Association of Directors
of Psychology
Training Clinics
www.adptc.org

Volume 4 Publications 2

June 2002

ADPTC NEWSLETTER

We're working on getting CE credit for adptc meetings!

Inside this issue:

Minutes	2
Profile: *Canada*	4
New Director	6
Annual Meeting	6
Director's Toolbox	7
ADPTC Book	7

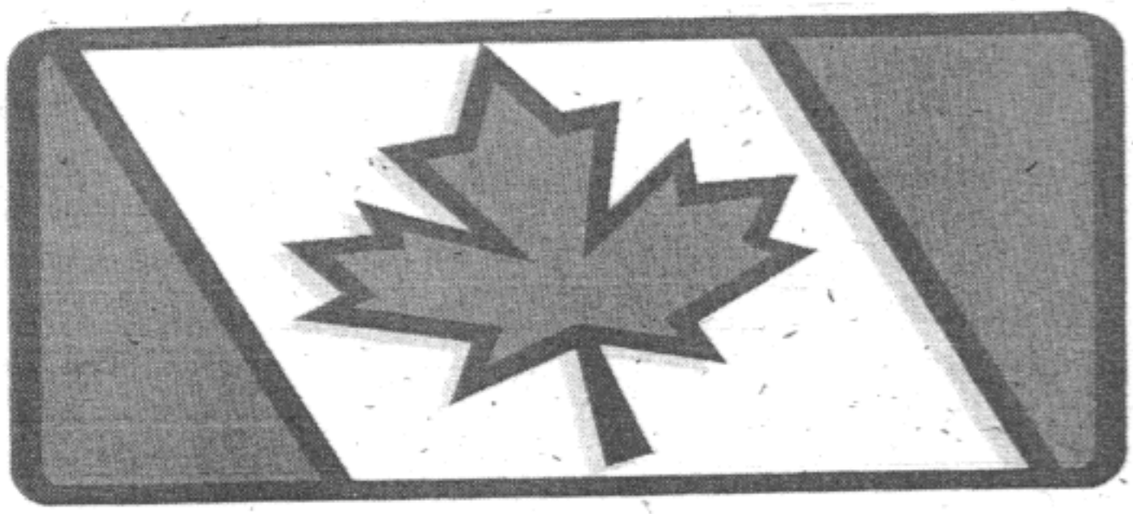
President's Column *Lee Cooper, Ph.D.*

Mid-Year Meeting

We had a very successful Mid-Year meeting in St. Louis. Afterwards, I found myself quite appreciative of all the members of ADPTC who actively contributed to the meeting. These members include the twenty-three enjoyable individuals who attended and participated in the Mid-Year meeting; Phyllis Terry-Friedman who did an awesome job of arranging a wonderful meeting site and Mary Alice Conroy and Holiday Rondeau for putting together an excellent set of presenters. Additionally, I have been impressed and thankful for the good number of folks who consistently respond on the listserv. These types of service activities from such a good percentage of our membership is both exhilarating and rewarding for those of us who have been involved with ADPTC over the past years.

I also found myself excited about the future of ADPTC. We have experienced a re-birth and significant growth. We are now at an opportune time to forge ahead with strengthening the infrastructure, resource availability, and advocacy capability of our organization. At the Mid-Year meeting a strategic plan was developed that included the formation of several new committees and task forces (see Minutes and New Committees sections for more detail). This strategic plan signals our commitment to examine our strengths and weaknesses, seize valuable opportunities, and provide tangible products that benefit all in our profession. If you have any interest, I strongly encourage you to contact a committee/task force chairperson and hopefully experience the professional and personal rewards of actively contributing to our future development.

Lee



Training Clinics in Canada— see p. 4

Minutes of the Mid-year Meeting 2002

BROAD AREA 1:
Organizational Structure

Membership – Bobbie Vollmer
Desired outcome:
Increased membership and accurate records.

Finance - Tony Cellucci
Desired outcome:
Balanced budget

Programming – Co-Chairs Mary Alice Conroy and Holiday Rondeau
Desired outcome: Two annual programs

Listserv – Beth Cohen
Desired outcome:
Coordination with new membership

Task Force on Public Relations – Colleen Bryne
Desired outcome:
Draw up brochure and get ADPTC's name out

BROAD AREA 2
Organizational Resources

Web-site– Karen Downey
Desired outcome:
Website development
Publications

St. Louis, MO
March 15-16, 2002

Attendance

23 ADPTC members attended the mid-winter meeting. A list of the attendees and their university affiliations is attached.

Friday Agenda

President **Lee Cooper** began *the meeting with welcoming remarks and introductions. A plaque was presented to* **Bob Hatcher** *for two years of service as president. This was followed by committee reports.* **Tony Cellucci,** *Secretary/Treasurer, reported that so far this year 102 clinics had paid dues with 12 additional associate members (assistant directors/DCTs). Approximately 15 clinics that paid dues in 2001 have not yet responded and will be dropped from membership if they do not respond to the last inquiry. It was suggested that future mailings be addressed "name of the director or current director" as these clinics may have changed leadership. It was decided to conduct a new membership drive in association with the APA Chicago meeting. Specifically, new members could join and come to the Chicago meeting and get approximately 3 months membership free. A notice recruiting new members will be posted on various listservs. The current budget balance for ADPTC is $11,418.00, although expenses associated with this meeting are not yet included.*

Karen Downey reported on *the resource committee's work. The website has been transferred and a new webmaster (Ryan Sexton) is in place. The committee has been collecting materials and the process of making website changes is underway. It was suggested that the association's* **"Standards and Guidelines for Training Clinics"** *be posted prominently. Also, it would be helpful to have a search mechanism on the website. Clinic directors were asked again to forward materials and links to their university clinics.*

Rob Heffer reported *progress on the survey project. Over the last year, all prior surveys were reviewed and a general template emerged. Committee members each took responsibility for rewriting questions for a portion of the survey and a draft document is under further review. Methods of data collection (e.g., web-based) were discussed as well as the need to streamline the lengthy document and work toward a respectable member return rate.* **Kim Lassiter** *from Ohio University joined the survey committee. The current goal is to finalize the survey plans by APA.*

The rest of the Friday *meeting was devoted to strategic planning for the organization.* **Lee Cooper** *focused the discussion on a) Strengthening the organization, b) Resource development, and c) Relationship to other professional groups. All members present participated. Specifically we brainstormed organizational strengths, weaknesses, opportunities and threats as they related to these topics. Many good ideas emerged which* **Lee Cooper** *and Vice President* **Phyllis Terry Friedman** *summarized for the next day.*

Saturday Agenda

The Saturday program *began with a joint report by* **Lee Cooper, Phyllis Terry Friedman,** *and* **Bob Hatcher.** *Lee attended the Council of Chairs training programs in DC. He stressed the welcome ADPTC was given as a participant and their support of ADPTC contributing significantly to the development of practicum training competencies. Phyllis attended the APA education leadership conference last October. She summarized the overall theme and direction of the conference. She also handed out a summary of Nadine Kaslow's summary from the subgroup addressing "Pre-Internship Supervised Practice".* **Bob Hatcher** *presented his reflections on ADPTC's past and current efforts in this area that dovetailed nicely with the ELC document. He stressed the importance of one's point of view (e.g., training programs vs. internship) and yet to be answered questions.*

Core skill areas in *practicum training as identified by ADPTC include: empathy/alliance, planning and implementing assessment and intervention strategies, case formulation and cogent reporting on cases, use of research literature, contentiousness (i.e. keeping up with case notes, timeliness of evaluations) and ethical behavior, multi-cultural awareness, and self-evaluation and use of supervision.*

It is clear that ADPTC is

Minutes of the Mid-year Meeting 2002

being looked to by CCTC and APA for its expertise and perspective and that a formal consensus on practicum competencies will effect training programs' student evaluations and potentially accreditation standards.

Dr. Michael Ross, DCT at *Saint Louis University, then presented to the conference on* "Creating an Ethical Culture" *in training programs and clinics. He briefly reviewed the philosophical foundations for ethics, and the components of Rest's moral theory. He emphasized Kitchner's normative principles and interestingly related them to issues related to student incompetence and distress/ impairment. His key points include the need to monitor 1) student limits of competence, 2) personal problems, 3) harmful supervision practices. Training programs need to be just in their evaluations of students and remediation efforts should be tied to specific criteria. Of interest, Antioch is experimenting with including assessment of ethical reasoning in their admissions process.*

The next presentation was *on accreditation and preparing for the APA site visit. Both* Bob Heffer *(Texas A & M) and* Holiday Rondeau *(Regent University) described their program's experiences. Rob suggested clinic directors need to be active in preparing the self-study data. He recently added to his informed consent a statement regarding clinic record access for quality assurance review and accreditation visits. Holliday talked about multi-cultural experiences at her site and the issue of expected faculty/ student ratios. She has developed a form for tracking APPIC hours.*

Presentations after lunch dealt *with specialty services within clinics.* Dr. Mary Alice Conroy *(Sam Houston State University) presented on forensic training. She provided background information in this area and argued that all psychologists should be "legally informed". Her presentation highlighted some of the advantages of training clinic involvement in this area and special considerations relating to supervision. Included were some recent legal case citations and her particular perspective on the use of various psychological tests.*

Melinda Henderson *(Wayne State University) provided an overview of the Critical Incident Stress Management (CISM) model including the controversy around debriefing (CISD). In addition to walking through the rationale and components of CISD, she discussed the evaluative literature on both sides of this important current issue.*

After the break, the *conference members reviewed a book prospectus proposed by* Mary Alice Conroy *and* Victor Pantesco. *Ideas for an inclusive title were generated along with suggestions to include a section on the history of ADPTC* (Jean Spruill), *a chapter on training core competencies, and adding several briefer specialty services, such as substance abuse, school consultation, and neuropsychology. The group voted to sponsor the book.*

Lee Cooper *summarized the results of the strategic planning session. As a result, several new committee chairs were appointed, as shown in the side bars of these pages.*

Finally, the mid-winter *meeting ended with time spent on generating ideas for the APA convention program. Several ideas were presented including a panel of various types of clinics addressing common themes, a speaker on HIPPA requirements as they apply to training clinics, and the topic of advocacy training including the availability of legislative fellowships. Another possibility is a speaker addressing clinical outcomes and the use of the OQ and finally the topic of evaluating students. It was emphasized that there should be time for round table discussions. Looking beyond APA, the group discussed sites for next year's mid-winter meeting. Houston was selected for 2003, with Atlanta or New Orleans being considered for 2004.*

Respectfully submitted,

Tony Cellucci, Ph.D.
ADPTC Secretary/ Treasurer

Edited Book – Mary Alice Conroy and Victor Pantesco

Newsletter – PT Friedman

Survey Project – Rob Heffer
Desired outcome:
Completed membership survey

Task Force on New Director Training Program – Eric Sauer
Desired outcome:
Training program for new directors including FAQ and manual

BROAD AREA 3 Organizational Advocacy

Liaison Committee- Lee Cooper and PT Friedman
Desired outcome:
Membership on CCTC, ELC, CoA, Coordinate with practice network

Task Force for Accreditation Standards – Chair Bob Hatcher assisted by Kim Lassiter
Desired outcome:
Develop standards related to practicum competencies

Task Force on Continuing Education – Chair Jean Spruill
Desired outcome:
Acquire APA approval for ADPTC education programs

PROFILES FROM CANADA: Simon Fraser University

Cheryl Bradley and Amy Janeck talk about operating training clinics in British Columbia

What is unique about your clinics?

Amy: University of British Cclumbia is a fully specialized treatment clinic, offering empirically validated therapies for most Axis I disorders. It is one of a very small handful of clinics in the area that offers specialized treatment at free or substantially reduced rates.

Cheryl: The clinic at Simon Fraser University occupies about half the ground floor of a small campus building with big windows overlooking a greenbelt, some distance from the 'hub' of the university. The clinic functions much like a community mental health facility, serving a broad range of clients and presenting problems year-round. The space was designed specifically for our use about ten years ago, and so we have excellent hard-wired recording facilities, several networked computers for student use, a number of observation windows, a small library, and space for case conference meetings and clinical seminars.

Since you probably know more about the US than we do about Canada, in what ways is operating a training clinic in Canada different?

Amy: Working in the context of socialized medicine. Canadian citizens are not accustomed to paying for health care. Psychological and psychiatric services are fully subsidized in hospitals. Thus, there is typically a very long waitlist to obtain the services found in hospitals. Extended health benefits (provided by employers) may not cover psychological services, thus, treatment seekers very often seek help at reduced fee clinics like ours. It is difficult to know whether it is a matter of will or ability, but it appears that for the treatment seekers who phone our clinic, private practitioners are an underused resource.

Cheryl: I agree, and I am not sure if the complications of a more managed care or government-based approach to funding psychological services would be beneficial for a number of the clients we see. At our clinic, and in private practice generally here, one has greater flexibility matching client needs and clinical approach than in many places in the U.S.A. – an important consideration in a non-specialized clinical setting that uses a variety of long and short-term treatment approaches. I would add that from the statistics I've seen, I imagine that the university-based funding at our clinic is greater than at some U.S.A. training clinics, where clinics must often pay for administrative salaries through fees.

What are your biggest challenges?

Amy: Because of the high demand for our services, we are overwhelmed with referrals. Because it is acknowledged that our specialized, reduced rate services are at a premium in the area, we keep a fairly large waitlist of treatment seekers. We do not promise treatment to anyone on the waitlist, but do give other treatment avenues for the person to explore and emphasize that they should follow up on ALL possible opportunities for treatment (especially if they cannot afford a private practitioner). Because we will never meet the service demand, we do try to compromise by pointing treatment seekers in other directions while giving them a chance to be picked up here.

Cheryl: Funding would be high on my list. We are also very busy, and are currently about at the limit of our capacity to develop further the clinic's training and service functions without more resources.

How do you generate income?

Amy: Income is generated by client fees, workshops and Faculty Practice Plan kickbacks. Clients pay a fee ranging from $20- 60 per contact hour and $20 per group session. The clinic is now attempting to sponsor one workshop a year, with profits going to the clinic account. We have also formalized a Faculty Practice Plan, wherein faculty who conduct private practice work in the building are asked to kickback 10% of their earnings to department – this money has been graciously earmarked for the clinic

Cheryl: We have two sources of funding. The university funds clinic administrative salaries, and the psychology department is generous with overflow staff support and equipment purchases. Client fees fund day-to-day office and training costs (including a regular colloquium series and periodic workshops). Our fees are $25/hour for psychotherapy, and $250-$350 for formal assessments, although we do have a sliding scale, and often virtually waive fees for clients unable to afford services.

How long have you been directors?

Amy: One year, non-tenure, full-time.

Cheryl: At SFU we have both a regular, tenure-track faculty director (.25 FTE), and myself as a non-tenure track associate director. The director has overall responsibility for the clinic, and ensures continuity with the clinical program; the associate director is responsible for day to day administration. I have been the associate director for two years now.

and University of British Columbia

What are you looking forward to developing in your program?

Amy: An integrated research programme, group therapies, and workshops to disseminate empirically validated therapies. To date, there has been very little research taking place in the clinic. Given the large supply of treatment seekers, it would be an ideal location for treatment outcome studies or other clinical research. In order to better meet service demands, I also plan to develop ongoing, resource efficient group treatments for some of our main problem types. This will also provide more training opportunities in group work. This was the second year that the clinic organized a workshop for the local psychological community. The response was huge. I'd like to follow up with additional continuing education opportunities for professionals in our area.

Cheryl: I want to expand SFU's services to offer regular psychoeducational groups, particularly for depression and anxiety, which as Amy has pointed out are not widely available in Vancouver. I would like to develop a practicum through the clinic, and eventually, in conjunction with a local hospital, an internship position. I also want to build a regular research program into the clinic's activities. We provide professional development opportunities to our community-based case supervisors; I have a fantasy of developing a regular continuing education series in professional practice for the local psychological community generally, in addition to periodic workshops which we also hold.

How many students are in your program?

Amy: There are 47 clinical students enrolled in the graduate programme. The number of students in the clinic in any given year is dependent on class size. Graduate students complete their first two years of clinical training in the clinic. Class sizes vary between 5–7 students. Thus, we have anywhere from 10–14 first and second year students seeing clients in the clinic. Additionally, advanced students (3rd year and higher) may join clinic teams for additional clinical training.

Cheryl: We have 30-35 pre-internship students at any one time, and an additional 3-5 students away on internship. Students are active in the clinic throughout their pre-internship years. In first year, their role is one of telephone intake worker and clinical back-up at the main reception desk. Active caseload begins in second year, and by third year, all students carry a minimum of two assessment or therapy cases in the clinic. Senior students carry 3- 4 cases.

How many faculty members

Amy: There are 9 clinical faculty members in our programme (excluding me).

Cheryl: We have 9 tenure-track faculty, and 3 limited term, non-tenure track faculty in the clinical program (excluding me).

What types of services do you offer?

Amy: Adults, children and adolescents from the local community and beyond. Cognitive-behavioural therapy and interpersonal therapy (e.g., empirically validated treatments): Addictive and impulse control disorders, Anxiety disorders, Attention Deficit/Hyperactivity Disorder, Behavioural Problems of Childhood (e.g., bedwetting, school refusal), Couples distress, Eating disorders, Interpersonal distress, Mood disorders , ODD, Pain management,. Perfectionism, Psychophysiological disorders, Smoking Cessation, Somatoform disorders

Cheryl: We screen out high risk cases and psychosis, but otherwise we see a broad range of clients. We offer psychodiagnostic, psychoeducational, vocational, and neuropsychological assessments. However, we do more psychotherapy than assessment, serving individual adults, couples, adolescents, children, and families. We are not diagnosis-driven in our intake criteria, and so, in addition to Axis I and some Axis II personality disorders, we see individuals who are working on a variety of sub-diagnostic quality of life and relationship issues. We strive to provide students with exposure to and practice in the main theoretical treatment orientations, especially psychodynamic and cognitive-behavioral. We also offer group therapy from time to time.

Do you conduct research at your clinic?

Amy: I am not currently conducting any research in the clinic, but have 2 grant proposals submitted. Both proposals are treatment outcome studies.

Cheryl: We facilitate graduate student research on topics such as depression and parenting groups. However, we do not have a regular research program at the clinic currently.

Lastly, what is the most rewarding part of your job?

Amy: Training graduate students while providing high quality, specialized services to people in need. It's wonderful to see these two goals work so well together.

Cheryl: I really enjoy working with the students – I am pleased that they consider me a useful resource, not just for specific clinical issues, but as a mentor and guide for becoming a professional psychologist. Watching them develop their skills, confidence, and identity is very rewarding.

"From the first moment I was struck by how genuinely nice this group of people was and I felt warmly welcomed into the group."

Impressions from a Fledgling Clinic Director

Editor's note: Whenever you attend an ADPTC meeting, we put you to work. . .

The 2002 Mid-Year Meeting in St. Louis was my first real exposure to members of ADPTC. I was introduced to ADPTC in July of 2001 when I started my job as Clinic Director at the University of Maryland. The previous director was retiring and told me how helpful his membership had been. This was my first position in an academic setting. I envisioned what I wanted the clinic to be, but mastering the details of the daily functioning sometimes seemed overwhelming. Due to concern about being new and inexperienced, I was hesitant to ask for help. After following the LISTSERV dialogue, I realized that even experienced Clinic Directors were facing the very same challenges. Although still hesitant to become involved, this encouraged me to attend the Mid-Year Meeting. From the first moment I was struck by how genuinely nice this group of people was and I felt warmly welcomed into the group. The job of Clinic Director is so different from other psychology department positions that it can be difficult to find colleagues who have similar experiences from which to draw when listening and giving advice. The other ADPTC members seemed to really understand the issues I was facing as a new director. The wealth of information I gathered at the Mid-Year Meeting will keep me going for a long time. Getting the support of ADPTC early in my career has been an invaluable experience, and keeping this support system as I grow into the position of Clinic Director will help preserve my sanity.

M. Colleen Byrne, Ph.D.
Psychology Clinic Director
University of Maryland
cbyrne@psyc.umd.edu

ADPTC Annual Meeting
Chicago 2002
Workshop August 21
Business Meeting August 24

ADPTC IN CHICAGO

Join Us in the Windy City!

ADPTC will hold our annual Pre Conference Meeting at APA on Wednesday, August 21st from 10 am -4 pm Hilton Chicago Hotel, Private dining Room #2.

Possible topics are HIPPA, advocacy training (including the availability of legislative fellowships), clinical outcomes and evaluating students. As always, there will be time for informal discussion about issues related to running a clinic.

We will also have a business meeting at 12:00 Saturday, August (location to be announced on the listserv). We'll talk about finances, ADPTC projects, such as our book and our liaisons to APA, as well as agenda item for the mid-year meeting in 2003. Houston was selected as the site for 2003.

We'd like to put together an email list of programs that are focused primarily on research. This will be an opportunity to discuss the concerns unique to PTC's in research programs. If interested, contact:

Amy Bertelson, Ph.D.
Director, Psychological Service Center
7 North Jackson Ave.
Washington University
St. Louis, Mo 63105
abertels@artsci.wustl.

DIRECTOR'S TOOLBOX

from Jerry Miller at University of Michigan

The University of Michigan *University Center for the Child and the Family*, now in its 13th year of existence, has had a very busy year. I want to highlight two, of several, new initiatives of the last two years which might be of interest to other directors.

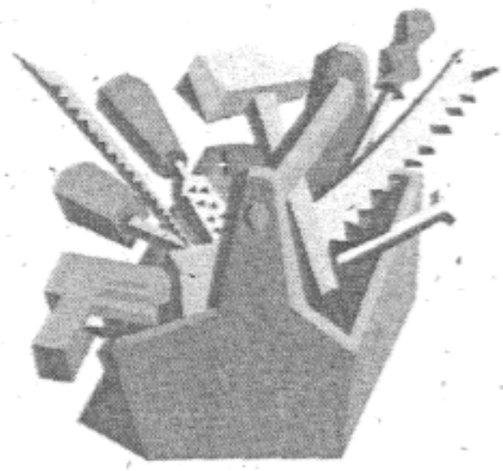
About 18 months ago, a student was working with a teenager whose mother had a mental illness. She thought it would be helpful if the girl could be in a group with other teens in her situation. After a search for such a group, and finding none, she asked if she could try to create one. I told her that if she could design the program, I would work to find funding for it. Largely on her own time, she wrote a six session manualized group. We have now received four small grants to offer the group to teens in area high schools at no cost to participants. Reception of the group has been beyond our expectations.

In a very different vein, we are about to publish our first Alumni Newsletter for the almost 150 students who have completed our program. We have created a colorful newsletter filled with alumni news and Center updates. Importantly, the newsletter was created with an underlying goal of staying in touch with former students who might form the base of an annual giving program. Later this year, we will begin asking alumni for annual contributions to help support our Family Assistance Fund. The latter fund was created about six years ago to help support indigent families who cannot pay our minimum $30 fee. Through the years, it has provided support for almost 100 families. Our hope is that students who have directly seen the benefits of this fund will help to keep it available for others.

Jerry Miller, Ph.D.

University of Michigan Center for the Child and the Family

jmmiller@umich.edu



"We have now received four small grants to offer the group to teens in area high schools at no cost to participants. Reception of the group has been beyond our expectations."

The Chapters of Our Book (in brief)

I. Introduction
A. The history of the PTC & ADPTC {Jean Spruill}
B. Clinic operations {Rob Heffer/Holiday Rondeau}

II. Administration
A. The clinic in the community {Sheila Ribordy}
B. Clinic leadership {Phyllis Terry-Friedman)

III. Risk management
A. Issues of legal liability {Eric Drogan, J. D., Ph.D.}
B. Ethics {Rob Heffer/Lee Cooper}
C. Troubled students {Linda Forest/Nancy Elman}

IV. Training issues
A. Training supervisory skills {Jill Waterman/Karen Downey}
B. Evaluation of core competencies {Bob Hatcher/ Kim Dudley Lassiter}
C. Difficult and high risk clients {Brian Lewis}
D. Empirically Supported Treatments {Ray Hawkins/ Bernadette Walter}

V. Specialty programs
A. Health psychology {Vic Pantesco}
B. Geropsychology {Dan Segal/Sara Qualls}
C. Family services {Kathi Borden}
D. Forensic services {Mary Alice Conroy}
E. Dialectical Behavior Therapy {Ruth Baer}
F. Substance abuse {Tony Cellucci, Peter Vik, Melinda Henderson}

VI. Furthering the scientist-practitioner model
A. The clinic as an engine for basic research George Tremblay}
B. Establishing a practice network {Tom Borkovec}
C. Measuring outcome {Terry Pace/Eric Sauer}

Caption describing picture or graphic.

We're on the Web!
adptc.org

ADPTC

Association of Directors of Psychological Training Clinics
Psychological Services Center
Saint Louis University
Shannon Hall 210
3511 Laclede Avenue
St. Louis, MO 63103

ST. LOUIS JUN 17 02 MO

U.S. POSTAGE 2.34 2 METER 9701197

Dr. Tony Cellucci
Idaho State University
ISU Psychology Clinic
Campus Box 8021
Pocatello ID 83209