

# Integrating needs of training Scribe document

***Please note and remind yourself frequently:*** The intent of this document is for it to lead to a public-facing record of your workgroup's activity. By the day of the Summit it will be accessible to anyone at the Summit, and after the Summit it will be turned into a fully public-facing document. This means that although you should take notes however makes sense for you, it will be important to refine the notes to be comprehensible to others.

**Guiding Committee: None before Summit**

**Moderator:** Bob Levenson

**Scribe:** Alytia Levendosky

**Describe intended product of the workgroup:**

**Who is willing to lead on this topic** (future efforts at the Summit and beyond):

## Main Notes Area

First question: What is the % integration of clinical application and research in your program:

Answer: the range was from 10-20% to 70-80% (only 1 program in this high range)

Most programs fell between 30-60%

Second question: What is the % integration of clinical application, research, and DEI?

Answer: the range was from 10-20% to 60-70%

Most programs fell between 20-50%.

Then some programs described their integration/lack of integration:

UWMadison was at the low end of integration of clinical and research. The representative discussed how it was difficult to integrate because most of the clinical science faculty were researchers only and were not licensed. Their program is very research heavy and the faculty are focused on getting RO1 grants and training students to be researchers.

University of Missouri representative described how their program also has, by design, a division between the clinical training faculty and the research faculty. This is somewhat successful, but there is some devaluing of the clinical faculty, which causes problems.

Florida International University representative described how they used to be 100% integration when they started (they are only 13 years old) because all faculty did treatment outcome research. However, now students also want other types of clinical experiences, so they have found other practicum placements for them, so their integration has fallen to about 80%.

Another theme that was discussed was the tension between internal and external practicum placements. Programs do not have control over external placements and so often they do not

follow clinical science model of training, but it is important for students to also have “real world” experiences with more diverse populations and more diverse problems. Some program representatives described how students return from these external placements with new appreciation for the clinical science approach; others expressed concerns about the poor modeling in these placements and that students may forget their clinical science approach. Finally, it was discussed how students should be trained in how to bring their clinical science approach to other agencies/sites where they are doing clinical work.

Another issue discussed was teaching credits for clinical supervision and how at many universities, this is not given credit or not enough credit. Along these lines of inadequate resources to support clinical training, we also discussed funding for internal clinics. Some representatives discussed how faculty are able to practice in the clinic which can bring in funds to the clinic. Others discussed getting grants or contracts to support particular activities in the clinic, but which also generally supports more infrastructure in the clinic.

A major discussion was about assessing the quality of the clinical work done in our internal clinics. We discussed the possibility of all collecting standard measures to then pool across clinics, though barriers to this (such as not agreeing among faculty and programs as to what the standard measures would be) were raised. Several programs described doing standard batteries at their internal clinics and having data available for students to use. Some programs successfully have had graduate students publish papers using data from their clinics (e.g. Emory, Ohio State, Florida State, UCLA). It was suggested that APTC was the best place for a plan to have standard measures given across sites and pooling of data to evaluate the effectiveness of our interventions in our clinics.

Our final discussion was about an ideal prototype or “dream” Clinic would be.

1. Scientifically trained and integrated supervision
2. Routine data collection
3. Increased creativity about our service delivery instead of only once/week individual therapy in physical clinic rooms
  - a. Including intervention in summer camps
  - b. Telehealth

Final thought on this: Clinics as Centers of Clinical Science - to transition our clinics to be flexible for the future, including:

1. Provide consultation
2. Provide clinical services
3. Provide community-engaged prevention and intervention
4. Education for the community about mental health and emotion regulation
5. Focus on the science of behavior change
  - a. Engage other disciplines, such as engineering, to partner to help create technology to support and encourage behavior change - opening up to NSF funding

### **Parking Lot**

*The parking lot is for anything that was noted during the group that does not fit well on the topic. You may wish to refer this information to other groups after your group meets.*

Some other ideas were:

Community engaged partnership as part of assessment or research methods course where faculty member is a consultant to the community organization and the students write a report that is useful to the organization.

A year of practicum training that is D&I focused where students are training the trainers or doing program evaluation.