one knows to be false, distorted, erroneous, incomplete, or misleading;

(39) failing to notify the client promptly when termination or interruption of service to the client is anticipated;

(40) failing to seek continuation of service, or abandoning or neglecting a client under or in need of professional care, without making reasonable arrangements for that care;

(41) abandoning employment under circumstances that seriously impair the delivery of professional care to clients and without providing reasonable notice to the employer;

(42) failing to terminate the professional counseling or clinical professional counseling services when it is apparent that the relationship no longer serves the client's needs or best interests;

(43) if the professional counselor or clinical professional counselor is the owner or custodian of client records, failing to retain these records for at least five years after the date of termination of the professional relationship, unless otherwise provided by law;

(44) supervising or directing in a negligent manner anyone for whom one has supervisory or directory responsibility;

(45) failing to inform a client if professional counseling services are provided or delivered under supervision or direction;

(46) engaging in a dual relationship with a client, student, or supervisee;

(47) failing to inform the proper authorities as provided in K.S.A. 38-2223, and amendments thereto, that one knows or has reason to believe that a client has been involved in harming or has harmed a child, whether by physical, mental, or emotional abuse or neglect or by sexual abuse;

(48) failing to inform the proper authorities as required by K.S.A. 39-1402, and amendments thereto, that one knows or has reason to believe that any of the following circumstances apply to a resident, as defined by K.S.A. 39-1401(a) and amendments thereto:

(A) Has been or is being abused, neglected, or exploited;

(B) is in a condition that is the result of abuse, neglect, or exploitation; or

(C) is in need of protective services;

(49) failing to inform the proper authorities as required by K.S.A. 39-1431, and amendments thereto, that one knows or has reason to believe that any of the following circumstances apply to an adult, as defined in K.S.A. 39-1430 and amendments thereto:

(A) Is being or has been abused, neglected, or exploited;

(B) is in a condition that is the result of abuse, neglect, or exploitation; or

(C) is in need of protective services;

(50) intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing the filing of a report or record required by state or federal law, or inducing another person to take any of those actions;

(51) offering to perform or performing any service, procedure, or therapy that, by the accepted standards of professional counseling or clinical professional counseling practice in the community, would constitute experimentation on human subjects without first obtaining the full, informed, and voluntary written consent of the client or the client's legal representative or representatives;

(52) practicing professional counseling or clinical professional counseling in an incompetent manner;

(53) practicing professional counseling or clinical professional counseling after one's license expires;

(54) using without a license, or continuing to use after the expiration of a license, any title or abbreviation prescribed by law for use solely by persons currently holding that type or class of license;

(55) ~~diagnosing or treating any client who a professional counselor practicing under direction or a clinical professional counselor has reason to believe is suffering from a mental illness or disease, as opposed to a mental disorder~~ Practicing inappropriate boundaries with clients with regards to use of social media including but not limited to, using a personal profile to connect or communicate with clients on any social media platform, or accessing a client's social media pages without previous consent; ~~or~~

(56) Disclosing confidential information through public social media;

(57) If engaged in distance-counseling, failing to fulfill these requirements:

(A) Informing the client of risks and benefits of distance counseling,

(B) Disclosing the possibility of technology failure and providing alternative methods of service,

(C) Detailing emergency procedures to follow when the counselor is unavailable, and

(D) Taking appropriate steps to encrypt or ensure the security of confidential client information or any activity which protects confidential client information from risk of privacy breach; and

~~(56)~~ (58) violating any provision of this act or any regulation adopted under it. (Authorized by K.S.A. 2007 Supp. 65-5809 and 74-7507; implementing K.S.A. 2007 Supp. 65-5809; effective Dec. 19, 1997; amended July 19, 2002; amended Jan. 9, 2004; amended Aug. 8, 2008; amended P-_____.)

Association of Marital and Family Therapy Regulatory Boards

Teletherapy Guidelines

September 2016

AMFTRB
Teletherapy Guidelines

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Overview

The AMFTRB Teletherapy Committee was created and tasked with developing a set of guidelines for use by Member Boards when regulating the practice of teletherapy by Licensed Marriage and Family Therapists (LMFTs) across the country. The Committee reviewed current AAMFT Codes of Ethics and other professional codes of ethics, state laws, research articles, and telehealth guidelines of many disciplines in creating the following guidelines for Licensed Marriage and Family Therapists.

Key Assumptions of the Teletherapy Committee

The committee agreed upon the following tenets which informed each of the guidelines herein:

I. Public protection must be the overriding principle behind each guideline.

II. Each guideline shall be written with special consideration of those uniquely systemic challenges.

III. All existing minimum standards for face-to-face client interaction are assumed for teletherapy practice.

IV. A teletherapy standard shall not be unnecessarily more restrictive than the respective face-to-face standard for safe practice.

V. Each guideline must be a recommendation for a minimum standard for safe practice *not* a best practice recommendation.

VI. The regulation of teletherapy practice is intertwined with the challenges of portability of LMFT licensure across state lines.

VII. Each guideline shall be written with consideration for the possibility of a national teletherapy credential.

The Process

The AMFTRB Teletherapy Committee members were identified in fall 2015. The committee began with a review of literature and current telehealth practice publications within the field of marriage and family therapy and across professional disciplines. Topical areas for telemental health guidelines were identified, and each committee member was charged with researching the critical elements to be included in the final draft. The committee met and reviewed each of the elements of the guidelines. Please be advised that the committee did not draft specific regulations regarding the appropriateness of telemental health and working with domestic violence victims, completing child custody evaluations, treating cyber addiction, or using technology for supervised sanctions as the research in each of these areas was limited. We also acknowledge that a method by which cultural competency may be measured is needed and encourage Member Boards to advise therapists to seek training in this area.

Committee members identified stakeholders whose input was desired in reviewing the draft guidelines. Comments were requested from marriage and family therapy graduate programs, continuing education resources, and state licensing boards. The committee reviewed and analyzed the comments from stakeholders, consulted the AAMFT Code of Ethics, and Guidelines, and incorporated this information into the final document. The draft guidelines were then submitted to the 2016 AMFTRB delegate assembly for discussion and adoption.

Introduction to Teletherapy Guidelines

Electronic practice in behavioral health has continued to garner momentum. With the creation of Facebook in 2004, the onset of 140 character messages through Twitter in 2006, and the proliferation of video conferencing platforms, therapists and clients have more options available to interact with each other than ever before. Telemental health is experiencing an "evident boom" for many reasons. Social media has significantly contributed to the growth. For example, as of July 2016, Facebook reports over 950 million users, 500 million of whom log in daily. The Pew Research Center (January 2014) reported 87% of American adults use the internet, up from 14% in 1995 (Pew, 2014). The Internet World Stats estimates 3,611 millions of users of the internet (Zephoria, 2016).

The State of Telemental Health in 2016 identifies five reasons for this growth. First, telemental health does not require physical contact with patients; therefore, technology based services are not that different from face-to-face therapy. While this statement overlooks the nuances of providing telemental health, it does support a burgeoning practice of clients receiving services without needing to step foot in a therapist's office. Second, telemental health has been accepted by a large number of payers, more than other telehealth disciplines. As more and more payers cover services provided through electronic practice, it is anticipated that a growing number of therapists will provide care electronically. Third, telemental health may reduce the stigma of those seeking care. One of the unspoken benefits of telemental health is that clients do not need to be seen entering a therapist's office. Therapists are cognizant of the concern clients have for confidentiality when determining where to house their brick-and-mortar practices. With the opportunity to receive telemental health electronically, the stigma of receiving counseling may be lessened. Not only is the potential for the stigma of mental health diminishing, more and more clients may also have an opportunity to receive care through telemental health. Fourth, the prevalence of mental health services and the shortage of mental health counselors is incentivizing stakeholders to look for alternatives to face-to-face care. For psychiatry, the American Medical Association reported that 60 percent of psychiatrists nationwide are at least 55 years old, with about 48 percent considering retiring in the next five years. "According to Mental Health American's latest report on mental health, there is only one mental health provider for every 566 people in the country." Maine has the highest number of mental health providers with a 1:250 ratio and Texas has the fewest (1:1,100). Finally, the patients who have received telemental health services have perceived their care to be effective (Epstein, Becker, & O'Brien, 2016).

Since the early discussions about telemental health, the technological landscape has changed. Cybercounseling (Hughes, 2000), e-counseling, e-therapy (Epstein, Becker, & O'Brien, 2016) and the current term of telemental health services have evolved as the shifting sands of modalities used in electronic practice have altered the modalities therapists use. Early publications about telemental

health services asked questions such as, “Should emails be encrypted?” (Mitchell, 2000), “What fee structures should be established for online services?” (Hughes, 2000), “Can a client decline to use secure systems?”, and “What if a client emergency is received, and there is no identifying information?” (Mitchell, 2000).

Discussions about online therapy have shifted as technologies available for therapy have shifted. Early discussions involved telephonic counseling and emails which evolved into video counseling, avatars, chats, blogs, and more. Social media and social networking sites have also altered the therapy landscape. Although the technologies have changed, the concerns associated with the provision of telemental health services have not. The assurance of confidentiality continues to be a concern (Hertlein, Blumer, & Mihaloliakos, 2014; Derrig-Palumbo & Eversole, 2011), as does boundary management ((Hertlein, Blumer, & Mihaloliakos, 2014; Hertlein et al, 2014), and management of crises (Hertlein, Blumer, & Mihaloliakos, 2014; Perle et al., 2013; Chester & Glass, 2006). Other concerns identified in research include the impact technology has on the therapeutic relationship, liability and licensing issues, and training and education required to provide effective telemental health services (Hertlein, Blumer, & Mihaloliakos, 2014).

As millennials enter the counseling field, the use of technology is anticipated to continue. Reith (2005) noted millennials are more comfortable with technology and have been dubbed the “digital natives”. Digital natives were “born into” a world of technology, more so than previous generations who have been termed “digital immigrants” (Prensky, 2001). Furthermore, Blumer, Hertlein, Allen, & Smith (2012) reported that millennials also feel technology is private and safe. This perception could impact the decisions made in the care and safekeeping of clinical information which fuels the need for technology specific regulations.

The proliferation of counseling-related websites has also impacted the need for technology-related regulations. In September 2008, Haberstroh (2009) identified 4 million websites when searching “online counseling”. In July 2016, a recent search of the same term netted 94 million results. This growth clearly indicates more and more counselors are turning to the internet to provide services of some type. Blumer, Hertlein, Allen, & Smith (2012) noted in their research that therapists used technology to augment treatment and Twist & Hertlein (2015) noted the use of technology for online professional networking.

While research indicates a growing use of technology in professional communications, Maheu & Gordon (2000) discovered that 78% of counselors acknowledged treating clients from other states online. Furthermore, Shaw & Shaw (2004) and Heinlen et al (2003) “found many online clinicians did not regularly follow ethical guidelines in their practices”. In a study of Swedish physicians, Brynold et al (2013) noted that physicians were tweeting in a manner deemed “unprofessional,” and the tweets were considered violations of patient privacy. Nearly 84% of family therapists were noted, in one study, to have communication with clients via email (Hertlein, Blumer & Smith, 2013).

Therapists may be confused about how to ethically and legally provide telemental health services. Haberstroh, Barney, Foster, & Duffey (2013) noted while no state licensing boards prohibit telemental health services, the language is vague. “Less than half of state boards directly allowed the practice of online clinical work through their local state laws or ethical codes…However, the specificity of the guidance provided by licensure boards varied greatly.” States seem to be grappling with the challenges of writing effective and somewhat timeless technology regulations. Therapists must comply with the

relevant licensing laws in the jurisdiction where the therapist is licensed when providing the care and the relevant licensing laws where the client is located when receiving care. Many states will only process complaints from residents of their state. Note, in the United States, the jurisdictional licensure requirement is usually tied to *where the client is physically located* when he or she is receiving the care, *not* where the client lives; however, therapists must ensure they are also compliant with any and all state and federal laws.

While the technologies and opportunities continue to emerge, few graduate programs provide meaningful guidance in how to establish a telemental health practice. Feedback received from graduate programs indicate the majority of programs, if they are addressing telemental health practice at all, are covering telemental health services typically in one class period. Many noted that the lack of clear regulations impacted their willingness to provide more comprehensive education about telemental health practice.

Therapists currently in the field rely on post-graduate training, typically in the form of continuing education workshops and programs, to expand their professional competence. Hertlein, Blumer & Smith (2013) noted that therapists should be trained in providing telemental health services, and yet, at the 2010 AAMFT conference, they note 1 of 220 workshops/posters focused on telemental health. Williams et al (2013) suggested a "framework that includes e-professionalism" be drafted. All of these events support the need for AMFTRB to establish telemental health guidelines.

Definitions

Asynchronous – Communication is not synchronized or occurring simultaneously (Reimers, 2013)

Competency - 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. (AAMFT Code of Ethics, 2015)

Electronic communication - Using Web sites, cell phones, e-mail, texting, online social networking, video, or other digital methods and technology to send and receive messages, or to post information so that it can be retrieved by others or used at a later time. (Technology Standards in Social Work Practice, 2016)

Encryption – A mathematical process that converts text, video, or audio streams into a scrambled, unreadable format when transmitted over the internet. (Trepal, Haberstroh, Duffey, & Evans, 2007)

HIPAA compliant – HIPAA, the Health Insurance Portability and Accountability Act, sets the standard for protecting sensitive patient data. Any company that deals with protected health information (PHI) must ensure that all the required physical, network, and process security measures are in place and followed. This includes covered entities (CE), anyone who provides treatment, payment and operations in healthcare, and business associates (BA)**,** anyone with access to patient information and provides

support in treatment, payment or operations. Subcontractors, or business associates of business associates, must also be in compliance. (What is HIPAA Compliance? 2016)

HITECH - Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules (HITECH Act Enforcement of Interim Final Rule, 2016)

PHI – Protected Health Information (HIPAA, 2016)

Social media/social networking - Social media are web-based communication tools that enable people to interact with each other by both sharing and consuming information (Webtrends, 2016)

Synchronous – Communication which occurs simultaneously in real time (Reimers, 2013)

Telesupervision - refers to the practice of supervision by a licensed (teletherapy) supervisor through synchronous or asynchronous two-way electronic communication including but not limited to telephone, videoconferencing, email, text, instant messaging, and social media for the purposes of developing trainee marital and family therapists, evaluating supervisee performance, ensuring rigorous legal and ethical standards within the bounds of licensure, and as a means for improving the profession of marital and family therapy.

Teletherapy/Technology-assisted services – refers to the scope of marriage and family therapy practice of diagnosis, evaluation, consultation, intervention and treatment of behavioral, social, interpersonal disorders through synchronous or asynchronous two-way electronic communication including but not limited to telephone, videoconferencing, email, text, instant messaging, and social media.

Verification – Measures to verify both counselor and client identities online (Haberstroh, 2009)

Virtual relationship - A relationship where people are not physically present but communicate using online, texting, or other electronic communication devise (Urban Dictionary, 2016)

Guidelines for the Regulation of Teletherapy Practice

1. Adhering to Laws and Rules in Each Jurisdiction

A. Therapists of one state who are providing marriage and family therapy to clients in another state must comply with the laws and rules of both jurisdictions.
B. Treatment, consultation, and supervision utilizing technology-assisted services will be held to the same standards of appropriate practice as those in traditional (in person) settings.

2. Training/Educational Requirements of Professionals

A. Therapists must be accountable to states of jurisdiction education requirements for teletherapy prior to initiating teletherapy.
B. Therapists may only advertise and perform those services they are licensed and trained to provide. The anonymity of electronic communication makes misrepresentation possible for both therapists and clients. Because of the potential misuse by unqualified individuals, it is essential that information be readily verifiable to ensure client protection.
C. Therapists shall review their discipline's definitions of "competence" prior to initiating teletherapy client care to assure that they maintain recommended technical and clinical competence for the delivery of care in this manner. Therapists shall have completed basic education and training in suicide prevention. While the depth of training and the definition of “basic” are solely at the therapist’s discretion, the therapist’s competency may be evaluated by the state board.
D. Therapists shall assume responsibility to continually assess both their professional and technical competence when providing teletherapy services.
E. Minimum 15 hours initial training. Must demonstrate continued competence in a variety of ways (e.g. encryption of data, HIPAA compliant connections). Areas to be covered in the training must include, but not be limited to:
    a. Appropriateness of Teletherapy
    b. Teletherapy Theory and Practice
    c. Modes of Delivery
    d. Legal/Ethical Issues
    e. Handling Online Emergencies
    f. Best Practices & Informed Consent
F. Minimum of 5 continuing education hours every 5 years is required.

3. Identity Verification of Client

A. Therapists must recognize the obligations, responsibilities, and client rights associated with establishing and maintaining a therapeutic relationship.
B. An appropriate therapeutic relationship has not been established when the identity of the therapist may be unknown to the client or the identity of the client(s) may be unknown to the therapist. An initial face-to-face meeting, which may utilize HIPAA compliant video-conferencing, is highly recommended to verify the identity of the client. If such verification

is not possible, the burden is on the therapist to document appropriate verification of the client.

C. A therapist shall take reasonable steps to verify the location and identify the client(s) at the onset of each session before rendering therapy using teletherapy.
D. Therapists shall develop written procedures for verifying the identity of the recipient, his or her current location, and readiness to proceed at the beginning of each contact. Examples of verification means include the use of code words, phrases or inquiries. (For example, "is this a good time to proceed?").

4. Establishing the Therapist-Client Relationship

A. A therapist who engages in technology-assisted services must provide the client with his/her license number and information on how to contact the board by telephone, electronic communication, or mail, and must adhere to all other rules and regulations in the relevant jurisdiction(s).
B. The relationship is clearly established when informed consent documentation is signed.
C. Therapists must communicate any risks and benefits of the teletherapy services to be offered to the client(s) and document such communication.
D. Screening for client technological capabilities is part of the initial intake processes. (Ex. This type of screening could be accomplished by asking clients to complete a brief questionnaire about their technical and cognitive capacities).
E. Teletherapy services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.
F. The therapist and/or client shall use connection test tools (e.g., bandwidth test) to test the connection before starting their videoconferencing session to ensure the connection has sufficient quality to support the session.

5. Cultural Competency

A. Therapists shall be aware of and sensitive to clients from different cultures and have basic clinical competency skills providing these services.
B. Therapists shall be aware of the limitations of teletherapy and recognize and respect cultural differences (e.g. when therapist is unable to see the client, non-verbal cues). Therapists shall remain aware of their own potential projections, assumptions, and cultural biases.
C. Therapists shall select and develop appropriate online methods, skills, and techniques that are attuned to their clients' cultural, bicultural, or marginalized experiences in their environments.
D. Client perspectives of therapy and service delivery via technology may differ. In addition, culturally competent therapists shall know the strengths and limitations of current electronic modalities, process and practice models, to provide services that are applicable and relevant to the needs of culturally and geographically diverse clients and members of vulnerable populations.

E. Therapists shall consider cultural differences, including clarity of communications.
F. Sensory deficits, especially visual and auditory, can affect the ability to interact over a videoconference connection. Therapists shall consider the use of technologies that can help with visual or auditory deficit. Techniques should be appropriate for a client who may be cognitively impaired, or find it difficult to adapt to the technology.

6. Informed Consent/Client Choice to Engage in Teletherapy

Availability of Professional to Client

A. The therapist must document the provision of consent in the record prior to the onset of therapy. The consent shall include all information contained in the consent process for in-person care including discussion of the structure and timing of services, record keeping, scheduling, privacy, potential risks, confidentiality, mandatory reporting, and billing.
B. This information shall be specific to the identified service delivery type and include considerations for that particular individual.
C. The information must be provided in language that can be easily understood by the client. This is particularly important when discussing technical issues like encryption or the potential for technical failure.
D. Local, regional and national laws regarding verbal or written consent must be followed. If written consent is required, electronic signatures may be used if they are allowed in the relevant jurisdiction.
E. In addition to the usual and customary protocol of informed consent between therapist and client for face-to-face counseling, the following issues, unique to the use of teletherapy, technology, and/or social media, shall be addressed in the informed consent process:
    a. confidentiality and the limits to confidentiality in electronic communication;
    b. teletherapy training and/or credentials, physical location of practice, and contact information;
    c. licensure qualifications and information on reporting complaints to appropriate licensing bodies;
    d. risks and benefits of engaging in the use of teletherapy, technology, and/or social media;
    e. possibility of technology failure and alternate methods of service delivery;
    f. process by which client information will be documented and stored;
    g. anticipated response time and acceptable ways to contact the therapist;
        i. agreed upon emergency procedures;
        ii. procedures for coordination of care with other professionals;
        iii. conditions under which teletherapy services may be terminated and a referral made to in-person care;
    h. time zone differences;
    i. cultural and/or language differences that may affect delivery of services;
    j. possible denial of insurance benefits;
    k. social media policy;
    l. specific services provided;
    m. pertinent legal rights and limitations governing practice across state lines or international boundaries, when appropriate; and
    n. Information collected and any passive tracking mechanisms utilized.

F. Given that therapists may be offering teletherapy to individuals in different states at any one time, the therapists shall document all relevant state regulations in the respective record(s). The therapist is responsible for knowing the correct informed consent forms for each applicable jurisdiction.
G. Therapists must provide clients clear mechanisms to:

    a. access, supplement, and amend client-provided personal health information;
    b. provide feedback regarding the site and the quality of information and services; and
    c. register complaints, including information regarding filing a complaint with the applicable state licensing board(s).

Working with Children

A. Therapists must determine if a client is a minor and, therefore, in need of parental/guardian consent. Before providing teletherapy services to a minor, therapist must verify the identity of the parent, guardian, or other person consenting to the minor's treatment.
B. In cases where conservatorship, guardianship or parental rights of the client have been modified by the court, therapists shall obtain and review a written copy of the custody agreement or court order before the onset of treatment.

7. Acknowledgement of Limitations of Teletherapy

A. Therapists must: (a) determine that teletherapy is appropriate for clients, considering professional, intellectual, emotional, and physical needs; (b) inform clients of the potential risks and benefits associated with teletherapy; (c) ensure the security of their communication medium; and (d) only commence teletherapy after appropriate education, training, or supervised experience using the relevant technology.
B. Clients must be made aware of the risks and responsibilities associated with teletherapy. Therapists are to advise clients in writing of these risks and of both the therapist's and clients' responsibilities for minimizing such risks.
C. Therapists shall consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the therapy process. Therapists shall educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.
D. Therapists shall be aware of the limitations of teletherapy and recognize and respect cultural differences (e.g. when therapist is unable to see the client, non-verbal cues). Therapists shall remain aware of their own potential projections, assumptions, and cultural biases.
E. Therapists shall recognize the members of the same family system may have different levels of competence and preference using technology. Therapists shall acknowledge power dynamics when there are differing levels of technological competence within a family system.
F. Before therapists engage in providing teletherapy services, they must conduct an initial assessment to determine the appropriateness of the teletherapy service to be provided for the client(s). Such an assessment may include the examination of the potential risks and benefits to provide teletherapy services for the client's particular needs, the multicultural

and ethical issues that may arise, and a review of the most appropriate medium (e.g., video conference, text, email, etc.) or best options available for the service delivery. It may also include considering whether comparable in-person services are available, and why services delivered via teletherapy are equivalent or preferable to such services. In addition, it is incumbent on the therapist to engage in a continual assessment of the appropriateness of providing teletherapy services throughout the duration of the service delivery.

8. Confidentiality of Communication

A. Therapists utilizing teletherapy must meet or exceed applicable federal and state legal requirements of health information privacy including HIPAA/HiTECH.
B. Therapists shall assess carefully the remote environment in which services will be provided, to determine what impact, if any, there might be to the efficacy, privacy and/or safety of the proposed intervention offered via teletherapy.
C. Therapists must understand and inform their clients of the limits to confidentiality and risks to the possible access or disclosure of confidential data and information that may occur during service delivery, including the risks of access to electronic communications.

9. Professional Boundaries Regarding Virtual Presence

A. Reasonable expectations about contact between sessions must be discussed and verified with the client. At the start of the treatment, the client and therapist shall discuss whether or not the provider will be available for phone or electronic contact between sessions and the conditions under which such contact is appropriate. The therapist shall provide a specific time frame for expected response between session contacts. This must also include a discussion of emergency management between sessions.
B. To facilitate the secure provision of information, therapists must provide in writing the appropriate ways to contact them.
C. Therapists are discouraged from knowingly engaging in a personal virtual relationship with clients (e.g., through social and other media). Therapists shall document any known virtual relationships with clients/associated with clients.
D. Therapists shall discuss and document, and must establish, professional boundaries with clients regarding the appropriate use and/or application of technology and the limitations of its use within the counseling relationship (e.g., lack of confidentiality, circumstances when not appropriate to use).
E. Therapists shall be aware that personal information they disclose through electronic means may be broadly accessible in the public domain and may affect the therapeutic relationship.

10. Social Media and Virtual Presence

A. Therapists shall develop written procedures for the use of social media and other related digital technology with clients. These written procedures, at a minimum, provide appropriate protections against the disclosure of confidential information and identify that personal social media accounts are distinct from any used for professional purposes.

B. In cases where therapists wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles shall be created to clearly distinguish between the two kinds of virtual presence.
C. Therapists must respect the privacy of their clients' presence on social media unless given consent to view such information.
D. Therapists must avoid the use of public social media sources (e.g., tweets, blogs, etc.) to provide confidential information.
E. Therapists shall refrain from referring to clients generally or specifically on social media.
F. Therapists who use social networking sites for both professional and personal purposes are encouraged to review and educate themselves about the potential risks to privacy and confidentiality and consider utilizing all available privacy settings to reduce these risks. They are mindful of the possibility that any electronic communication can have a high risk of public discovery.
G. Therapists who engage in online blogging shall be aware that they are revealing personal information about themselves and shall be aware that clients may read the material. Therapists shall consider the effect of a client's knowledge of their blog information on the professional relationship, and when providing marriage and family therapy, place the client's interests as paramount.

11. Sexual Issues in Teletherapy

A. Treatment and/or consultation utilizing technology-assisted services must be held to the same standards of appropriate practice as those in face to face settings.
B. Therapists must be aware of statutes and regulations of relevant jurisdictions regarding sexual interactions with current or former clients or with known members of the client's family system.

12. Documentation/Record Keeping

A. All direct client-related electronic communications, shall be stored and filed in the client's medical record, consistent with traditional record-keeping policies and procedures.
B. Written policies and procedures must be maintained at the same standard as face-to-face services for documentation, maintenance, and transmission of the records of the services using teletherapy technologies.
C. Services must be accurately documented as remote services and include dates, place of both therapist and client(s) location, duration, and type of service(s) provided.
D. Requests for access to records require written authorization from the client with a clear indication of what types of data and which information is to be released. If therapists are storing the audiovisual data from the sessions, these cannot be released unless the client authorization indicates specifically that this is to be released.
E. Therapists must create policies and procedures for the secure destruction of data and information and the technologies used to create, store, and transmit data and information.
F. Therapists must inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.

G. Clients must be informed in writing of the limitations and protections offered by the therapist's technology.
H. The therapist must obtain written permission prior recording any/or part of the teletherapy session. The therapist shall request that the client(s) obtain written permission from the therapist prior to recording the teletherapy session.

13. Payment and Billing Procedures

A. Prior to the commencement of initial services, the client shall be informed of any and all financial charges that may arise from the services to be provided. Arrangement for payment shall be completed prior to the commencement of services.
B. All billing and administrative data related to the client must be secured to protect confidentiality. Only relevant information may be released for reimbursement purposes as outlined by HIPAA.
C. Therapist shall document who is present and use appropriate billing codes.
D. Therapist must ensure online payment methods by clients are secure.

14. Emergency Management

A. Each jurisdiction has its own involuntary hospitalization and duty-to-notify laws outlining criteria and detainment conditions. Professionals must know and abide by the rules and laws in the jurisdiction where the therapist is located and where the client is receiving services.
B. At the onset of the delivery of teletherapy services, therapists shall make reasonable effort to identify and learn how to access relevant and appropriate emergency resources in the client's local area, such as emergency response contacts (e.g., emergency telephone numbers, hospital admissions, local referral resources, a support person in the client's life when available and appropriate consent has been authorized).
C. Therapists must have clearly delineated emergency procedures and access to current resources in each of their client's respective locations; simply offering 911 may not be sufficient.
D. If a client recurrently experiences crises/emergencies suggestive that in-person services may be appropriate, therapists shall take reasonable steps to refer a client to a local mental health resource or begin providing in-person services.
E. Therapists shall prepare a plan to address any lack of appropriate resources, particularly those necessary in an emergency, and other relevant factors which may impact the efficacy and safety of said service. Therapists shall make reasonable effort to discuss with and provide all clients with clear written instructions as to what to do in an emergency (e.g., where there is a suicide risk). As part of emergency planning, therapists must be knowledgeable of the laws and rules of the jurisdiction in which the client resides and the differences from those in the therapist's jurisdiction, as well as document all their emergency planning efforts.
F. In the event of a technology breakdown, causing disruption of the session, the therapist must have a backup plan in place. The plan must be communicated to the client prior to

commencement of the treatment and may also be included in the general emergency management protocol.

15. Synchronous vs. Asynchronous Contact with Client(s)

A. Communications may be synchronous with multiple parties communicating in real time (e.g., interactive videoconferencing, telephone) or asynchronous (e.g. email, online bulletin boards, storing and forwarding information). Technologies may augment traditional in-person services (e.g., psychoeducational materials online after an in-person therapy session), or be used as stand-alone services (e.g., therapy provided over videoconferencing). Different technologies may be used in various combinations and for different purposes during the provision of teletherapy services. The same medium may be used for direct and non-direct services. For example, videoconferencing and telephone, email, and text may also be utilized for direct service while telephone, email, and text-may be used for non-direct services (e.g. scheduling). Regardless of the purpose, therapists shall be aware of the potential benefits and limitations in their choices of technologies for particular clients in particular situations.

16. HIPAA Security, Web Maintenance, and Encryption Requirements

A. Videoconferencing applications must have appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose.
B. Video software platforms must not be used when they include social media functions that notify users when anyone in contact list logs on (skype, g-chat).
C. Capability to create a video chat room must be disabled so others cannot enter at will.
D. Personal computers used must have up-to-date antivirus software and a personal firewall installed.
E. All efforts must be taken to make audio and video transmission secure by using point-to-point encryption that meets recognized standards.
F. Videoconferencing software shall not allow multiple concurrent sessions to be opened by a single user.
G. Session logs stored by 3rd party locations must be secure.
H. Therapists must conduct analysis of the risks to their practice setting, telecommunication technologies, and administrative staff, to ensure that client data and information is accessible only to appropriate and authorized individuals.
I. Therapists must encrypt confidential client information for storage or transmission, and utilize such other secure methods as safe hardware and software and robust passwords to protect electronically stored or transmitted data and information.
J. When documenting the security measures utilized, therapists shall clearly address what types of telecommunication technologies are used (e.g., email, telephone, videoconferencing, text), how they are used, whether teletherapy services used are the primary method of contact or augments in-person contact.

17. Archiving/Backup Systems

A. Therapists shall retain copies of all written communications with clients. Examples of written communications include email/text messages, instant messages, and histories of chat based discussions even if they are related to housekeeping issues such as change of contact information or scheduling appointments.
B. PHI and other confidential data must be backed up to or stored on secure data storage location.
C. Therapists must have a plan for the professional retention of records and availability to clients in the event of the therapist's incapacitation or death.

18. Electronic Links

A. Therapists shall regularly ensure that electronic links are working and are professionally appropriate.

19. Testing/Assessment

A. When employing assessment procedures in teletherapy, therapists shall familiarize themselves with the tests' psychometric properties, construction, and norms in accordance with current research. Potential limitations of conclusions and recommendations that can be made from online assessment procedures should be clarified with the client prior to administering online assessments.
B. Therapists shall consider the unique issues that may arise with test instruments and assessment approaches designed for in-person implementation when providing services.
C. Therapists shall maintain the integrity of the application of the testing and assessment process and procedures when using telecommunication technologies. When a test is conducted via teletherapy, therapists shall ensure that the integrity of the psychometric properties of the test or assessment procedure (e.g., reliability and validity) and the conditions of administration indicated in the test manual are preserved when adapted for use with such technologies.
D. Therapists shall be cognizant of the specific issues that may arise with diverse populations when providing teletherapy and make appropriate arrangements to address those concerns (e.g., language or cultural issues; cognitive, physical or sensory skills or impairments; or age may impact assessment). In addition, therapists shall consider the use of a trained assistant (e.g., proctor) to be on premise at the remote location in an effort to help verify the identity of the client(s), provide needed on-site support to administer certain tests or subtests, and protect the security of the testing and/or assessment process.
E. Therapists shall use test norms derived from telecommunication technologies administration if such are available. Therapists shall recognize the potential limitations of all assessment processes conducted via teletherapy, and be ready to address the limitations and potential impact of those procedures.

F. Therapists shall be aware of the potential for unsupervised online testing which may compromise the standardization of administration procedures and take steps to minimize the associated risks. When data are collected online, security should be protected by the provision of usernames and passwords. Therapists shall inform their clients of how test data will be stored (e.g., electronic database that is backed up). Regarding data storage, ideally secure test environments use a three-tier server model consisting of an internet server, a test application server, and a database server. Therapists should confirm with the test publisher that the testing site is secure and that it cannot be entered without authorization.
G. Therapists shall be aware of the limitations of "blind" test interpretation, that is, interpretation of tests in isolation without supporting assessment data and the benefit of observing the test taker. These limitations include not having the opportunity to make clinical observations of the test taker (e.g., test anxiety, distractibility, or potentially limiting factors such as language, disability etc.) or to conduct other assessments that may be required to support the test results (e.g., interview).

20. Telesupervision

A. Therapists must hold supervision to the same standards as all other technology-assisted services. Telesupervision shall be held to the same standards of appropriate practice as those in in-person settings.
B. Before using technology in supervision, supervisors shall be competent in the use of those technologies. Supervisors must take the necessary precautions to protect the confidentiality of all information transmitted through any electronic means and maintain competence.
C. The type of communications used for telesupervision shall be appropriate for the types of services being supervised, clients and supervisee needs. Telesupervision is provided in compliance with the supervision requirements of the relevant jurisdiction(s). Therapists must review state board requirements specifically regarding face-to-face contact with supervisee as well as the need for having direct knowledge of all clients served by his or her supervisee.
D. Supervisors shall: (a) determine that telesupervision is appropriate for supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform supervisees of the potential risks and benefits associated with telesupervision, respectively; (c) ensure the security of their communication medium; and (d) only commence telesupervision after appropriate education, training, or supervised experience using the relevant technology.
E. Supervisees shall be made aware of the risks and responsibilities associated with telesupervision. Supervisors are to advise supervisees in writing of these risks, and of both the supervisor's and supervisees' responsibilities for minimizing such risks.
F. Supervisors must be aware of statutes and regulations of relevant jurisdictions regarding sexual interactions with current or former supervisees.
G. Communications may be synchronous or asynchronous. Technologies may augment traditional in-person supervision, or be used as stand-alone supervision. Supervisors shall be aware of the potential benefits and limitations in their choices of technologies for particular supervisees in particular situations.

Contributors

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MFT Training Programs and Faculty:

Abilene Christian University (MMFT)	**Dale Bertram**
Antioch University Seattle (MA)	**Paul David, Kirk Honda**
Argosy University - Salt Lake (MA)	**Anthony Alonzo**
Argosy University- Twin Cities (MA)	**Jody Nelson**
Central Connecticut State University (MS)	**Ralph Cohen**
Converse College-(MMFT)	**Kelly Kennedy**
Council for Relationships (PDI)	**Michele Southworth**
East Carolina University (MS)	**Damon Rappleyea**
East Carolina University (PhD)	**Jennifer Hodgson**
Edgewood College (MS)	**Will Hutter, Peter Fabian**
Evangelical Theological Seminary (MA)	**Joy Corby**
Kansas State University (MS) (PhD)	**Sandra Stith**
Lewis and Clark College (MCFT)	**Carmen Knudson-Martin**
Louisville Presby. Theol. Sem. (MA)	**Loren Townsend**
Minnesota, University of (PhD)	**Steven Harris**
Mount Mercy University	**Randy Lyle**
Northcentral University (MA)	**Lisa Kelledy**
Northcentral University (PhD)	**James Billings, Mark White**
Nova Southeastern University (MS)	**Anne Rambo**
Our Lady of the Lake University-Houston (MS)	**Leonard Bohanon**
Pfeiffer University (MA)	**Laura Bryan, Susan Wilkie**

Philadelphia Child & Family Ctr (PDI)	**Marion Lindblad-Goldberg**
Purdue University-Calumet (MS)	**Megan Murphy**
Reformed Theological Seminary (MA)	**Jim Hurley**
Rochester, University of (MS)	**Jenny Speice**
Seattle University (MA)	**Christie Eppler**
Southern Mississippi, University of (MS)	**Pam Rollins**
St. Cloud State University (MS) (PDC)	**Jennifer Connor**
St. Mary's University (MA) (PhD)	**Jason Northrup**
St. Mary's University of Minnesota-(MA) (PDI)	**Samantha Zaid**
Texas Tech University (PhD)	**Doug Smith**
Virginia Tech University- Blacksburg (PhD)	**Scott Johnson**
Virginia Tech University- Falls Church (MS)	**Eric McCollum**
Wisconsin Stout, University of (MS)	**Dale Hawley**

State Licensing Boards, Executive Directors, and Board Members:

Alabama	**Alan Swindall**
Alaska	**Laura Carrillo**
Arizona	**Tobi Zavala**
Arkansas	**Michael Loos**
Delaware	**Bill Northey**
Guam	**Vincent Pereda**, **Mamie Balajadia**
Hawaii	**Lynn Bhanot**
Idaho	**Piper Field**
Illinois	**David Norton**
Kentucky	**Jane Prouty**
Louisiana	**Penny Millhollon**
Maryland	**Tracey DeShields**
Massachusetts	**Jacqueline Gagliardi**
Massachusetts	**Erin LeBel**

Minnesota	**Jennifer Mohlenhoff**
Missouri	**Loree Kessler**
Montana	**Cyndi Reichenbach**
New Mexico	**Evelyn Tapia-Barnhart**
New York	**David Hamilton**
Ohio	**Brian Carnahan**
Oregon	**Charles Hill, LaRee Felton**
Pennsylvania	**Joy Corby**
Rhode Island	**Arlene Hartwell**
South Carolina	**Danny Garnett**
South Dakota	**Mary Guth**
Texas	**Rick Bruhn**
Washington	**Brad Burnham**
West Virginia	**Roxanne Clay**
Wisconsin	**Peter Fabian**
Wyoming	**Kelly Heenan**

Teletherapy Committee Members:

Most importantly, AMFTRB wants to recognize the exceptional and dedicated work of the Teletherapy Committee.

Mary Alice Olsan, Committee Chair (Louisiana)

Jennifer Smothermon (Texas)

Leon Webber (Alaska)

Jeremy Blair (Alabama)

Susan Meyerle (Nebraska)

Lois Paff Bergen, AMFTRB Executive Director

Resources

Alaska Board of Marital & Family Therapy, Professional Licensing, Division of Commerce, Community, and Economic Development, Corporations, Business, & Professional Licensing, Board of Marital and Family Therapy

www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardofMaritalFamilyTherapy

American Association for Marriage and Family Therapy (AAMFT)

www.aamft.org

American Counseling Association (ACA)

www.counseling.org

Association of Social Work Boards (ASWB)

www.aswb.org

American Psychological Association (APA)

www.apa.org

American Telemedicine Association (ATA)

www.americantelemed.org

Australian Psychological Society (APS)

www.psychology.org.au

Federation of State Medical Boards

www.fsmb.org

International Society for Mental Health Online

www.ismho.org

National Association of Social Workers (NASW)

www.socialworkers.org

National Board for Certified Counselors (NBCC)

www.nbcc.org

Ohio Psychological Association

www.ohpsych.org

Online Therapy Institute

www.Onlinetherapyinstitute.com

Renewed Vision Counseling Services

www.renewedvisioncounseling.com

Texas State Board of Examiners of Marriage and Family Therapists

www.dshs.texas.gov/mft/mft_rules.shtm

TeleMental Health Institute

www.telehealth.org

U.S. Department of Health and Human Services

www.hhs.gov/hipaa/for-professionals/special-topics/mental-health

Zur Institute

www.zurinstitute.com/telehealthresources.html

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Best Practices in the Online Practice of Couple and Family Therapy

Report of the Online Therapy Workgroup
Presented to the Board of AAMFT
February 17, 2017

Benjamin E. Caldwell, PsyD, Chair
Richard J. Bischoff, PhD
Kathleene A. Derrig-Palumbo, PhD
Jeffrey D. Liebert, MA

AAMFT
American Association for Marriage and Family Therapy

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Note: Throughout this document, we have interpreted the scope of our charge narrowly, to encompass the provision of therapy services online. As such, we have not addressed here the use of text messaging, email, online scheduling, or related technologies used as an adjunct to in-person treatment. We also have not addressed here the use of technology solely for marketing purposes by those MFTs who see clients in person. Each of these uses of online tools raises its own set of ethical considerations.

Summary of findings on knowledge-based questions

The Online Therapy Workgroup was tasked with developing best-practice guidelines for the online practice of marriage and family therapy, which is a form of what laws often refer to as telehealth. Our charge letter asked that these be developed as guidelines for MFTs "to consider" when providing such services, and not that they be proposed as binding standards.

Part of our charge included consideration of four Knowledge-based questions. Below are the findings that have emerged from our exploration of these questions. Following our responses to the questions, we address currently-unavailable additional data points that we believe would be useful to have for organizational decision-making.

Question 1. What do we know about our stakeholders' needs, wants, and preferences that is relevant to this decision?

NEED, WANT, OR PREFERENCE	STAKEHOLDER(S)	SOURCE
Legal and ethical compliance, including clarity on practice across state lines	MFTs, Licensing boards	AAMFT Code of Ethics DeAngelis, 2012 HIPAA and related state, provincial, and federal laws
Flexibility in scheduling	MFTs, Clients	Cook & Doyle, 2002
Low-cost, easy-to-use platforms	MFTs, Clients	Cook & Doyle, 2002 Derrig-Palumbo & Ziene, 2005
Access to qualified and appropriate care	MFTs, Clients, Referral sources	Brazell, 2015
Evidence that online therapy outcomes are comparable to in-person outcomes	MFTs, Clients, Third-party payers	Doss, Benson, Georgia, & Christensen, 2013
Confidential communications	MFTs, Clients, Third-party payers	Derrig-Palumbo & Eversole, 2011
Insurance reimbursement for services	MFTs, Clients	eTherapi, 2014
Network infrastructure (access, bandwidth, and security)	MFTs, Clients, Third-party payers	Morgan, 2012 Hertlein, Blumer, & Mihaloliakos, 2015
Secure record-keeping and payment systems	MFTs, Clients, Third-party payers	Hecht, Shin, Matusek 2015 HIPAA and related state and federal laws
Clarity on the identity and location of the client at the time of service	MFTs, Licensing boards	Hertlein, Blumer, & Mihaloliakos, 2015

Question 2. What do we know about the current realities and evolving dynamics of our environment that is relevant to this decision?

Key realities and evolving dynamics of the online psychotherapy environment include:

- **Online therapy is rapidly growing in utilization.** Clinicians and clients alike express a desire for online services to be more readily accessible. Online therapy is increasing consumers' access to qualified care (US Department of Health and Human Services, 2013), potentially contributing to increased utilization of treatment among military veterans (Mott, Hundt, Sansgiry, Mignognia, & Cully, 2014). Online therapy also is reducing costs for payors through increased efficiency (Townley & Yalowich, 2015).

- **Research on the effectiveness of online therapy is promising.** Online services appear to produce client acceptance, satisfaction, and retention at similar rates to in-person therapy (Simpson & Reid, 2014). Outcome research has also produced positive results in a number of areas, including depression, anxiety, and panic disorder (Carlbring et al., 2006; Mohr, Vella, Hart, Heckman, & Simon, 2008; Spence et al., 2011). However, we caution that **there appear to have been no studies to date examining the effectiveness of online therapy with couples and families.** A content analysis of 18 family therapy journals in 2013 found just 10 articles related to online family therapy out of more than 13,000 total articles published over 15 years. All 10 were opinion articles and case studies (Livings, 2013). The closest parallel to online family therapy may be online groups, which participants have rated as being inferior to in-person groups on measures of cohesiveness, safety, and delivery (Holmes & Koslowski, 2015). However, online therapy for couples and families remains promising as technology improves, particularly for couples and families unable to attend therapy together in person. For example, online therapy has been used to assist military couples with conflict resolution during deployment (Farero, Springer, Hollist, & Bischoff, 2015).

- While the evidence is limited, **many MFTs appear to lack basic knowledge of their obligations** when providing telehealth services. For example, many MFTs talk openly of using Skype and FaceTime in their provision of services, even though these platforms do not provide the Business Associate Agreements (BAAs) required under HIPAA in the United States (Huggins, 2016).

- **Legal recognition of online therapy, as with other telehealth services, is evolving rapidly.** Many states and provinces now recognize online therapy through regulatory language. Additionally, many states and provinces now require health insurers to cover services provided via telehealth, often with the additional requirement that these services be covered at the same reimbursement rates as when the service is provided in person (TeleMental Health Institute, no date). However, insurers may require additional documentation in order for payment to be made. Furthermore, regulations vary widely from location to location. State and provincial regulatory boards appear to be responding to the evolving landscape with new or clarified regulations. We cannot expect that the regulatory landscape of 2016, in regard to online therapy, will be the regulatory landscape in years to come.

- State and provincial licensing boards are recognizing the challenges posed when clients move from one state to another. **Several US states have considered, and at least five states (Arizona, Colorado, Florida, Kansas, New Jersey, Utah, and Wyoming) have implemented, "carve-outs" to their licensure laws** that allow a therapist licensed in another state to continue seeing a client who moves into their state, under a variety of specific conditions (CAMFT, 2016).

- At the same time, **those states that have implemented regulation specific to telehealth have typically placed additional requirements on the therapist providing telehealth services.** One state (Arkansas) requires a specialized license to practice telehealth (California Board of Behavioral Sciences, 2015). This places a higher standard of care, and thus a higher burden, on MFTs wanting to provide online services versus those providing in-person services. We believe that additional training is an appropriate requirement for those wishing to provide services online, though we do not believe a specialized license is a necessary or appropriate means of ensuring competence in online therapy.

- **Licensing boards generally recognize therapy as occurring where the client is physically located at the time of service.** (The CAMFT Code of Ethics, like some licensing boards, specifically uses the word "located" in its standards, reinforcing this framework.) Licensing boards in multiple health professions have enforced this framework. California has prosecuted a psychiatrist in Colorado for practicing in California without a license when the psychiatrist prescribed to a California teenager through an internet pharmacy (American Medical Association, 2009). Pennsylvania similarly took action against an Israeli psychologist who was marketing online services to Pennsylvania residents without being licensed there (Maheu, 2014). However, the perspective that therapy takes place where the client is located is not universally shared among licensing boards (CAMFT, 2016). Therapists should be cautious to ensure that they have the necessary credentials to work with a client online, based on the requirements of (1) the jurisdiction in which the client is physically located at the time of service; (2) the jurisdiction in which the therapist is physically located at the time of service; and (3) the jurisdiction of the therapist's licensure or registration.

- **Therapists are using new technologies before regulations or professional standards have been developed regarding their use.** For example, it is only now that the US Department of Health and Human Services is developing HIPAA regulations around the use of text messaging, despite the fact that many therapists have been communicating with clients via text for years (Sude, 2013, provides a useful review of the literature on therapists and text messaging). This does not mean that being an early adopter of a technology is necessarily problematic (Greene, 2012); rather, it means that providers should be cautious to ensure that their use of new technologies is consistent with existing ethical principles, especially those related avoiding potential harm. It also means that professional associations and government regulators must exercise caution so that regulations and standards protect clients without standing in the way of opportunities for technological innovation that could increase the reach, effectiveness, and convenience of treatment for clients. Rules must be written broadly enough that they can apply to technologies that have not yet been developed.

- **The future is unknowable.** New regulations are introduced annually, professional associations are increasingly clarifying their stances and codes of ethics, the variety and accessibility of high quality telecommunications is continually increasing, and providers are continually looking to exploit these technologies to make services more accessible to clients and potential clients. It is possible that a future legal action could lead US courts to consider psychotherapy and other forms of health care, when conducted across state lines, to be **interstate commerce** and thus subject to federal, and not state, regulation (Dear, 2015). Negatively, this would create something of a "Wild West" situation with little regulatory oversight of online therapy until clear federal regulations could be established. Positively, such a finding could pave the way for national licensure standards, reducing or eliminating the patchwork of different standards across state and provincial borders that can make it difficult for therapists to move from one state to another (Caldwell, 2012).

Question 3. What do we know about the capacity and strategic position of our organization that is relevant to this decision?

We address these as separate but related questions, beginning with the strategic position of the AAMFT.

STRATEGIC POSITION

- **The AAMFT Code of Ethics covers technology issues more thoroughly in its 2015 version than in prior versions.** At the same time, it is less specific in addressing several technology issues than the 2014 ACA Code of Ethics, which addresses counselor Web Sites, Social Media usage, and related issues in greater detail.

- **The standards related to technology in the 2015 AAMFT Code of Ethics frequently defer to applicable law** rather than setting a particular professional standard. (See standards 6.1, 6.3, 6.4, and 6.5.) This stance recognizes that laws surrounding telehealth can vary widely and change quickly, and that MFTs must be aware of the current laws in their state or province. Federal law in the US is also likely to continue to evolve, either through legislation or rulemaking (specifically surrounding HIPAA). This deference to applicable regulatory language may leave practitioners confused about where to turn for clarity around compliant online practice, and believing that they cannot rely on the association for related guidance.

- **MFTs are behind other mental health professions in pursuing interstate compacts, certifications for online practice across state and provincial lines, or other avenues to reduce or eliminate barriers to interstate practice.** To date, four US states have signed on to the American Association of State Counseling Boards' interstate compact for licensure recognition (ACA, 2015), and one has adopted the Association of State and Provincial Psychology Boards' PSYPACT language designed specifically to facilitate online practice (ASPPB, 2016). The ASPPB also has a separate interstate compact, which currently has four US states and two Canadian provinces as signatories (ASPPB, no date).[1] The AAMFT and Association of Marriage and Family Therapy Regulatory Boards (AMFTRB), to our knowledge, have not yet pursued such projects. Doing so would require coordination of effort among Central and Division advocacy leaders, Family TEAM volunteers, the AMFTRB, and its member boards. This would require a more significant investment of resources, but could have meaningful impact, particularly given the hesitance some MFTs show toward online practice due to jurisdictional concerns (Hertlein, Blumer, & Mihaloliakos, 2015). We note here that while these projects in other professions have been pushed forward by their licensing boards, the professional associations appear to have been instrumental in supporting and facilitating them.

- Through both its federal lobbying staff and state advocates participating in Family Team, **the AAMFT has strategic resources that could be deployed toward key advocacy objectives related to online practice.** This topic is further addressed below. We acknowledge that all advocacy resources have their limits, and that use of resources for advocacy objectives related to online practice may require shifting these resources away from other worthwhile goals.

1 ACA interstate compact member states include Kentucky, Tennessee, Virginia, and West Virginia. PSYPACT has been adopted by the state of Arizona. ASPPB's interstate compact counts Arkansas, Missouri, Nebraska, Texas, Manitoba, and Ontario as signatories.

ORGANIZATIONAL CAPACITY

While the position of AAMFT is largely similar to that of other mental health professional organizations, the AAMFT is well-positioned with the capacity to do more if so desired:

- AAMFT, like its sister organizations, appears to lack the in-house expertise to become a direct provider of products such as a telehealth platform or EHR system. Such systems require significant initial investment and are complex and expensive to build and maintain. **Affinity agreements** can be negotiated with companies that provide these products. Such agreements generally do not require initial investment. They bring discounts to members, revenue to the association, and confidence to those members using the service that they are acting in accordance with ethical and professional standards. The AAMFT is currently involved in an affinity agreement with Valant, a provider of electronic medical record systems. Valant provides a discount on its products to AAMFT members and has implemented record-keeping protocols designed for those who work with couples and families. AAMFT could seek out affinity agreements with companies that offer secure, HIPAA-compliant platforms for therapy, and actively shape how such companies might coordinate couple- or family-based services.
- AAMFT is well positioned to **inform and educate** its members about best practice guidelines related to online therapy services. Efforts to this end can include:
  - The development of this best-practices document
  - Online continuing education in the area of online therapy
  - Webinars
  - A recurring column in *Family Therapy* Magazine about online practice
  - An online therapy track at the Annual Conference
  - Additional publications or events

Such efforts would not represent significant costs to the association, and in some instances may be revenue-generating.

- **AAMFT can work with the COAMFTE to develop competencies and educational standards for online therapy to be embedded in COAMFTE accredited programs.** Research has already been done to lay groundwork for development of specific competencies for online practice in MFT (Blumer, Hertlein, & VandenBosch, 2015). Given the growth in online mental health services, and the likelihood that a significant portion of new MFT graduates will be conducting at least some services online during their careers, standardizing the training around such services has significant potential benefit.
- Similarly, **AAMFT can actively partner with outside organizations advancing technology in mental health practice**, to further influence emerging standards and develop consensus across professions. Such organizations include but are not limited to the Coalition for Technology in Behavioral Science and the American Telemedicine Association.

- The existing **Ethics Committee can provide clearer interpretation of existing standards** around online practice, or ask the Board to appoint a task force to draft new, more detailed ethical standards surrounding online practice.
- Some MFTs are more comfortable with technology, and more likely to engage in online services, than others. The association can readily assist with **connecting members who have an interest in online practice.** The AAMFT can provide opportunities for these therapists to connect through the AAMFT Community platform. Considering the many public policy issues and questions raised by the growth of online practice, it is worth noting that the AAMFT Family Team already offers a forum for those interested in advocacy work related to distance therapy and supervision.
- While the AAMFT could develop the capacity to issue **certificates for online practice** (and has offered trainings in online practice in the past), if the association were to pursue a project like PSYPACT with the intention of recognition from licensing boards, this would be new territory for the association. It may be more effective to enlist AMFTRB as the certificate issuer. State governments may prefer using the AMFTRB structure over an AAMFT structure where they may have little influence over future changes. (The PSYPACT project will involve the Association of State and Provincial Psychology Boards [ASPPB] issuing certificates to those Psychologists wishing to engage in online practice across some state lines.)
- Also related to advocacy, AAMFT's Family Team can push for **regulatory clarity surrounding online practice in each state and province.** State and provincial laws currently vary widely, but this variance is actually less of a concern than some locations' complete lack of regulation of online mental health care. This leaves practitioners unclear about the limits of who they can serve and what online treatment can look like.
- As we note under Question 4 below, research on the online delivery of couple and family therapy is in its infancy. **The AAMFT Research & Education Foundation could support groundbreaking research into online couple and family therapy**, either through direct research or through a grant process, raising the profile of the foundation.

Question 4. What are the ethical implications?

There are two ways of considering this question. One way is to consider the implications *to the association* when considering online practice. Another is to consider the implications *for individual practitioners* who are engaging in online practice. Here, we address both, beginning with the implications for the association.

ETHICAL IMPLICATIONS FOR THE AAMFT

- **The AAMFT Code of Ethics appears to hold online therapy to a higher standard than traditional (i.e., face-to-face) treatment modalities.** The term "best practices" appears only three times in the AAMFT Code of Ethics, all within Standard VI: Technology-Assisted Professional Services (see 6.3, 6.4, and 6.6). These standards require the use of best practices, which moves best practices from their more typical position as **optimal** standards to a position of being *minimal* standards. As online therapy becomes more mainstream, the AAMFT needs to be careful to ensure that technology-assisted treatments are not unnecessarily held to a higher standard than are non-technology assisted treatments. The AAMFT will need to clarify when a best-practice standard is the minimal standard, and where appropriate, apply that to all modalities of treatment. Otherwise, practitioners and licensing boards may experience confusion in attempting to interpret the standards.

- It may be premature to simply presume the success and continued growth of online therapy, particularly in couple and family-based treatment contexts where the effectiveness of online therapy has not yet been determined. The AAMFT Code of Ethics requires MFTs to practice in accordance with the best scientific knowledge currently available (Statement adopted by the AAMFT Board of Directors, March 25, 2009). MFTs are also ethically obligated to inform clients of the "potential risks and benefits of treatments for which generally recognized standards do not yet exist" (standard 1.2(c)). At the present time, it would seem prudent for therapists engaged in online couple or family therapy to inform clients of the lack of research surrounding such treatment. While research results for individual therapy online are certainly promising, we could locate no studies that have directly examined the effectiveness of couple or family interventions in an online context compared to in-person treatment. **Further research on the online delivery of couple and family therapy is necessary to establish the effectiveness of online service delivery.**

- When considering possible best practices for online therapy, as well as other strategic initiatives including those described above, the AAMFT must **strike an effective balance between encouraging the development and use of innovative service delivery systems and promoting high professional standards for those services.** If the standards for online practice are set in a manner that is too burdensome or too vague, practitioners may be more reluctant to venture into online practice. Some may even disregard the ethical standards, writing those standards off as irrelevant to their work. On the other hand, if standards are set in a manner that is clear, specific, adaptive (or, more likely, subject to regular updating), and achievable for the average practitioner, family therapists can remain on the cutting edge of effective service delivery.

ETHICAL IMPLICATIONS FOR INDIVIDUAL PRACTITIONERS

The ethical considerations for individual MFTs engaging in online practice are many. We encourage readers to carefully review the most current AAMFT Code of Ethics and ensure compliance with each standard.

- While many MFTs are not yet comfortable delivering online services, **many MFTs are already utilizing technology in at least some elements of their practices.** For example, many MFTs report using web sites and online directories to market their practices, and using email and text messaging to communicate with clients. At the same time, ethical concerns are commonly cited by MFTs as reasons not to further integrate online practice into their work (Hertlein, Blumer, & Mihaloliakos, 2015). We believe this speaks to a desire for further clarity on how MFTs can practice ethically in an online environment. Put more simply, the current AAMFT Code of Ethics may not provide sufficient guidance for most MFTs to feel confident that they are abiding by professional ethical standards when moving into online service delivery.

- Based on our anecdotal experience with colleagues, it appears that **MFTs who provide therapy services online via email may not recognize the security and confidentiality risks inherent to such service.** As with other technologies, the provision of therapy services by email triggers additional ethical responsibilities. In many locations, additional legal responsibilities are triggered as well. Most email accounts are not secure, and even when the therapist is using a secure account, the client may not be. In addition, client email (even when accessed via secure account) may be accessed by other family members.

- **MFTs who provide therapy online are subjecting themselves to an additional set of professional standards, not simply a *different* set.** All of the legal and ethical obligations typically attached to therapy apply, as well as those additional standards that specifically relate to online service provision. For example, when a client agrees to participate in online therapy, they are not waiving any of their existing protections for confidentiality, privacy, or other consumer protection. MFTs are still responsible to the full breadth of applicable state or provincial law and the AAMFT Code of Ethics.
- **MFTs who provide therapy online may not understand where to find appropriate best practice standards or how to use them.** Multiple organizations have produced or are producing best-practice documents for online mental health practice, including AMFTRB (in draft) and the American Telemedicine Association (2013). Practitioners are likely to have varying degrees of familiarity with these documents, and may not understand whether it is acceptable to adopt some, but not all, of the best practices any single document recommends. This can contribute to fears of ethical breaches based on a lack of clarity about what the existing ethical standards actually require.

Additional data that would be useful

In addition to the knowledge questions above, we were asked to describe *what we wish we knew* – data that may be useful to the association and its members in making decisions related to the online practice of family therapy. While some of these issues are addressed elsewhere in this document, these data points may be of service to the Board, policymakers, and individual practitioners.

- **Effectiveness of online couple and family treatment.** As noted above, current effectiveness research on online therapy has focused on individual clients receiving largely cognitive-behavioral services.
- **Current and planned use of various technologies in service delivery among MFTs.** Understanding the proportion of MFTs who are currently offering services online or who are planning to in the next few years may help the association determine the level of future resources to devote to this mode of service delivery.
- **Rates of technology failure, data breach, and confidentiality problems in online service delivery (and as compared with in-person service delivery).** While many MFTs considering online services express these as concerns, it is presently difficult to determine the degree to which these concerns are appropriate.
- **Licensing boards' interpretations of where psychotherapy takes place.** While some boards have made clear that they believe therapy takes place where the client is located at the time of service, other boards have not yet offered an interpretation, contributing to the regulatory uncertainty many MFTs experience around online therapy.

Best practices for the online practice of couple and family therapy

The following best practices are guidelines for couple and family therapists to consider in the provision of online psychotherapy. They are non-binding practices designed to minimize risk to client and therapist alike, and to facilitate appropriate communication on technology issues.

For ease of reading and navigation, we have broken these guidelines into the following sections.

1. Compliance

2. Infrastructure

3. Advertising and marketing

4. Informed consent

5. Initial assessment

6. Ongoing services

7. Crisis management

8. Failures and breaches

9. Accountability and review

Of course, technologies change quickly. So too can the regulatory environment surrounding the use of technology in online service delivery. MFTs are fundamentally obligated to remain abreast of changes in both law and technology that may impact their ability to effectively practice online.

1. Compliance

Follow applicable standards. MFTs engaging in online practice maintain awareness of, and follow, current applicable law and all other relevant standards surrounding online provision of psychotherapy where the client is physically located at the time of service, as well as where the therapist is licensed. This includes federal law (such as HIPAA in the US), state and provincial law, applicable local law, ethical standards, the current standard of care for online services, and all other relevant rules. When a session involves multiple clients participating from multiple geographic locations, the therapist is bound to the laws of *all* client locations at the time of service.

Role clarity. MFTs engaging in online practice clarify with anyone participating in a service what the role and responsibility of that person is. Participants may include clients, family members, advocates, social service workers, probation officers, teachers, consultants, supervisors, and others. Documentation of therapy, including documentation to third-party payors, accurately reflects the services provided and the roles of each participant.

Verification of licensure. MFTs engaging in online practice provide clients information on the MFT's licensure status, and with means to verify the MFT's licensure status. Consistent with the AAMFT Code of Ethics, MFTs present information on their licensure in a manner that is truthful and not misleading.

2. Infrastructure

Bandwidth. MFTs engaging in online practice have adequate, secure, and reliable network bandwidth to provide the services being offered. They regularly evaluate the adequacy, security, and reliability of the available bandwidth, and keep bandwidth updated to current standards. Broadband service is a minimal standard for video-based services.

Local network. MFTs engaging in online practice ensure that their local network (such as a wireless home or office network) is secure and reliable. Passwords are always required to access a local network. Network passwords are regularly changed.

Hardware. MFTs engaging in online practice only use hardware that is functional and secure, and ensure that the MFT has adequate training and experience with the hardware to operate it comfortably. Computers, microphones, video cameras, and any related equipment are regularly tested to ensure continued functionality. The therapist has a backup plan in place in the event of a hardware failure. Hardware systems are password-protected.

Software. MFTs engaging in online practice regularly evaluate the adequacy, security, and reliability of the software used. They only use software that is functional, secure, and reliable, and for which they have adequate training and experience. Unless required by applicable law or policy, they do not require clients to purchase software to participate in online services.

Encryption. MFTs engaging in online practice use end-to-end encryption when providing services via technology. Such encryption is available for phone-based, text-based, and video-based communication. Clients are specifically made aware of when encryption is not being used (such as for unsecured email communication between sessions). Client data is stored in encrypted formats.

Therapist. MFTs engaging in online practice have current and adequate training and preparation for the provision of online service delivery. They seek regular consultation and retraining to maintain current knowledge and skills.

3. Advertising and marketing

Advertising. To the degree to which it can be controlled, MFTs engaging in online practice only advertise their services to consumers the MFT can legally engage in treatment. The MFT's advertising either directly provides, or links to, a clear indication of the geographic locations in which the MFT is legally authorized to provide services.

Social media. MFTs engaging in online practice separate their personal social media profiles from professional profiles or pages. When professional social media profiles and pages are used, personal data is secured such that it is not publicly accessible. MFTs who utilize social media are cautious in their social media communications and inform clients about their policies surrounding social media communications.

Web sites. MFTs engaging in online practice clearly indicate on their web sites and other materials (1) the geographic locations in which they provide online services (2) the specific services that can be accessed online, (3) the hardware, software, and related requirements that clients must fulfill in order to be considered for online services; (4) alternatives to online treatment, and (5) their licensure or registration information in accordance with applicable law.

Content. MFTs engaging in online practice describe their online services and qualifications for providing those services in truthful and non-misleading language.

4. Informed consent

Risks and benefits. **MFTs engaging in online practice inform clients in writing of the known risks and benefits of online therapy.** Services and modes of service delivery that are experimental or innovative in nature are identified as such.

Technology failure. **MFTs engaging in online practice inform clients in writing of the plan for technological failure.** This plan is provided in writing to the client as part of the informed consent process. It establishes such guidelines as who should first attempt to re-establish a connection, how long to wait before presuming that a connection cannot be re-established, when to attempt alternate technologies (such as phone), how fees for services are impacted by technological failure, and other elements as deemed appropriate by the therapist.

Alternate treatment. **MFTs engaging in online practice inform clients in writing of alternate treatment options, including in-person options.** When in-person services are not accessible to the client, due to geographic, language, or other barriers, MFTs engaging in online practice document these barriers and inform clients of alternate treatment options that may be accessible via technology.

Privacy and security. MFTs engaging in online therapy recognize their responsibility for protecting client confidentiality and the security of data transfer and storage. **MFTs engaging in online practice inform clients in writing of the steps they take to guard clients' privacy and security.** They inform clients of how client information is gathered and retained, how treatment records are stored, procedures for requesting treatment records, and related privacy practices. They inform clients of the use of third-party systems for treatment, record-keeping, billing, or related professional services, and of the limits to the MFT's ability to ensure confidentiality and security.

Availability. **MFTs engaging in online practice inform clients of their availability for additional communication between scheduled sessions, and for crisis intervention.** They inform clients of the best means of between-session communications (phone, email, text messaging, etc.) and typical response time for such communications. MFTs inform clients of typical office days and hours, and of times when the therapist is not expected to be available. They inform clients of the best way to notify the MFT that the client is in a crisis situation. They further inform clients of the MFT's ability to provide resources local to the client in the event of a crisis. MFTs using email or text messaging obtain specific written consent from clients to do so, and provide information on the risks and benefits of such communication technologies.

5. Initial assessment

Appropriateness for online services. MFTs recognize that in some cases, online therapy is not the most appropriate treatment option. **Prior to committing to the ongoing provision of online services, MFTs engaging in online practice assess whether online services are appropriate to client needs.** This assessment includes consideration of the type and severity of symptoms; the nature of the treatment being sought; client access to adequate, secure, and confidential means of online communication with the therapist; and client ability to effectively use the relevant technology. The MFT documents this assessment process and the criteria used to determine fit for online services.

Verification of identity and age for non-anonymous services. **MFTs engaging in online practice take reasonable steps to verify the identity and age of each client.** This does not prohibit anonymous service provision when such anonymity is appropriate (for example, services performed for an online crisis line). In such instances, MFTs should carefully consider their ability to meet all other legal and ethical requirements, and those best practices appropriate to the provision of anonymous services.

6. Ongoing services

Client identity. MFTs engaging in online practice establish and utilize a procedure to reconfirm the identity of the client at each session. This can be done through the use of a password or code word, visual recognition, or other means that would not be obvious to anyone other than the client.

Client location. MFTs engaging in online practice confirm and document the physical location of the client at each session.

Appropriateness for online services. MFTs engaging in online practice regularly reassess the client to determine appropriateness for online services. Such reassessment is documented. MFTs understand that clients may initially appear appropriate for online services and then, for a variety of reasons, become inappropriate for online care.

Monitoring progress. MFTs engaging in online practice regularly evaluate client progress. When the MFT determines that alternative treatments are more likely to be effective than the current treatment, the therapist assists the client in identifying appropriate alternative services, including in-person services.

Communication between sessions. MFTs engaging in online practice maintain clear professional boundaries when communicating with clients between sessions. They abide by stated policies regarding such communication.

Access to records. MFTs engaging in online practice have procedures in place to allow clients and others access to records in a manner consistent with applicable law. Third-party requests for records are fulfilled only after the MFT has taken reasonable steps to verify the identity of the party requesting records.

7. Crisis management

Advance planning. MFTs engaging in online practice prepare a crisis management plan with every client as soon as practicable in therapy. This plan includes resources local to the client, such as local crisis lines, hospitals, or other emergency services, as appropriate. Both the MFT and the client retain copies of the plan.

Coordination of care. MFTs engaging in online practice coordinate care with local crisis resources as appropriate when a client engages those resources. This ensures adequate continuity of care between providers.

Reassessment. MFTs engaging in online practice reassess the appropriateness of the client for online services as soon as practicable following a client crisis. This reassessment is appropriately documented.

8. Failures and breaches

Significant technology failure. In the event of a significant failure of technology that will impact the MFT's ability to provide online services as scheduled, MFTs engaging in online practice contact clients to make alternate arrangements for continued care. Continued care may be in-person, via phone, online through reasonably equivalent alternative technology, or online through alternate providers, as appropriate to the needs of the client.

Data breach. MFTs engaging in online practice contact affected clients as soon as practicable upon becoming aware of a data loss or breach that could impact client data. MFTs engaging in online practice also contact regulatory and governmental bodies in accordance with applicable law to promptly report data breaches impacting client data.

Confidentiality breach. MFTs engaging in online practice are alert to possible breaches of security or confidentiality in their online communications with clients. Upon becoming aware of such a breach, the MFT promptly informs the client of the breach and any necessary steps to ensure improved confidentiality in the future. Depending on the nature of the breach, these steps may be on the client end or the MFT end.

9. Accountability and review

Annual review of technology and security protocols. MFTs engaging in online practice evaluate, at least once per calendar year, the adequacy and security of their technology infrastructure, updating hardware, software, and related equipment as appropriate. For password-protected hardware and software, passwords are updated at least once per calendar year.

Regular evaluation of competency and effectiveness in online practice. MFTs engaging in online practice regularly review their treatment outcomes. They seek out additional training and experience in the use of technology for online service delivery.

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102-5-3. Education requirements. (a) Definitions. For purposes of this regulation, the following terms shall be defined as follows:
(1) ‘‘Core faculty member’’ means an individual who is part of the program’s teaching staff and who meets the following conditions:
(A) Is an individual whose education, training, and experience are consistent with the individual’s role within the program and are consistent with the published description of the goals, philosophy, and educational purpose of the program;
(B) is an individual whose primary professional employment is at the institution in which the program is housed; and
(C) is an individual who is identified with the program and is centrally involved in program development, decision making, and student training as demonstrated by consistent inclusion of the individual’s name in public and departmental documents.
(2) ‘‘In residence,’’ when used to describe a student, means that the student is present at the physical location of the institution for the purpose of completing coursework during which the student and one or more core faculty members are in face-to-face contact.
(3) ‘‘Primary professional employment’’ means a minimum of 20 hours per week of instruction, research, any other service to the institution in the course of employment, and the related administrative work.
(b) Each applicant for licensure shall meet both of the following education requirements:
(1) Each applicant shall have been awarded a master’s or doctoral degree that meets the standards in subsection (c), (e), or (f).
(2) The applicant shall have completed no less than 50% of the coursework for the degree ‘‘in residence’’ at one institution, and the required practicum shall be completed at the same institution.
(c) To qualify for licensure with a master’s or doctoral degree from a marriage and family therapy program, both of the following requirements shall be met:
(1) The college or university at which the applicant completed a master’s or doctoral degree in marriage and family therapy shall be regionally accredited, with accreditation standards equivalent to those in Kansas.
(2) The marriage and family therapy program through which the applicant completed a master’s or doctoral degree either shall be accredited by the commission on accreditation for marriage and family therapy education or shall meet the standards set out in subsection (d).
(d) Each marriage and family therapy program that is not accredited by the commission on accreditation for marriage and family therapy education shall meet all of these conditions:
(1) The program requires satisfactory completion by the applicant of a marriage and family therapy practicum, or its equivalent, that is provided by the program and that fulfills these conditions:
(A) Is a part-time clinical experience that integrates didactic learning with clinical experience and that is completed concurrently with didactic coursework at a typical rate of five to 10 hours of direct client contact per week;
(B) consists of at least 300 total hours of client contact; and
(C) includes at least 60 total hours of supervision that is provided by the program’s core faculty and off-site supervisors. The practicum shall provide a minimum of 30 supervised

hours in an individual format and no more than 30 supervised hours in a group format. Supervision shall occur at least once a week.

(2) The program requires that each marriage and family therapy student successfully complete a minimum of nine graduate semester credit hours, or the academic equivalent, in each of the following substantive content areas:

(A) Human development and family study courses in which the interplay between interpersonal and intrapersonal development is stressed and issues of gender, ethnicity, and ecosystems are addressed as they relate to human development. These courses may include studies in sexuality, sexual functioning, sexual identity, sexism, stereotyping, and racism;

(B) theoretical foundations of marital and family functioning courses, including an overview of the historical development of systems theory and cybernetics, a study of the life cycle of the family, and a study of family processes and the modification of family structures over time. These courses may include studies in the birth of the first child, adolescent sexual development, death of a family member, and issues of context, including gender and ethnicity; and

(C) marital and family assessment and therapy courses that underscore the interdependence between diagnosis or assessment and treatment by insuring that students can use appropriate assessment instruments and methods within a systemic context. These courses shall provide a thorough understanding of the major theoretical models of systemic change, including structural, strategic, intergenerational, contextual, experiential, systemic, and behavioral theories. These courses also shall teach the principles and techniques evolving from each theory. In addition, the courses shall identify the indications and contraindications for use of each theory or technique, and shall address the rationale for intervention, the role of the therapist, and the importance of considering gender and ethnicity in selecting and using assessment and treatment methods.

(3) The program requires that each marriage and family therapy student successfully complete a minimum of three graduate semester credit hours, or the academic equivalent, in each of the following substantive content areas:

(A) A professional study course that contributes to the development of a professional attitude and identity by examining the role of professional socialization, professional organizations, licensure and certification, the code of ethics, the legal responsibilities and liabilities of clinical practice and research, and interprofessional cooperation, as these topics relate to the profession and practice of marriage and family therapy. A generic course in ethics shall not be considered appropriate for this area of study; and

(B) a research course in which students gain an understanding of research methodology, data analysis, computer research skills, and evaluation and critical examination of professional research reports. The emphasis of the course shall be placed on the quantitative and qualitative research that is relevant to marriage and family therapy.

(e) To qualify for licensure with a master’s or doctoral degree in a related field, both of the following requirements shall be met:

(1) The college or university at which the applicant completed a master’s or doctoral degree in a related field shall be regionally accredited, with accreditation standards equivalent to those in Kansas.

(2) To be considered equivalent to a marriage and family therapy program, the related-field degree program shall have provided and the applicant shall have completed the requirements of subsection (d).

(f) To qualify for licensure with a master's or doctoral degree in a related field with additional coursework in marriage and family therapy, both of the following requirements shall be met:

(1) The college or university at which the applicant completed a master's or doctoral degree in a related field shall be regionally accredited, with accreditation standards equivalent to those in Kansas.

(2) The marriage and family therapy program through which the applicant obtained additional coursework in marriage and family therapy either shall be accredited by the commission on accreditation for marriage and family therapy education or shall meet the standards approved by the board as set out in subsection (d).

(g) Each applicant for licensure as a clinical marriage and family therapist whose master's or doctoral degree is earned on or after July 1, 2003 shall meet the following education requirements:

(1) A graduate degree as required by the board for licensure as a licensed marriage and family therapist in accordance with subsection (c), (e), or (f); and

(2) in addition to or as a part of the academic requirements for the graduate degree, completion of 15 graduate semester credit hours, or the academic equivalent, supporting diagnosis and treatment of mental disorders using the ''diagnostic and statistical manual of mental disorders'' as specified in K.A.R. 102-5-14. Three of the 15 semester credit hours, or the academic equivalent, shall consist of a discrete academic course with the primary and explicit focus of psychopathology and the diagnosis and treatment of mental disorders as classified in the ''diagnostic and statistical manual of mental disorders.'' The remaining 12 graduate semester credit hours, or their academic equivalent, shall consist of academic courses with the primary and explicit focus of diagnostic assessment, interdisciplinary referral and collaboration, treatment approaches, and professional ethics or other coursework that specifically contains identifiable, equivalent instruction. The 15 graduate semester credit hours shall be from an educational institution and graduate degree program meeting the requirements described in subsection (c), (e), or (f).

(h) The following activities shall not be substituted for or counted toward any of the education or supervised experience requirements set out in subsections (b) through (g):

(1) Academic courses that the applicant completed as a part of or in conjunction with undergraduate degree requirements;

(2) independent studies;

(3) thesis or independent research courses;

(4) academic coursework that has been audited rather than graded;

(5) academic coursework for which the applicant received an incomplete or a failing grade;

(6) graduate or postgraduate coursework or experiential training provided by colleges, universities, institutes, or training programs that do not qualify under subsection (c), (e), or (f); and

(7) continuing education, an in-service activity, or on the job training.

(Authorized by K.S.A. 2010 Supp. 65- 6404 and K.S.A. 2010 Supp. 74-7507; implementing K.S.A. 2010 Supp. 65-6404; effective March 29, 1993; amended Dec. 19, 1997; amended July 7, 2003; amended Oct. 27, 2006; amended April 15, 2011.)

COAMFTE

Commission on Accreditation for
Marriage and Family Therapy Education

Accreditation Standards

Graduate & Post-Graduate Marriage and Family Therapy
Training Programs

Version 12.5

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Introduction to COAMFTE Standards Version 12.5

Accreditation, the Commission on Accreditation for Marriage and Family Therapy Education ("COAMFTE" or "the Commission"), and the Accreditation Community

Accreditation is a voluntary and public service developed through a consensus process of professionals dedicated to ensuring quality educational/training experiences that provide established, recognized and evolving standards for the profession. Once accreditation is granted, programs must maintain or exceed these standards of accreditation throughout their approved terms of accreditation and review cycles. This is accomplished by continually evaluating themselves in relation to their institution's vision, their program's mission, goals and student learning outcomes.

Upholding these standards of accreditation provides:

- Regulatory bodies certainty that a program's instructional quality, public transparency, and student learning outcomes are consistent with practice requirements across multiple jurisdictions.
- The public assurance that a program is committed to reliable educational standards for the profession that meet the expectations of its communities of interest.
- Students receive a sound foundation for their evaluation and selection of educational programs.
- Prospective employers' confidence that graduates are positioned to enter the workforce ready for entry-level professional practice.

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) strives to ensure excellence in educational programs that serve the mental health profession of Marriage and Family Therapy (MFT) through four ongoing commitments:

- Competency-based educational standards endorsed by the Marriage and Family Therapy (MFT) profession developed with the involvement of multiple communities of interest.
- External review of individual educational programs to assure substantial compliance with program quality, content, and student learning outcomes as defined in COAMFTE Standards.
- Public access to programs' data on graduate achievement.
- Promotion of best practices and program-level innovation for effective graduate and post-graduate professional education.

The Commission on Accreditation for Marriage and Family Therapy Education is recognized by the Council on Higher Education Accreditation (CHEA) and is a member of the Association of Specialized and Professional Accreditors (ASPA). COAMFTE is a standing committee of the American Association for Marriage and Family Therapy (AAMFT) and as such has autonomous decision-making authority in all accreditation decisions.

Priorities Continuing from COAMFTE Standards Version 12

These following priorities and concerns from Version 12 remain relevant and their contributions continue in Version 12.5:

1. MFTs must have a relational/systemic philosophy and endorse relational/systemic ethics;
2. Programs must have an outcome-based educational framework that allows them to assess competency levels of students prior to and for a time after graduation.
3. Programs must strive for an inclusive and diverse learning environment.
4. Growth of the profession that accommodates the diversity of Marriage and Family Therapy programs within a variety of different educational contexts.
5. Programs have a responsibility to adequately prepare students for licensure under current applicable regulation.

The titles of Marriage and Family Therapy (MFT) and Marriage and Family Therapist originated during the early stages of the profession's development and remain existing legal designations for the profession today. Based on the importance of these terms in the regulatory environment, COAMFTE Standards Version 12.5 continues to use these formal titles. However, COAMFTE recognizes these terms are commonly altered by professionals and programs who self-reference as Couple/Marriage and Family Therapists, Couple and Family Therapists or Relational/Systemic Therapists in order to acknowledge diverse relationship commitments. These efforts align with COAMFTE's commitments to inclusion and diversity.

Priorities Guiding COAMFTE Standards Version 12.5

Priority One: Recognition of Key Influences Affecting the MFT Profession

MFT Relational/Systemic Supervision *– Standards Version 12.5 provides a definition and qualifications for meeting this definition as a program clinical supervisor.*

COAMFTE Developmental Competency Components *– Standards Version 12.5 identifies five COAMFTE Developmental Competency Components:*

- Knowledge of the MFT profession
- Practice of relational/systemic therapy as a qualified behavioral/mental health provider
- Commitment to ethical practice through ethical codes of the MFT profession and pertinent regulatory bodies
- Awareness, knowledge and skill to responsibly serve diverse communities
- Development and application of research to further the knowledge and practice of the MFT profession.

Teletherapy *– Standards Version 12.5 sets parameters for inclusion of entry-level training and experience in teletherapy practice appropriate to the contexts of accredited educational programs and the profession's qualifying graduate degree.*

Priority Two: Advancement in Use of Input- and Outcome-Based Standards

Refinement of Outcome-Based Education constructs that include:

- Outcomes – specific student competencies needed to enter the MFT profession and postgraduate supervised practice.
- Achievement – measures of learning that the program uses to assess the development of outcomes.
- Competency Measurement - evaluation, rubric and feedback data consistently reviewed to improve student readiness and program effectiveness (*closing the loop*).

Within this framework, educational outcomes and their measures are commonly organized in two categories that must be evidenced:

- Student achievement – student learning outcomes accomplished during the student's required plan of study.
- Graduate achievement – postgraduate accomplishments in the graduate's entry into professional practice, including graduation, exam pass rate, and job placement.

At the program level, formative assessment data are typically used to monitor student progress, while summative assessment data is typically used to measure student learning outcomes.

- Formative – addressing learning contexts in which specific competencies are introduced and initially practiced (e.g. early-scheduled courses and pre-practicum experiences).
- Summative – addressing learning contexts in which advanced competency development is expected (e.g. capstone course, integrative projects, and final supervisory evaluations).

Clarification of Eligibility Review as a process completed by programs seeking initial accreditation only, for the following purposes:

- Demonstration of input-based criteria necessary to support successful implementation of COAMFTE's outcome-based education framework.
- Engagement of COAMFTE's accreditation processes and program resources prior to the significant effort of completing a program Self-Study for Initial Accreditation.

Clarification of Process-Focused Standards that define the program's:

- Framework for outcome-based education
- Curricular design and implementation
- Systems for assessment and review of resources, curriculum, and faculty effectiveness
- Collection and utilization of achievement data for program improvement

Priority Three: Support for Accredited Program Success

Standards Version 12.5 includes the following efforts to further implement COAMFTE's long-standing commitment to be responsive to COAMFTE's communities of interest and support accredited programs in implementing their unique missions and giving public recognition of identified and achieved outcomes. The changes are intended to accomplish the following:

- *Reduction of redundancy in key element requirements*
- *Transparency in minimum threshold for substantial compliance*
- *Clarification of terms through glossary revisions*

The Role of Accredited Master's Degree, Doctoral Degree, and Post-Degree Programs

COAMFTE accredits three categories of MFT education: master's degree, doctoral degree, and post-degree programs that meet the standards set by COAMFTE for the profession of marriage and family therapy. Standards guide programs while also creating a context that supports and encourages innovation. Programs are exempt from those standards that would conflict with state, provincial, and national laws.

Each type of MFT educational program aspires to the following:

- Master's degree programs are committed to providing students with:
  - Foundational Practice Component preparation for varying community settings such as mental health agencies, schools, health care, and independent practice.
  - Workplace Competency for graduates across varying populations from a MFT relational/systemic philosophy that is multiculturally-informed and uses relational/systemic ethics.
  - Curriculum Design and Instruction within the master's degree program that satisfies the educational and practice regulatory requirements for entry-level practice in the state, province, or location in which the program and/or student resides.
  - Transparency about differences in state or provincial educational requirements for post program practice. Encouraging students to educate themselves regarding the requirements in the state(s), province(s), or location(s) in which they intend to practice.
  - Preparing students for further education in doctoral degree and post-degree programs.

- Doctoral degree programs are committed to providing students with:
  - Advanced Practical Experience Component and professional competencies to advance the profession in roles such as researchers, educators, program clinical supervisors, policy makers, administrators, clinical innovators, and/or theoreticians.
  - Multiculturally-Informed best practices demonstrated through a MFT relational/systemic philosophy.
  - Contributing to scholarship by encouraging the production of original research and promoting advanced knowledge beyond that covered within master's degree programs.

- Post-degree programs are committed to providing:
  - Completion of the Foundational Practice Component to ensure graduates meet educational and practice regulatory requirements for entry-level practice in the state, province, or location in which the program resides or in which students intend to practice.
  - Advanced Clinical Practice/Innovation for MFTs with a mental health degree other than a Marriage and Family Therapy degree.
  - Competency in a Specialized Area of Advanced Practice to practice with varying populations from a MFT relational/systemic philosophy that is multiculturally-informed, uses relational/systemic ethics, and protocols and perspectives valuable to multiple communities of interest.

Orientation to the Structure and Use of the Standards Document

Thank you for your involvement in the COAMFTE accreditation community. This brief orientation describes how to navigate the document's four components and the Self-Study process. COAMFTE staff are always available to assist with specific questions related to accreditation and the accreditation process. Further explanation and clarification are provided for each key element within its' associated interpretation guide section including a rubric that is embedded within the Standards document.

Accreditation systems needed for reliable educational outcomes and quality typically have threads that touch multiple components and key elements across standards. Treating any single requirement in isolation is both inefficient and ineffective for achieving the program benefits supported through accredited education. From time to time, the Commission offers resources and trainings to assist program leaders in becoming more familiar with these connections. However, the essential beginning point for developing this knowledge and accreditation competency is simply reading the full document with curiosity and interest.

Component One: Introduction to COAMFTE Standards Version 12.5
The introduction to Standards Version 12.5 begins with a discussion of the role of accreditation in higher education and COAMFTE communities of interest. The introduction also identifies the priorities continuing from Version 12 and an accounting of issues/contexts instrumental in shaping Version 12.5.

Component Two: Eligibility for Accreditation
Eligibility criteria are input-based expectations that ensure the foundational aspects of accreditation are in place. Programs applying for *initial accreditation* must meet all Eligibility Criteria before proceeding further in the accreditation process and demonstrating compliance with Standards I through IV. After Eligibility Criteria materials have been submitted and reviewed, programs seeking initial accreditation must be invited by the Commission to submit their Self-Study. Programs seeking *renewal of accreditation* are no longer required to undergo Eligibility Review due to having completed at least one full accreditation process and continuing to demonstrate Maintenance of Accreditation on an annual basis.

Component Three: Accreditation Standards
Accreditation Standards present the essential systems and elements necessary for assuring program quality and reliability to COAMFTE communities of interest. Standards Version 12.5 articulates the current expectations regarding the competencies and preparation required of entry-level MFT professionals. The four standards are outlined below. In addition, there are 19 corresponding key elements across the standards that provide more specificity on the focus for each standard. Each key element is presented with additional direction in the Commission's Interpretation Guide, which is embedded within the standards document, and in the Tables for Response, that are located on the COAMFTE website on the forms page.

- *Standard I: Outcome-Based Education Framework and Environmental Support.* This standard focuses on the description of the program's outcome-based education framework and the program's environmental supports, as well as assessment plans for both areas.

- *Standard II: Program Leadership, Program Faculty, and Program Clinical Supervisors.* This standard focuses on the demonstration of the program's evaluation of program leadership, faculty, and supervisor qualifications and effectiveness.
- *Standard III: Curriculum.* This standard focuses on the description of how the program's curriculum trains students to accomplish COAMFTE developmental competency components and the program's student learning outcomes.
- *Standard IV: Program Achievement and Improvement.* This standard focuses on the analysis and discussion of the program's assessment data according to the plan indicated in Standard I.

Accreditation Standards serve as the heart of the COAMFTE accredited program's commitment to ongoing self-review for improvement and accountability.

Component Four: Maintenance of Accreditation

Once a program implements COAMFTE Standards and meets all compliance thresholds, the program is awarded COAMFTE accreditation for a specific number of years. During this term,the program is responsible for maintaining ongoing compliance with all key elements as approved in the accreditation review process. Additionally, COAMFTE identifies a limited number of specific compliance concerns that programs must continue to address annually, called Maintenance Criteria. COAMFTE Standards Version 12.5 addresses the following three Maintenance Criteria:

- Maintenance Criterion A: Ongoing Fiscal Viability
- Maintenance Criterion B: Ongoing Evidence of Graduate Achievements
- Maintenance Criterion C: Substantive Changes

Component Five: Glossary

Throughout the COAMFTE Standards Version 12.5 document, glossary terms appear as **boldface.** In some cases, glossary definitions provide expanded details describing limitations,qualifications, or parameters. Such information serves to both clarify minimum thresholds of compliance and guide program innovation. Hover the mouse over the boldface glossary terms to view the glossary definition. Also, clicking on the boldface glossary term links directly to the glossary.

Eligibility for Accreditation Process

Initial COAMFTE accreditation is a process that occurs once a program has implemented a program design consistent with all elements of COAMFTE Accreditation Standards Version 12.5. Eligibility review is the first step of this process allowing a program to demonstrate that specific foundational components are in place before providing a response to Standards I-IV in the program's Self-Study. Several eligibility criteria directly support specific program standards while others are more connected to institutional concerns. Of particular importance is Eligibility Criterion A that serves as the program's first submission of the **outcome-based education** framework fully evaluated later under Key Element I-A. Programs are expected to have carefully studied Standards I-IV and their **key elements** before beginning eligibility review.

Eligibility Criteria

Programs seeking initial accreditation provide evidence of each of the following prerequisites in order to be eligible for accreditation.

Eligibility Criterion A: Outcome-Based Framework with Systemic Focus

The program has an overall outcome-based education framework that includes the following:

- Specific program **goals** with measurable **student learning outcomes** that are clearly derived from the program's **mission** and that promote the development of Marriage and Family Therapists.
- Alignment of the program's mission, goals, student learning outcomes and published materials with **COAMFTE Developmental Competency Components**. (See glossary)

INTERPRETATION GUIDE

Rubric for Response

- Completed Table for Eligibility Criterion A to map the program's mission, goals, and student learning outcomes to COAMFTE Developmental Competency Components.
- In addition to other program specific goals and student learning outcomes, the COAMFTE Developmental Competency Components must be addressed by either the program goals or student learning outcomes.
- Student learning outcomes (SLOs) should only be used for one program goal, although programs can have multiple SLOs to support the same program goal.
- Provide the required links to program materials.

Required Evidence/Documents:

- Completed Table for Eligibility Criterion A: Outcome-Based Education Framework with Systemic Focus.
- Specific links, or page numbers when relevant, to program materials.

See Table for Eligibility Criterion A: Outcome-Based Education Framework with Systemic Focus

Eligibility Criterion B: Institutional Accreditation and Oversight

Master's degree programs and **doctoral degree programs** reside in educational institutions that have legal authority to confer higher education degrees (i.e., regional/national institutional accreditation, **Association of Universities and Colleges of Canada** [AUCC] approval, other[1]).
Post-degree programs are chartered or otherwise state authorized to offer educational certificate programs and have a governance board that ensures the integrity of the program.

INTERPRETATION GUIDE

Required Evidence/Documents:

- Completed Table for Eligibility Criterion B: Institutional Accreditation and Oversight.
- Verification of institutional accreditation for master's and doctoral degree programs.
- Charter or state license for degree or certificate authority (post-degree programs only).
- Documentation of governance board (post-degree programs only).

See Table for Eligibility Criterion B: Institutional Accreditation and Oversight

Eligibility Criterion C: Financial Viability

The program must be financially viable to enable the program to support the achievement of its' program goals and student learning outcomes.

INTERPRETATION GUIDE

Required Evidence/Documents:

- Completed Table for Eligibility Criterion C: Financial Viability.
- Statement of Support from institutional administrator: The letter must be signed, dated, on institutional letterhead, AND from an administrator who has oversight of the program and does not serve as the program director.

See Table for Eligibility Criterion C: Financial Viability

Eligibility Criterion D: Diversity and Inclusivity Policies

COAMFTE acknowledges the importance of programs recognizing human dignity and defines **diversity** as being inclusive of race, age, gender, ethnicity, sexual orientation, relationship status, gender identity, socioeconomic status, disability, health status, religious or spiritual belief, religious or spiritual affiliation and national origin.

- The program strives for a diverse student body and faculty including instructors, supervisors, other relevant educators and professional staff.
- The program documents its diversity and **inclusion** policies.

[1] For non-U.S. institutions in countries in which legal authority to award degrees is not available, the program meets this requirement if it demonstrates that its institution has standing and significant support in the local community or other communities of interest, e.g., well-known professional organizations and other respected entities that support the institution.

- The program publishes material regarding the diversity composition of its' students, faculty, and supervisors, unless doing so would be prohibited by law.
- The program does not discriminate on the basis of race, age, gender, ethnicity, sexual orientation, relationship status, gender identity, socioeconomic status, disability, health status, religious or spiritual belief, religious or spiritual affiliation or national origin in any of its activities or policies relating to students, faculty, including instructors, supervisors, other relevant educators and professional staff.

Programs with a religious mission, purpose or affiliation with policies that are directly related to their religious mission, purpose or affiliation that are in conflict with the aforementioned COAMFTE diversity definition, must have published policies that are accessible, publicly available and disclosed to all individuals seeking to have an affiliation with the program.

In all instances, the program must comply with applicable state, provincial and federal nondiscrimination laws and regulations.

INTERPRETATION GUIDE

Rubric for Response

- Provide web links and/or handbook/catalog page numbers for diversity/inclusion/anti-discrimination policies.
- Provide a published link accessible to the public, with information about the diversity composition of the student body, program faculty, and program clinical supervisors.

Required Evidence/Documents:

- Complete Table for Eligibility Criterion D: Diversity and Inclusivity Policies.
- Web links and/or handbook/catalog page numbers for published materials related to diversity, inclusion and non-discrimination policies.
- A web link to the program's demographic composition information.

See Table for Eligibility Criterion D: Diversity and Inclusivity Policies

Eligibility Criterion E: Accuracy and Program Transparency in Policies and Publications

Published and/or promotional materials accurately describe the program to students and the public. The program has accessible published policies that are readily available to applicants, students, faculty, and the public.

- Published materials include but are not limited to:
  - Descriptions of the program's guidelines, mission, goals**,** and student learning outcomes
  - **Graduate achievement** data
  - Academic calendar
  - Tuition and fees
  - Degree completion requirements
  - Degree completion timeframes including percentage of students graduating within advertised timelines

- Accessible published policies include but are not limited to policies concerning:
  - Student **complaints and grievances**
  - Grading and assessment
  - Remediation and dismissal
  - Student technology requirements
  - Authenticity of student work
  - Informed acknowledgement of potential differences in MFT licensure requirements across state/provincial regulatory bodies

The program provides evidence that *before* students begin their program of study, students acknowledge in writing they have been informed and are aware that licensing regulations may differ across states and provinces.

INTERPRETATION GUIDE

Rubric for Response

- Complete Table for the Eligibility Criterion E with location of policies and information described in publications.
- Provide web links and/or handbook/catalog page numbers for:
  - Program mission
  - Program goals
  - Student learning outcomes
  - Graduate Achievement Data Table
  - Academic calendar
  - Tuition and fees
  - Degree completion requirements
  - Degree completion timelines
- Policies on:
  - Complaints and grievances
  - Grading and assessment
  - Remediation and dismissal
  - Student technology requirements
  - Authenticity of student work
  - Informed acknowledgement of potential differences in MFT licensure requirements across state/provincial regulatory bodies
- Provide evidence that before a student begins the program of study, that the student acknowledges, in writing, that they were provided information that licensing regulations may differ across states and provinces.

Required Evidence/Documents:

- Complete Table for Eligibility Criterion E: Accuracy and Program Transparency in Policies and Publications by providing links and/or page numbers to program policies and publications.
- Provide the student acknowledgment policy and form demonstrating students received information about portability of the degree.

See Table for Eligibility Criterion E: Accuracy and Program Transparency in Policies and Publications

Eligibility Criterion F: Graduate Achievement or Student Program Status Data

Master's degree programs or post-degree programs applying for initial accreditation must have graduate data for the program for which they are seeking accreditation.

Doctoral degree programs applying for initial accreditation must have achievement data for students who have completed the **advanced curriculum** and one of the **advanced practical experience components**. Doctoral programs may apply for initial accreditation prior to having a graduate as long as all of the following conditions have been met:

- Students have completed the advanced curriculum.
- Students have completed one of the two areas of the required advanced practical experience component.
- Students are in the process of satisfying the second required area of advanced practical experience.

INTERPRETATION GUIDE

Rubric for Response

- Master's degree and post-degree programs must provide a list of graduates from the most recent graduating cohort.
- Doctoral degree programs must provide a list of students in the program who have completed required curriculum and experience components.
- Programs must identify current students and present graduate achievement data as appropriate for the degree earned by each individual graduate.

Required Evidence/Documents:

- Completed Table for Eligibility Criterion F: Graduate Achievement or Student Program Status Data.
- Graduate data for each graduate of the master's or post-degree program.
- Current student program status information for each student enrolled in the doctoral program.

See Table for Eligibility Criterion F: Graduate Achievement or Student Program Status Data

Accreditation Standards

Programs must demonstrate compliance key element by key element with each of the Accreditation Standards.

Standard I: Outcome-Based Education Framework and Environmental Support

Programs use an **outcome-based education** philosophy where the focus is on advancing program quality through ongoing assessment of **graduate achievement**, student achievement, and environmental supports. Student achievement is learning and the development of specific competencies measured against program **goals**. Programs assess the effectiveness of key environmental supports for students, including how it successfully maintains an **inclusive and diverse learning environment**, and responsiveness for all learners. **Communities of interest**, identified by the program, provide input into review processes and **student learning outcomes** and are informed about key changes based on the review process.

Please Note: Assessment data for the key elements in Standard I are presented in Standard IV.

Key Element I-A: Outcome-Based Education Framework

The program has an overall outcome-based education framework that includes the following:

- A program **mission** generally consistent with the program's larger institutional setting.
- Specific program goals that implement the program's mission and promote the **COAMFTE Developmental Competency Components**.
- Student learning outcomes (SLOs) that set clearly defined **targets** for measuring specific student **competencies** and achievement of program goals. Note: Please refer to the glossary definition of **assessment measure.**
- Annual collection and publishing of **graduate achievement** required by type of program (masters, doctoral, post-degree).
- Selected **communities of interest** (COI's) who are direct stakeholders in the program's outcomes, effectiveness, and improvement.
- Availability of the program's outcome-based education framework to communities of interest and others selected by the program.

INTERPRETATION GUIDE

Rubric for Response

- Identify program mission consistent with institutional mission.
- State program goals that implement the program mission and promote COAMFTE Developmental Competency Components.
- Identify measurable student learning outcomes and link the SLOs to the appropriate program goal (each SLO should be used for one only program goal).
- Identify assessment measures for each SLO and identify the program targets for each measure (implement glossary definition of assessment measure and target).
- Confirm that Graduate Achievement Data (GAD) are collected and published.
- Identify communities of interest and their relevance to program improvement.

See Table for Key Element I-A: Outcome-Based Education Framework

Key Element I-B: Plan for Assessing Outcome-Based Educational Achievement

The program has an overall **assessment plan** for collecting, reviewing, and acting on the achievement data identified in Key Element I-A for the purpose of program improvement. Data-informed review actions may address improvements to program mission, goals, student learning outcomes measures and **targets**, communities of interest inclusion, and review processes/policies.

The outcome-based education assessment plan includes the following:

- A description of how and by whom assessment data for student learning outcomes and graduate achievement are collected, reviewed, and acted on as needed.
- Mechanisms for assuring that selected communities of interest input are included in the review process.
- An **assessment timeline** that identifies expected completion of assessment review cycles.
- A description of how and by whom the program's outcome-based education framework and its assessment plan are reviewed for improvement actions as needed.

Please note: Graduate achievement data are presented and discussed in Key Element IV-A. Student learning outcome data are presented and discussed in Key Element IV-B.

INTERPRETATION GUIDE

Rubric for Response

- Describe the process and assessment timeline for collecting, aggregating, and preparing each program's student learning outcome and required graduate achievement data for review.
- Describe the process for incorporating identified communities of interest input into review of achievement data (required table) and communication about outcomes.
- Describe how the program reviews and revises the program's outcome-based education framework and assessment plan.

See Table for Key Element I-B: Plan for Assessing Outcome-Based Educational Achievement

Key Element I-C: Plan for Assessing Environmental Supports

Environmental supports are institutional and program resources that contribute to successful student achievement, program quality and an inclusive and diverse learning environment. The program has a plan for maintaining effective environmental supports through a process of review that includes collection of feedback from identified communities of interest, program review, focused corrective action/advocacy where needed, and input to and from institutional leaders.

The plan for reviewing environmental supports includes the following areas:

- How the program promotes an **inclusive and diverse learning environment**.
- How the program follows **published policies** for receiving, reviewing, and responding to **complaints and grievances**, and student concerns.

- How the program monitors other environmental supports including:
  - fiscal and **physical resources**
  - **technological resources**
  - **instructional and clinical resources**
  - **academic resources and student support services**
- How the program complies with institutional policies and procedures concerning the use or technology, including policies on disaster planning and recovery of information, and responses to illegal or inappropriate uses of technology systems and resources.
- How the program ensures the reliability of technology systems, the integrity and security of data, and safeguards student and client information in accordance with applicable regulations and guidelines.

Please note: Results of this review process are reported and discussed in Key Element IV-C.

INTERPRETATION GUIDE

Rubric for Response

- Identify environmental resources and supports in the program.
- Describe the process of assessing, reviewing, and responding to feedback about the program's inclusive and diverse learning environment, to student concerns and for monitoring environmental supports.
- Describe how the program receives, reviews, and responds to formal complaints and grievances and program experiences noted within in the past 5 years.
- Include links for policies that ensure technological resources are secure and confidential, according to state, provincial and federal guidelines.

See Table for Key Element I-C: Plan for Assessing Environmental Supports

Standard II – Program Leadership, Program Faculty, and Program Clinical Supervisors

Program faculty are identified as **core faculty** and **non-core faculty**. Program faculty and **program clinical supervisors** are qualified to provide the education and **MFT relational/systemic supervision** needed for the program to meet its commitments, including those for student learning outcomes and graduate achievement data defined in Standard I. The roles of the **program director,** program faculty, program clinical supervisors and others in program leadership positions are clearly defined and align with the program's goals. The program demonstrates that it monitors and reviews program faculty and program clinical supervisor effectiveness as a means of ensuring that students are able to meet student learning outcomes and the program can meet its goals.

Key Element II-A: Program Leadership Qualifications and Effectiveness

Direction and oversight of the program occurs continuously throughout the year (12 months). Program leadership is qualified, assigned ultimate responsibility for the administration of the program, and meets the following criteria:

- Is a core faculty member who demonstrates **professional identity as a Marriage and Family Therapist.**
- Is responsible for oversight of the outcome-based education framework, assessment activities, curriculum, clinical training program, facilities, services, and the maintenance and enhancement of the program's quality.
- In master's degree programs, has or shares leadership responsibilities for the **foundational curriculum** and **foundational practice component** and is an **AAMFT Approved Supervisor** or **AAMFT Supervisor Candidate** (Supervisor Candidate who assumes this role must become an AAMFT Approved Supervisor within three years.).
- In post-degree programs offering the foundational curriculum or any specialized clinical curriculum, is an AAMFT Approved Supervisor or Supervisor Candidate. (Supervisor Candidate who assumes this role must become an AAMFT Approved Supervisor within three years.).
- In doctoral degree programs offering the advanced curriculum, is an AAMFT Approved Supervisor unless the program has an AAMFT Approved Supervisor or Supervisor Candidate on the core faculty.
- Participates in an established effectiveness review that includes input from communities of interest and as needed, plans to support further leadership development and enhanced effectiveness.

INTERPRETATION GUIDE

Rubric for Response

- Demonstrate that the program leader is a core faculty member who demonstrates professional identity as a Marriage and Family Therapist.
- Describe the role of program leader(s) who are responsible for program administration.
- Describe oversight responsibilities for curriculum, clinical training, facilities, services, and maintenance and enhancement of program's quality.
- Describe the evaluative process and measures used to determine the effectiveness of program leadership.
- Provide aggregated data that demonstrates the effectiveness of program leadership.

See Table for Key Element II-A: Program Leadership Qualifications and Effectiveness

Key Element II-B: Qualifications of Program Faculty and Program Clinical Supervisors

Program faculty and **program clinical supervisors** who contribute to the program's curriculum and application components are qualified to fulfill their specific roles. Qualifications and roles are identified in the context of the program's institution and congruent with the program's goals.

- All program faculty members and program clinical supervisors are academically, professionally, and experientially qualified to fulfill their specific program responsibilities.
- Program faculty and program clinical supervisors have expertise in their area(s) of teaching and/or supervisory responsibility and knowledge of their instructional modality (e.g., distancelearning) or method of **MFT relational/systemic supervision** (e.g., teletherapy, live observation).
- Program clinical supervisor roles are distinguished from instructional faculty roles and consistent with the program's application component.
- All program faculty receive position descriptions describing their responsibilities, required qualifications and institutional and program expectations for scholarship, teaching, research, MFT relational/systemic supervision, practice, and/or service.
- Fifty percent or more of core faculty, including the program leader(s) are qualified to provide MFT relational/systemic supervision as a program clinical supervisor.

INTERPRETATION GUIDE

Rubric for Response

- Credentials and experience that qualify program faculty to train MFT students.
- Program faculty contributions to the MFT Profession.
- Credentials that qualify core faculty to provide MFT relational/systemic supervision.
- Describe how the MFT program core faculty are clearly identified to communities of interest.

See Table for Key Element II-B: Qualifications of Program Faculty and Program Clinical Supervisors

Key Element II-C: Core Faculty and Program Clinical Supervisor Sufficiency

The core faculty and program clinical supervisors must be sufficient to implement the program's outcome-based education framework (Standard I), curriculum instruction, and application component.

- **Core faculty** sufficiency is demonstrated by
  - a core faculty-to-student FTE ratio of 1:15, OR
  - as an alternative, the program may designate and meet a core faculty-to-student FTE ratio that the program demonstrates to be sufficient to support core faculty responsibilities and institutional and program expectations as reported in Key Element II-B. The program must define sufficiency criteria that support the alternative ratio and demonstrate how these criteria are evaluated, reviewed, and revised as needed. Non-core faculty may be included in this alternative ratio if the program demonstrates defined and ongoing non-core faculty contributions that support core faculty areas of responsibility beyond course instruction and/or clinical supervision.
- The program must have a sufficient number of **program clinical supervisors** to support the program's application component in Key Element III-C, as demonstrated by a ratio the program determines to be sufficient to meet program responsibilities and expectations for program clinical supervisors.

INTERPRETATION GUIDE

Rubric for Response

- Identify core faculty-student ratio (according to IPEDS).
- If core faculty-student ratio exceeds 1:15, describe how the program defines program faculty sufficiency and how faculty sufficiency criteria are reviewed and revised.
- Describe how the program uses a supervisor-student ratio as a factor in determining a sufficient number of program clinical supervisors, as well as how these are reviewed and revised.

See Table for Key Element II-C: Core Faculty and Program Clinical Supervisor Sufficiency

Key Element II-D: Program Faculty Evaluation and Effectiveness

Program faculty which includes core faculty and non-core faculty members, meet the expectations of their institutional and program roles. The program reviews program faculty effectiveness and contributions to program quality.

- The program must have an established process for evaluation of the contributions and effectiveness of program faculty as appropriate to each individual faculty member's role.
- The evaluation process must identify who directs the process, the evaluation methods and data used, timeline, and as needed, include a plan to support further development and enhanced effectiveness.
- The program must demonstrate that it completes its program faculty evaluation and effectiveness review process and assures that the results of the evaluation are provided to each program faculty member.

INTERPRETATION GUIDE

Rubric for Response

- Describe the ongoing evaluation process and measures used to determine the effectiveness of faculty contributions to the program.
- Present aggregated data of program faculty effectiveness.

See Table for Key Element II-D: Program Faculty Evaluation and Effectiveness

Key Element II-E: Program Clinical Supervisor Evaluation and Effectiveness

Program clinical supervisors meet the expectations of their program and professional roles. The program reviews clinical supervisor effectiveness and contributions to program quality.

- The program must have a stated process for evaluation of the program clinical supervisor's contribution and effectiveness appropriate to the supervisor's role.
- The evaluation process must identify who directs the process, the evaluation methods and data used, timeline, and as needed, include a plan to support further development and enhanced effectiveness.
- The program must demonstrate that it completes its program clinical supervisor evaluation and effectiveness review process and assures that the results of the evaluation are provided to each program clinical supervisor.

INTERPRETATION GUIDE

Rubric for Response

- Describe the ongoing evaluative process and measures used to determine the effectiveness of program clinical supervisor's contributions to the program (See glossary for MFT relational/systemic supervision definition).
- Present aggregated data of program clinical supervisor effectiveness.

See Table: Key Element II-E: Program Clinical Supervisor Evaluation and Effectiveness

Standard III: Curriculum

All accredited programs will have a curriculum and an **application component** consistent with the program's mission, goals, and student learning outcomes that substantially reflect the **COAMFTE Developmental Competency Components**. The purpose of the foundational curriculum with its accompanying foundational practice component is to prepare students to practice as MFTs. The advanced curriculum with its **advanced practical experience component** and emphasis on research focuses on two areas of specialization. The type of program along with the program's mission, goals, and student learning outcomes determine specific requirements regarding implementation of the curriculum and the application component.

Key Element III-A: Curriculum Alignment and Monitoring

The program must provide descriptions of:

- How the curriculum and practice components support the program attainment of student learning outcomes and aligns with the **COAMFTE Developmental Competency Components**.
- Logical sequencing of the curriculum and practice components.
- Processes and procedures used to monitor and ensure student progress and completion of requirements in the curriculum and practice components.
- **Governance** processes and procedures for designing, approving, implementing, reviewing, and changing the curriculum.

INTERPRETATION GUIDE

Rubric for Response

- Provide a curriculum map that aligns required program courses with COAMFTE Developmental Competency Components and student learning outcomes.
- Explain how the curriculum and the practice component are logically sequenced.
- Describe the processes and procedures the program uses to monitor student progress across the curriculum and practice components.
- Provide documentation that outlines the process and procedure for designing, approving, implementing, reviewing, and changing the curriculum.

See Table for Key Element III-A: Curriculum Alignment and Monitoring

Key Element III-B: Foundational and Advanced Curricula

Foundational Curriculum

The **foundational curriculum areas** (FCAs) below cover the knowledge and skill required to practice as a Marriage and Family Therapist (MFT):

- Master's degree programs must demonstrate they offer course work that covers all the foundational curriculum areas that make up the foundational curriculum.
- Post-degree programs must demonstrate they offer coursework and assess competency in all foundational curriculum areas or that students have previously completed coursework and demonstrate competence in all foundational curriculum areas.
- Programs may combine more than one of these foundational curriculum areas into a single course, as they build their curriculum in ways that are congruent with the program's mission, goals, and student learning outcomes.
- Programs may emphasize some of the areas more than others and include other areas that are consistent with their program's mission, goals and student learning outcomes. Programs may include another layer of requirements based on a specialization or emphasis (e.g., faith-based orientation, licensure laws, specialized certification, and so on) as long as there is a clear rationale and MFT relational/systemic philosophy in the majority of the program.
- Programs must require students to develop and/or present an integrative/capstone experience before completion of their degree program as part of the foundational curriculum below. Programs must decide how to meet this requirement in keeping with the program's mission, goals, and student learning outcomes. Examples include: requiring students to complete a theory of change/therapy theory presentation/paper, a thesis, a therapy portfolio, or a capstone course.

FCA 1: Foundations of Relational/Systemic Practice, Theories & Models (Minimum of 6 semester credits/8 quarter credits/90 clock hours)

This area facilitates the development of competencies in the foundations and critical epistemological issues of MFT. It includes the historical development of the **MFT relational /systemic philosoph**y and contemporary conceptual foundations of MFT, and early and contemporary models of MFT, including evidence-based practice and the biopsychosocial framework.

FCA 2: Clinical Treatment with Individuals, Couples and Families (Minimum of 6 Credits/8 quarter credits/90 clock hours)

This area facilitates the development of competencies in treatment approaches specifically designed for use with a wide range of diverse individuals, couples, and families, including sex therapy, same-sex couples, working with young children, adolescents and elderly, interfaith couples, and includes a focus on evidence-based practice. Programs must include content on crises intervention.

FCA 3: Diverse, Multicultural and/or Underserved Communities (Minimum of 3 Credits/4quarter credits/45 clock hours)

This area facilitates the development of competencies in understanding and applying knowledge of diversity, power, privilege, and oppression as these relate to race, age, gender, ethnicity, sexual orientation, gender identity, socioeconomic status, disability, health status, religious, spiritual and/or beliefs, nation of origin or other relevant social identities throughout the curriculum. It includes practice with diverse, international, multicultural, marginalized, and/or underserved communities, including developing competencies in working with sexual and gender minorities and their families, as well as anti-racist practices.

***FCA 4: Research & Evaluation (Minimum* of 3 Credits/4 quarter credits/45 clock hours)**

This area facilitates the development of competencies in MFT research and evaluation methods, and in evidence-based practice, including becoming an informed consumer of couple, marriage, and family therapy research. If the program's mission, goals, and student learning outcomes include preparing students for doctoral degree programs, the program must include an increased emphasis on research.

FCA 5: Professional Identity, Law, Ethics & Social Responsibility (Minimum of 3 Credits/4 quarter credits/45 clock hours)

This area addresses the development of a MFT identity and socialization and facilitates the development of competencies in ethics in MFT practice, including understanding and applying the AAMFT Code of Ethics and understanding legal responsibilities.

FCA 6: Biopsychosocial Health & Development Across the Life Span (Minimum of 3 Credits/4 quarter credits/45 clock hours)

This area addresses individual and family development, human sexuality, and biopsychosocial health across the lifespan.

FCA 7: Systemic/Relational Assessment & Mental Health Diagnosis and Treatment (Minimum of 3 Credits/4 quarter credits/45 clock hours)

This area facilitates the development of competencies in traditional psycho-diagnostic categories, psychopharmacology, the assessment, diagnosis, and treatment of major mental health issues as well as a wide variety of common presenting problems including addiction, suicide, trauma, abuse, intra-familial violence, and therapy for individuals, couples, and families managing acute chronic medical conditions, utilizing a **MFT relational/systemic philosophy.**

The following areas must be covered in the curriculum in some way, though there are no minimum credit requirements.

FCA 8: Contemporary Issues

This area facilitates the development of competencies in emerging and evolving contemporary challenges, problems, and/or recent developments at the interface of Marriage and Family Therapy knowledge and practice, and the broader local, regional, and global context. This includes such issues as immigration, technology, same-sex marriage, violence in schools, etc. These issues are to reflect the context of the program and the program's mission, goals, and student learning outcomes. Programs are encouraged to innovate in this FCA.

FCA 9: Community Intersections & Collaboration
This area facilitates the development of competencies in practice within defined contexts (e.g., healthcare settings, schools, military settings, private practice) and/or nontraditional MFT professional practice using therapeutic competencies congruent with the program's mission, goals, and student learning outcomes (e.g., community advocacy, psycho-educational groups). It also addresses developing competency in **multidisciplinary collaboration**.

FCA 10: Preparation for Teletherapy Practice
This area facilitates the development of competencies in **teletherapy**. This may include such issues as emerging legal and ethical requirements, documentation, response to crises, awareness of the therapeutic space, joining, appropriate individual and systemic interventions (e.g., couples, play therapy), or other topics of importance to the context of the program and with diverse populations. Programs are encouraged to innovate in this FCA.

Advanced Curriculum
The **advanced curricula areas (ACAs)** advances knowledge and skill by addressing the curricular areas below.

- Doctoral degree programs must describe how students demonstrate competence in the COAMFTE Developmental Competency Components.
- Doctoral degree programs must provide evidence of coursework in all the **advanced curricular areas** (ACA). Programs may emphasize some of the ACAs, more than others, and include other areas that are consistent with the program's mission, goals, and student learning outcomes.
- Post-degree programs may offer components of the **advanced curriculum**.
- Programs may emphasize some of the areas more than others and include other areas that are consistent with their program's mission, goals, and student learning outcomes.

ACA 1*: *Advanced Research
This area facilitates the development of competencies in:

a) **advanced research**, including demonstrated proficiency in quantitative methods and analysis techniques, qualitative methods and analysis techniques, or mixed methods and analysis techniques appropriate to carrying out relational research;
b) methodologies and analysis techniques outside of their proficiency area (e.g., if a student decides to become proficient in quantitative methods, they will have a working knowledge of qualitative methods as well);
c) understanding the theoretical complexity of change within relationships and how this complexity informs research;
d) understanding and demonstrating sensitivity to and awareness of how issues of diversity in terms of culture, gender, sexual orientation, age, socio-economic status, etc. play a role in their choice of research topics and their conduct of research activities; and
e) preparing and disseminating research through a variety of activities (e.g., grants and grant writing, program evaluation, professional publications and presentations).

ACA 2: Advanced Relational/Systemic Clinical Theory

This area facilitates the development of advanced clinical competencies including:

a) advanced understanding and application of multiple family and couple models and empirically-supported interventions;
b) skill in working with diverse populations across the lifespan through direct clinical work or in MFT relational/systemic supervision of the therapy of others;
c) awareness of cultural issues, differences, and personal blind spots in their clinical and supervisory work; and
d) development of a specialized clinical area that is grounded in research and is at an advanced level of intervention and understanding.

ACA 3: Advanced Relational/Systemic Applications to Contemporary Challenges

This area facilitates the development of leading-edge professionals who are competent in relational/systemic innovations. This includes application to controversial moral and advanced ethical dilemmas, international, cross-cultural, and multicultural issues in Marriage and Family Therapy professional roles, responsibilities, practices, and applications to other contemporary problems. This area also includes a focus on family policy and/or family law.

ACA 4: Foundations of Relational/Systemic Teaching, MFT Relational/Systemic Supervision, Consultation, and/or Leadership

This area facilitates the development of competencies in relational/systemic teaching, MFT relational/systemic supervision, and/or MFT consultation. This may include educational/learning theories, relevant research, multicultural content, evaluation and assessment methods, ethics and professional issues, and personal philosophy. This area also addresses administrative competencies including program development and policy, leadership roles and evaluation of MFT educational and service-oriented institutions and agencies. Students who intend to teach at the higher education level will develop and apply a teaching philosophy, as well as demonstrate the capacity to develop and apply course evaluation methods and student learning outcomes. All students will demonstrate skills in clinical MFT relational/systemic supervision. Students who have teaching opportunities in formal or informal settings will demonstrate a sensitivity to issues of diversity in the material they teach, to the persons they are teaching, and in the ways in which information and correction is provided.

INTERPRETATION GUIDE

Rubric for Response

- Identify where and/or how the foundational curriculum areas or advanced curriculum areas are addressed in the curriculum.
- For post-degree programs, demonstrate that course work is offered and/or that students have completed course work in all the areas contained in the foundational curriculum or that students demonstrate competence in those areas.
- For doctoral degree programs, describe how students demonstrate competence in the COAMFTE Developmental Competency Components.
- For programs offering the foundational curriculum, provide a description of and rationale for the program's required integrative/capstone experience.

See Tables for Key Element III-B: Foundational and Advanced Curricula

Key Element III-C: Foundational and Advanced Application Components

The program must demonstrate it offers an application component with appropriate placement in the curriculum, duration, focus, and intensity consistent with the program's mission, goals, and student learning outcomes.

Foundational Practice Component

Master's degree programs and post-degree programs that teach the foundational curriculum must offer the **foundational practice component** (practicum and/or internship) with the following requirements:

- **Direct clinical contact hours:** Students must acquire a minimum of 300 direct clinical contact hours with individuals, couples, families, or other systems, at least 100 of which must be **relational hours** that occur over a minimum of twelve months of clinical practice.
  - Programs including **teletherapy** for required direct clinical contact hours must have policies and procedures in place to support student teletherapy practice and its MFT relational/systemic supervision by program clinical supervisors including attention to applicable legal and ethical requirements and current/emerging professional guidelines.
- **MFT relational/systemic supervision:** Students must receive at least 100 hours of MFT relational/systemic supervision from a program clinical supervisor on a regular and consistent basis while seeing clients. When the supervision schedule is interrupted for any reason, the program must have a plan to assure student access to supervisory support. MFT relational/systemic supervision can be **individual MFT relational/systemic supervision** (one supervisor with one or two supervisees) or **group MFT relational/systemic supervision** (one supervisor and eight or fewer students) and must include a minimum of 50 hours of MFT relational/systemic supervision utilizing **observable data**.
- Published procedures and agreements with practice sites: Programs must have formal agreements in place that outline the responsibilities of the institution, practice sites and students, and policy in place for managing any difficulties with sites, program clinical supervisors, or students.

INTERPRETATION GUIDE

Rubric for Response

- For master's degree programs and post-degree programs that teach the foundational curriculum, demonstrate the program's requirements for meeting the foundational practice component (FPC) for direct clinical contact hours.
- Describe how the application component's placement in the curriculum, duration, focus, and intensity is consistent with their program's mission, goals, and student learning outcomes.
- For master's degree programs and post-degree programs that teach the foundational curriculum, demonstrate the program's commitment to MFT relational/systemic-oriented supervision and how the standard's minimum supervisory requirements are accomplished, including a specific description of the use of digital technology, if relevant.
- If any of the direct clinical contact hours are acquired through teletherapy, present any policies and procedures pertaining to legal and ethical requirements and current/emerging professional guidelines.
- If MFT relational/systemic supervision provided by program clinical supervisors is mediated by technology, present any policies and procedures pertaining to legal and ethical requirements and current/emerging professional guidelines.

- Provide examples of the program's agreements with practice sites that outline the responsibilities of the institution, practice sites and students, and policy in place for managing any difficulties with sites, program clinical supervisors, or students.

See Table for Key Element III-C: Foundational Application Component

The Advanced Practical Experience Component

Programs that teach the advanced curriculum must offer the **advanced practical experience component** that includes:

- Selected experiences consistent with the program's mission, goals, and student learning outcomes in any of the following areas: advanced research, grant-writing, teaching, MFT relational/systemic supervision, consultation, advanced clinical theory, clinical practice/innovation, program development, leadership, or policy. In addition, programs may offer experiences in presenting and professional writing.
- Appropriate and adequate **mentoring** of students during the experience.
- For doctoral programs, a minimum of two of the areas noted above can be combined over a minimum of 9 months.
- For post-degree programs, a minimum of one area over a minimum of 6 months is required.

INTERPRETATION GUIDE

Rubric for Response

- For programs that teach the advanced curriculum, map the advanced practice experience component (APEC) areas utilized by the program to the student learning outcomes.
- Provide evidence that students must complete an advanced practice experience that includes:
  - for doctoral programs: at least two required areas for a duration of at least nine months.
  - for post-degree programs: at least one required area for a duration of at least six months.
- For programs that teach the advanced curriculum, demonstrate how students receive mentoring during the APEC.

See Table for Key Element III-C: Advanced Application Component

Key Element III-D: Experience with Diverse, Marginalized, and/or Underserved Communities

The program demonstrates student experience in Marriage and Family Therapy practice with diverse, marginalized, and/or underserved communities. Experiences may include:

- Professional activities (such as therapy, research, MFT relational/systemic supervision, consultation, teaching, etc.) with diverse, marginalized, and/or underserved communities; and/or
- Other types of activities (such as projects, service, interviews, workshops, etc.), as long as the program can demonstrate that the experience is directly related to MFT activities, and students are in interaction with members of these communities.

INTERPRETATION GUIDE

Rubric for Response

- Describe how the program facilitates student experience with diverse, marginalized, and/or underserved communities.

See Table for Key Element III-D: Experience with Diverse, Marginalized, and/or Underserved Communities

Key Element III-E: Program Transparency and Informed Acknowledgement

The program demonstrates that the curriculum aligns with the educational and clinical practice requirements (e.g., coursework, clinical experience, and supervision) that satisfy the regulatory requirements for entry-level practice either in the state/province/location in which the program physically resides or in which the student intends to practice.

Programs must provide prospective and entering students information regarding the MFT profession's licensure and regulatory requirements as follows:

- The program demonstrates use of a policy and process to ensure that all students are informed of the MFT profession's general regulatory structure and that practice/licensure requirements, including qualifying degree requirements, may vary across state/provincial jurisdictions.
- This information, along with resources for contacting state/provincial regulatory bodies, must be provided to students and acknowledged in writing, prior to beginning the program's course of study.
- Programs that include **teletherapy** and/or **virtual supervision** as part of the clinical practice experience must have a policy on how the program ensures that such practices are compliant with relevant federal, state, or provincial **regulatory requirements**.

INTERPRETATION GUIDE

Rubric for Response

- Provide the student acknowledgment policy of regulatory variance.
- Provide program policies of regulatory compliance.
- Describe how students are informed of the regulatory requirements in the state, province or location they plan to practice.
- If applicable, provide policies that ensure teletherapy and/or virtual supervision are practices are compliant with relevant federal, state, or provincial regulatory requirements.

See Table for Key Element III-E: Program Transparency and Informed Acknowledgement

Key Element III-F: Curriculum/Practice Alignment with Communities of Interest

The program demonstrates that it considers the needs and expectations of identified communities of interest in developing and revising its curriculum and application component.

INTERPRETATION GUIDE

Rubric for Response

- Identify communities of interest (COI) relevant to curriculum and practice.
- Describe how the needs and expectations of these COI's are considered in curriculum/practice revision.
- Provide examples of how the review process has led to curriculum/practice improvement.

See Table for Key Element III-F: Curriculum/Practice Alignment with Communities of Interest

Standard IV: Program Achievement and Improvement

Programs report the results of their outcome-based education framework based on their assessment plan activities as detailed in Standard I. Programs present and discuss assessment data and review actions for program improvement as needed in the key elements below. Each key element should demonstrate completion of the assessment process, review decisions, and program action. Finally, the program should demonstrate how results from assessment data and program responses are communicated to relevant communities of interest.

Key Element IV-A: Demonstrated Graduate Achievement and Improvement

The program demonstrates that aggregated data on graduate achievement is collected and reviewed as specified in Key Element I-B. Graduate achievement data and analysis demonstrate that the program is meeting established **benchmarks** or is using the data to make improvements.

INTERPRETATION GUIDE

Rubric for Response

- Identify the areas of graduate achievement, as defined in the glossary of COAMFTE Standards, and selected by the program for data collection.
- Analyze and present aggregated data for graduate achievement collected in Key Element I-B.
- Provide examples to demonstrate how the aggregated data is used to meet graduate achievement and/or for program improvement.

See Table for Key Element IV-A: Demonstrated Graduate Achievement and Improvement

Key Element IV-B: Demonstrated Achievement of Program Goals and Improvement

The program demonstrates that aggregated data on student achievement is collected and reviewed as specified in Key Element I-B. Student learning outcome data and analysis demonstrate that the program is meeting program goals or is using the data to make improvements.

INTERPRETATION GUIDE

Rubric for Response

- Present aggregated data produced by the outcome-based education framework and assessment measures described in Standard I with clear targets for each student learning outcome.
- Provide evidence that data related to SLOs is used to inform program improvements when necessary.
- Describe program improvements implemented as needed, based on results from the review of data from SLOs.

See Table for Key Element IV-B: Demonstrated Achievement of Program Goals and Improvement

Key Element IV-C: Review and Improvement of Environmental Supports

The program demonstrates that aggregated data on environmental supports are collected and reviewed as specified in Key Element I-C. Data and analysis from program review demonstrate that the program is maintaining its environmental supports or making improvements where needed.

INTERPRETATION GUIDE

Rubric for Response

- Present aggregated data collected as specified in Key Element I-C.
- Provide evidence that data related to environmental supports/resources, including technology and teletherapy (if relevant) is used to inform program improvements when necessary.
- Describe program improvements implemented as needed, based on review of the environmental supports/resource data.

See Table for Key Element IV-C: Review and Improvement of Environmental Supports

Key Element IV-D: Communication with Communities of Interest

The program demonstrates that it communicates results of assessment data compiled according to the program's assessment plan (outlined in Standard I) and any resulting program changes to relevant communities of interest.

INTERPRETATION GUIDE

Rubric for Response

- Provide evidence of communications provided to communities of interest regarding changes made to the program or its resources based on assessment data provided in Standard IV.

See Table for Key Element IV-D: Communication with Communities of Interest

Maintenance of Accreditation

All accredited programs must demonstrate ongoing compliance with accreditation standards. A limited number of specific requirements are identified as Maintenance Criteria due to their high public importance. Each maintenance criterion describes a key element requirement that accredited programs must meet to demonstrate ongoing compliance with accreditation on an annual basis.

Maintenance Criteria

Programs must demonstrate ongoing compliance with the following Maintenance of Accreditation Criteria.

Maintenance Criterion A: Ongoing Financial Viability

The program provides evidence annually of **financial viability.**

INTERPRETATION GUIDE

Rubric for Response

- Provide evidence of financial viability. Minimal evidence of financial viability includes a statement from an institutional leader affirming the program's financial viability. The letter must:
- Be dated
- Be on the institution's letterhead
- Contain a signature and title of the institutional administrator with direct oversight of the program's budget (ex. Department Chair, Dean, Provost)
- Indicate that there is support from the institution that resources are in place for the MFT program

Maintenance Criterion B: Ongoing Evidence of Graduate Achievements

The program must report annually on **graduate achievement** collected in Accreditation Standard I, Key Element I-B. Programs must provide reliable, current, accessible, and consistentgraduate achievement information to the public on their website homepage and in published materials and must demonstrate that this is done annually.

INTERPRETATION GUIDE

Rubric for Response

- Provide updated data for Graduate Achievement for each cohort of the program.
- Complete all sections of the Graduate Achievement Data (GAD) Disclosure Table that is required to be published on the program's website, including initial accreditation date, advertised graduation rates, and percentage rates for each track of the program (i.e., part or full time).
- Provide the URL link to the program's landing/homepage which must clearly display the COAMFTE Graduate Achievement Data either on the homepage itself or be "one click away" in a button or link on the homepage that is clearly identifiable that directly leads to the SAC table. The URL link must be a working link.
- Update the data on the COAMFTE Graduated Achievement Data Disclosure Table that is published on the website annually so that the data is consistent with the Graduate Achievement Criteria Data that is reported in the program's Annual Report.

Maintenance Criterion C: Substantive Changes

The program must notify COAMFTE for any **substantive change**.

INTERPRETATION GUIDE

Rubric for Response

- See the COAMFTE Accreditation Manual for list of substantive changes required to be reported prior to implementation.
- Description of proposed change.
- Describe how it complies with applicable accreditation standards.

Glossary

*Glossary definitions will appear in **boldface** to help with clarification in the standards document. Once published, the Glossary is considered to be a component of Standards Version 12.5 and will be altered only through a formal standards revision process.*

Academic Resources and Student Support Services are tools or services available to students that facilitate and support a student's physical safety and ability to successfully achieve the program's educational goals. Examples include but are not limited to: Library, Writing Centers, The Office of Disability, Counseling Services, Academic Advisement, Financial Aid Office, Office of Diversity and International Services, etc.

Advanced Practical Experience Component is the phase of doctoral or post-degree education that includes the application of advanced training in areas relevant to the program's mission, such as advanced research, teaching, MFT relational/systemic supervision, advanced clinical theory building, etc.

Advanced Curriculum refers to a focus in the curriculum on advanced knowledge and skills beyond the foundational curriculum as described in the curricular areas, and includes the content required for MFTs at the doctoral or post-graduate level.

Advanced Research refers to conducting original research as in completing a dissertation or participating in a research study/project with the prescribed programmatic mentorship.

AAMFT Approved Supervisor is an individual who has satisfied all of the academic, clinical requirements, and supervisory training requirements set by the AAMFT to be designated an AAMFT Approved Supervisor.

AAMFT Code of Ethics is the document of professional conduct set forth by the AAMFT.

AAMFT Supervisor Candidate is an individual who has contracted with an AAMFT Approved Supervisor and is working towards meeting the criteria to become an AAMFT Approved Supervisor.

Anti-racism Practices involve racial and self-awareness in one's personal life and professional activities, consciousness and analysis of all program governance, policy and practices, including a professional response that address racism in its many forms, including taking action to oppose racism, and an appreciation of the discrimination that those from non-white and/or minority groups experience as a result of living in a racist society.[2]

Application Component refers to the practical/applied phase required for the foundational and the advanced curriculums. For the foundational curriculum, it is the foundational practice component and for the advanced curriculum, it is the advanced practical experience component.

[2] Consistent with two decades of research highlighting the overall lack of training that students in accredited programs received related to working with racially diverse clients (Hardy & Lazloffy, 1994; Inman, Meza, Brown, & Hargrove, 2004; Lawless, Brooks, & Julye, 2006; McDowell, 2004) the standards include a specific focus on teaching students anti-racism practices. For a review of the most recent research highlighting the lack of training the students receive related to working with racially diverse clients see Schomburg and Prieto (2011).

Assessment Measure, as used to determine student achievement of professional competencies, is an evaluative tool for determining student progress toward and attainment of a specific outcome such as an identified knowledge, skill, or disposition. Assessment measures typically are embedded in assessment mechanisms such as examinations, written or oral presentations, skill-based demonstrations, or direct observation of student functioning. An assessment measure includes identification of the competency being evaluated and descriptions of achievement that describe progress and final outcome. The structure of an assessment measure must make the expected learning clear to the student being assessed, the evaluator completing the assessment, and reviewers making use of the assessment data. Examples include scores on specific examination topics (MFT theories section on Comprehensive Exam), project rubrics (specific rubrics scoring identified competencies in a Capstone project), and behavior-based observational scales (supervision evaluation).

Assessment Plan is the program's stated course of action for systematically measuring all elements of the outcome-based education framework in order to improve student learning. The plan includes operationalized program goals, assessment methods and processes (how data will be gathered and aggregated), expected student learning outcomes with threshold targets for each outcome, specific plans for the use of the data for program improvement, and an Assessment Timeline.

Assessment Timeline details when each component of the Assessment Plan will be administered or implemented, as well as details for when and how aggregated data will be fed back into the program for revision of the Assessment Plan.

Association of Universities and Colleges of Canada (AUCC) is an organization that promotes quality in higher education and university research and participates in the development of public policy to find solutions to economic and social challenges faced in Canada.

Benchmarks refer to a level of achievement determined by a source external to the accredited program such as COAMFTE, which sets specific thresholds expected at specific times. For Example: COAMFTE may set a benchmark that master's programs must demonstrate a XX% pass rate on the MFT licensure exam for each cohort.

COAMFTE Developmental Competency Components refer to the primary areas of professional learning and skill-development central to the effective and ethical practice of a future Marriage and Family Therapy professional including:

- knowledge of the profession;
- practice of therapy;
- human diversity and social structures;
- professional identity, ethics, and law; and
- research and evidence-based practice.

This framework is intended to encompass historical, current, and future elements of MFT professional identity and practice, and to organize student learning outcomes expected of a graduate of the COAMFTE Accredited program.

Codes of Conduct are shared statements regarding a commitment to ethical, legal and professional beliefs, values, and behavior that serve as foundational standards for making decisions and taking actions.

Competencies are demonstrated knowledge, skills, or capacities that are the result of learning, training, or experience.

Communities of Interest are stakeholders of the program that may include but are not limited to students, administrators, program core and non-core faculty, program clinical supervisors, consumers, graduates, germane regulatory bodies, and diverse/marginalized/underserved groups within these communities.

Complaints and Grievances refer to formal complaints filed with the program and/or the university through a formal grievance channel. They refer to issues that may violate students' rights. Examples include sexual harassment and discrimination. COAMFTE requires all educational programs to maintain a written record of all formal student complaints and grievances. The documentation should consist of the written complaints or grievances, program action and resolution. Records regarding the resolution of grievances are generally kept on file for a period of time based on the program's and/or university's policy.

Core Faculty Members hold an annual contracted position with the University or organization in which the program resides, AND 50% or more of their assigned role is specific to the MFT program. Along with the **program director**, core faculty members share responsibility for the creation, evaluation, revision, and maintenance of the program's outcome-based education framework, curriculum, policies, and procedures. Core faculty demonstrate professional identity as a marriage and family therapist and contribute to the MFT profession in various ways such as scholarship, research, teaching, MFT relational/systemic supervision, practice, and/or service. The MFT program core faculty are clearly identified to students, communities of interest, and the public. (See also Non-core Faculty Members)

Couples are defined as two partners who request treatment for their intimate and/or family relationships.

Direct Clinical Contact Hours are defined as a therapeutic meeting of a therapist and client (individual, relational, or group) occurring in-person synchronously, either physically in the same location or mediated by technology. Assessments may be counted if they are in-person processes that are more than clerical in nature and focus. Also, therapy services delivered through interactive team modalities may provide direct client contact for specific team members who have in-person interaction with the client/system during the session. Therapy team members who engage the therapeutic process only behind the mirror may not count the experience as direct client contact. Activities such as telephone contact, case planning, observation of therapy, record keeping, trainings, role-playing, travel, administrative activities, consultation with community members or professionals, and/or MFT relational/systemic supervision are not considered direct client contact.

Diverse, Marginalized, and/or Underserved Communities refers to groups from non-majority populations currently discriminated against and underrepresented with regard to their race, age, gender, ethnicity, sexual orientation, gender identity, socioeconomic status, disability, health status, religious and spiritual practices, nation of origin or other social categories, immigration status, and/or language.

Diversity is a program's commitment to: a) include the representation of multiple groups in the student body, program clinical supervisors~~,~~ program core and non-core faculty with regard to race, age, gender, ethnicity, sexual orientation, gender identity, socioeconomic status, disability, health status, religious or spiritual affiliation, nation of origin or other relevant social categories; and b) ensure issues of diversity are central to all aspects of the training environment.

Doctoral Degree Program is an academic unit(s) that administers the education and training of students obtaining a PhD, DMFT, DMin, or PsyD. The program may stand alone within an organizational structure or may consist of more than one branch in different locations.

Families are a social unit of two or more individuals, related by blood or non-blood, characterized by emotional engagement and/or commitment, and self-defined as family.

Financial viability refers to a program's ongoing access to institutional funding necessary to achieve its mission, goals, and outcomes and serve its students.

Foundational Curriculum covers the knowledge and skills required to practice as a MFT. The foundational curriculum is based upon coursework addressing nine specified domains incorporating a systemic/relational foundation.

Foundational Practice Component is the practicum and/or internship phase of the program associated with the foundational curriculum, where students apply what they are learning in clinical practice. The foundational practice component requires a minimum number of therapy hours and a specified ratio of relationally/systemically oriented individual and group clinical, MFT relational/systemic supervision to therapy hours completed.

Goals (Program Goal) describe broad learning outcomes and concepts (what students need to acquire in terms of knowledge and skills) expressed in general terms.

Governance refers to the transparent structures and processes through which decision-making occurs related to specified program functions which involves multiple levels of influence such as institutional, departmental, and programmatic. Program core and non-core faculty and student participation in any specific level of decision-making or any decision-making task should be defined and transparent. Such participation may include roles and processes for identified bodies such as the program's core faculty, student advisory groups, program director, clinical director, or department council. Such participation may also include identified informal processes by which individuals may influence decision- making specific to program, faculty and/or student concerns. Program governance activities may include program resources review, curriculum review, instructional and supervisory effectiveness, student- faculty relationships, or other areas directly affecting the program's achievement of its mission, goals, and student learning outcomes. The primary purpose for clarification of decision-making roles and processes is to support open and transparent access to influence by all persons directly involved in the learning environment.
Examples of Governance: Student Representatives, Faculty Meetings, Advisory Council

Graduate Achievements are statements that articulate the professional accomplishments of a program's graduates, aligned with the program's mission, beginning with completion of the educational program. Accomplishments include indicators such as graduation rates, licensure

examination pass rates, job placement rates, employment in clinical, academic, MFT relational/systemic supervision, training and/or research settings, and licensure as a Marriage and Family Therapist.

Group MFT relational/systemic supervision consists of one supervisor and eight or fewer students. Regardless of the number of program clinical supervisors present, a group cannot exceed eight students to qualify for group relational/systemic supervision. For example, ten students and two program clinical supervisors are not appropriate because the number of students exceeds eight.

Inclusion refers to a commitment by programs to incorporate diverse perspectives with accompanying strategies and structures for acknowledging, respecting, and honoring differences.

Inclusive and Diverse Learning Environment refers to an overall atmosphere within the program (including classroom, MFT relational/systemic supervision, research, clinical, and other relevant settings) that is sensitive to the needs of diverse, marginalized, and or underserved communities and promotes an open, safe, and respectful exchange of diverse views and opinions.

Individual MFT relational/systemic supervision is defined as one supervisor with one or two supervisees.

Input-Based Standards are those prescribed requirements, which an accrediting body develops and sets forth as expected of programs. Input-based standards are prescriptive in nature and address specific structural, administrative, and programmatic aspects that programs must have.

Instructional and Clinical Resources are tools or services, which assist program faculty in successfully teaching the curriculum and practice component. Clinical Resources are tools or services, which assist program faculty or program clinical supervisors in successfully providing all aspects of clinical training. These include but are not limited to a clinic, clientele, technological resources, administrative assistance, and staff. Instructional resources are tools or services that assist program faculty in optimally teaching their courses. These include but are not limited to library assistance, library sources, computer access, teaching assistants and technological resources.

Key Element is a subset of a COAMFTE accreditation standard and an essential feature that defines the minimum requirement of that standard.

Marriage and Family Therapy Education refers to the training of MFTs in a master's degree program, doctoral program, and/or post-degree program.

Master's Degree Program is an academic unit(s) that administers the education and training of students obtaining a master's degree. The program may stand alone within an organizational structure or may consist of more than one branch in different locations.

Mentoring is an academic endeavor of a more experienced core or non-core faculty or advanced student accompanying, supporting and guiding a less experienced student in all areas necessary for program completion, professional development, as well as acculturation into the field of MFT. Mentoring involves a multidimensional and increasingly collaborative relationship between the mentor and the mentee requiring optimal communication and can be a formal or informal process.

MFT Relational/Systemic Philosophy is a framework for how MFTs view the world. This perspective focuses on relationships, including patterns of interaction between individuals that organizes relationship dynamics with an emphasis on what is happening rather than why it is happening. Relational systems comprised of individuals are seen as self-organizing, dynamic entities embedded in contexts of larger systems and function both as subsystems and suprasystems with biopsychosocial influence. Recognizing and respecting the relational field of interconnection and influence serves as the foundation for professional efforts to engage others, make meaning, and participate in change.

MFT Relational/Systemic Supervision is the practice of developing the clinical competencies and professional growth of the student as a supervisee, consistent with the MFT relational/systemic philosophy, ethics, and practices of the marriage and family therapy profession. Supervision is distinguishable from psychotherapy or teaching. MFT Relational/Systemic Supervision may be provided though virtual supervision.

Mission is a description of a program's aims, fundamental purpose, and/or philosophical stance that guides the program's educational goals, objectives, and activities. The audience of the mission includes the program's communities of interest.

Multiculturally-informed refers to an educational approach that: a) represents a commitment to local and global diversity, and prepares students for living in a global world; b) includes an understanding of how larger social processes lead to systemic inequality and disadvantage for diverse and marginalized communities; and c) endorses the ethical responsibility/role of MFTs in addressing and intervening in these systems when working with diverse and marginalized communities. Its commitment to being multiculturally-informed is found throughout all programmatic aspects including its mission, goals, student learning outcomes, curriculum, practice component, and organizational structure.

Multidisciplinary Collaboration occurs when a diverse group of professionals is tasked to work together on a project or in a department and does so with a commitment to co- constructing the outcome.

Non-core Faculty Members either hold: a) a short-term position with the university or organization in which the program resides, with a primary assignment to the MFT program and provide instruction within the MFT program, OR b) a permanent position in the University or organization with a primary assignment in another program but teach specific courses in the MFT curriculum for which they are professionally, educationally and experientially prepared. Non-core faculty members teach courses within the MFT curriculum, or fulfill specific role assigned by the program (e.g., accreditation specialist, field placement coordinator). This designation does not include program clinical supervisors, please see Program Clinical Supervisor definition.

Observable Data includes audio and video recordings, as well as live (behind the mirror, in the room co-therapy, reflecting teams, etc.).

Outcomes are empirical measures of student achievement at the student and program levels. Objectives are the specific skills, values, and attitudes students should exhibit *and* the student/graduate achievement (i.e., graduation, licensure, employment, publications, etc.) that reflect the broader program goals. They are in measurable form, data is collected on them, and

results are used to improve the quality of the program. Measures may include both direct and indirect assessment methods, and measurement of cognitive (what students/graduates to need to know), behavioral (what students/ graduates need to be able to do), affective (what students/graduates need to think or care about) objectives. The program will provide data demonstrating that it has accomplished the overall program mission.

Outcome-Based Education is a framework where the focus is on the assessment of program outcomes (empirical measures of student achievement at the student and program level) rather than on the assessment of inputs (such as coursework and resources available to students). The primary focus of assessment is evaluating a program's goals and outcomes based solely on specific measures of student competency. To ensure excellence in programs, accreditation may include a combination of input and outcome-based standards.

Outcome-Based Standards are those prescribed requirements, which an accrediting body develops and sets forth as expected of programs. Outcome-based standards are expected goals or outcomes, which refer to the attainment of specific required skills or mastery of content by students.

Physical Resources comprise the space needed to operate and implement the program, including administrative and instructional space. Examples of physical space include but are not limited to a training clinic, research labs, smart classrooms, audiovisual equipment, computers, etc.

Post-degree Programs are academic or free-standing training programs designed to provide foundational or advanced training for Couple or Marriage and Family Therapy professionals or for those with a minimum of master level mental health or related degree.

Professional Identity as a Marriage and Family Therapist is demonstrated by publicly displayed and accessible indicators of commitment to the marriage and family therapy profession such as a graduate degree from a COAMFTE accredited program, marriage and family therapist licensure/registration, membership in a relationally-focused professional association dedicated to promoting the marriage and family therapy profession, advanced credentials in a practice area specific to the marriage and family therapy profession, or contributions specific to the marriage and family therapy profession such as leadership, training, or scholarly activities.

Program Director is a core faculty member with the primary responsibilities to provide oversight to the overall operations of the education and practice components in the program.

Program Clinical Supervisors provide MFT relational/systemic supervision within a COAMFTE accredited program. Program Clinical Supervisor qualifications include the following:

a) demonstration of professional identity as a marriage and family therapist, and

b) demonstration of training in MFT relational/systemic supervision by one of the following:

- A graduate course in MFT relational/systemic supervision equivalent to three semester-credit hours
- Postgraduate professional education in MFT relational/systemic supervision of at least 30 clock hours
- A state established MFT supervisor designation that includes relational/systemic supervision training
- Designation as an AAMFT Approved Supervisor or AAMFT Approved Supervisor Candidate

Program Faculty are defined as **core faculty** and **non-core faculty**.

Published Policies are written, accessible documents in print or electronic format, which describe an institution or program requirements and procedures and are readily available to applicants, students, program faculty, program clinical supervisors and other public stakeholders for information and comment.

Regulatory Requirements are the licensing laws of the state, province, or location in which the program resides. For example, contact information for all states that have MFT regulations can be found on the AMFTRB website at https://amftrb.org/ and the Registry for Canadian Marriage and Family Therapy (RMFT) website at https://camft.ca/ .

Relational Hours is a category of direct clinical contact hours in which a clinician delivers therapeutic services with two or more individuals conjointly, who share an ongoing relationship beyond that which occurs in the therapeutic experience itself. Examples include family subsystems, intimate couple subsystems, enduring friendship/community support subsystems, and residential, treatment, or situationally connected subsystems.

- Relational hours also may be counted with relational subsystems that include a person whose only available means to participate in the in-person therapeutic meeting is telephonic or electronic (e.g., incarcerated, deployed or out-of-town subsystem members.)
- Group therapy can be counted as relational hours if those in the group therapy have a relationship outside of (above and beyond) the group itself. Conversely, group therapy sessions of otherwise non-related individuals are not considered as relational hours.

Relational/Systemic Ethics refer to ethics that recognize distinct ethical guidelines and issues that evolve from practicing with more than one individual or having a relational/systemic view of the world.

Relationally-focused Organization is: a) a professional organization such as AAMFT, National Council on Family Relations, American Family Therapy Academy, International Family Therapy Association or subgroups within an organization such as the Division of Family Psychology of the American Psychological Association; b) groups that may form with a relational/systemic underlying approach to treatment of a specific group, community, or issue/diagnoses; or c) a group of relational/systemic MFTs organized for some other related purpose.

Sexual and Gender Minorities is a broad term that includes those who identify as lesbian, gay, bisexual, pansexual, asexual, transgender, transsexual, intersex or intergender, genderqueer, questioning, and/or queer. Work with sexual and gender minorities should involve LGBT Affirmative Practices that encourage a positive and supportive view of lesbian, gay, bisexual, transgender or queer identities and an appreciation of the discrimination that LGBT persons experience as a result of living in a heterosexist society.[3]

[3] Consistent with two decades of research highlighting the overall lack of training that students in accredited programs received related to working with lesbian, gay, bisexual, and transgender clients (Clark & Serovich, 1997; Carlson & McGeorge, 2013; Green, 1996; Long & Serovich, 2003; Rock, Carlson, & McGeorge, 2010), the standards include a specific focus on teaching students skills for working with sexual and gender minorities. For a review of the most recent research highlighting the lack of training students receive related to working with LGBT clients see Rock, Carlson, and McGeorge (2010).

Student Concerns are informal and relate to minor issues that can be solved between individuals such as student/instructor or student/program director and are usually communicated to the program director or program faculty verbally or through informal written communication (i.e., email). Examples may include concerns about course scheduling, timeliness of faculty feedback, etc. Programs do not generally keep formal records of student concerns, although they should have a policy in place for responding to them.

Student Learning Outcomes are statements that clearly articulate what students should be able to achieve, demonstrate, or know, as a result of attending the educational program. Each Student Learning Outcome is competency based, measurable, and aligned with a specific program goal used to implement the program's mission. Programs aggregate data on Student Learning Outcomes at the program level to demonstrate attainment of program goals and to inform program improvements.

Substantive Changes are program changes described in the COAMFTE Accreditation Manual.

Supervisors (See Program Clinical Supervisors)

Targets are levels of achievement determined by the accredited program core faculty that sets a specific threshold of student learning expected at a specific time as assessed by a specific measure in order to demonstrate student learning outcome achievement. Programs may select multiple assessment measures with unique targets for demonstrating student learning outcome achievement.

> Examples: Student Learning Outcome 1 achievement target – 85% of learners will score proficient or distinguished on the final clinical competency evaluation completed by clinical supervisors; Student Learning Outcome 2 – 80% of learners will score 3 or higher on the Cultural Competency rubric completed during the Capstone's Final Case Review project.

Technological Resources are used to deliver instruction to students and/or facilitate and support a program's data analysis and collection processes. The technologies may include a) the internet; b) one-way and two-way transmissions through open broadcast, closed circuit, cable, microwave, broadband lines, fiber optics, satellite, wireless communications devices; c) audio conferencing; d) video cassettes, DVDs, and CD-ROMs, if the cassettes, DVDs, or CD- ROMs are used in a course in conjunction with any of the technologies listed in (a) – (c) or software and learning management systems.

Teletherapy is the process of delivering synchronous therapeutic services using a secure video platform according to relevant state, federal, and provincial regulatory requirements or guidelines. The online therapeutic interaction is consistent with state or provincial regulations for the location in which the clinical student therapist and participant(s) are physically located.

Transparency is a program's effort to openly and overtly disclose the underlying rationale or purpose of an activity, action, policy or procedure in order to be inclusive.

Virtual Supervision is the process of delivering synchronous MFT relational/systemic supervision using a secure video platform. The online supervisory interaction is compliant with relevant state, federal, and provincial regulations for the location in which the clinical student therapist and supervisor are physically located.

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