

Accountability of CS 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: Ann Kring

Scribe: Emily Ricketts

Describe intended product of the workgroup: How can we change clinical science training and how can we be accountable for these changes?

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

Main Notes Area

Lisa Onken: Need interventions that not only work but are usable in the real-world. From her perspective the lack of integration of basic science in the development of our interventions, has stymied our ability to implement our interventions because if we do not know how or why something is working then we have a harder time trying to simplify it and widdle it down to its essential components.

In order to fix this we can follow the NIH Stage model ; focuses on implementability early on And there is a focus on making sure these interventions can be created and delivered with fidelity in the community.

Howard: Stop requiring internships; allows students to not be bound to worrying about getting into an internship. It will free up student time to work on other important activities (e.g., APPIs).

Helen: Wants to incentivize students to conduct community engagement research to understand more about what diverse populations need. There is not the space and time given to that sort of work.

Ellen University of South Florida: We should incentivize research that solves critical problems rather than mechanism.

For community participatory research a lot of our universities have schools of public health. Collaborations across programs would help us get out into the community and re-think the lens from which we are approaching treatment. She was recently speaking with a researcher and one university calls on a DEI committee to review applications for new hires.

Most mental health services are not delivered by psychologists; they are delivered by PCPs, LCSWs, etc., Obtain 500 applications for graduate school. Can we set up masters programs to train people in what we know or do we need to send our science into the places where patients are being treated. We are not quite translating what is effective.

Daniel Taylor University of Arizona: He just proposed a master's program on cross cultural psychology, but got shot down very quickly, as there are only three states where you can get licensed with a Masters. So this is something that we can push at a policy-level.

it would be helpful to train students to go out into the community to train paraprofessionals who treat patient populations. We should also think about prevention.

Erica (NIH): Following up on Lisa, there was a question about D&I being added to training and she feels it should.

Terese (FSU): Need to change attitudes within our training programs. There is a real discouragement to engage in clinical work after graduate school. We should be encouraging well trained clinical scientists to have careers focused on clinical work

Dan Bagner (FIU): Jumping on prevention, he feels this will be key to make a dent. If we really want to make an impact on a broader school, we need to start early and focus on health promotion.

Stacey: We should be cautious about overstating what works and does not work in terms of treatments. We tend to be arrogant about how we summarize our knowledge. Paraprofessional workforce (e.g., and street teams) are out there doing the work and we can partner with them. It would be helpful in bridging science and community mental health, it would be important to stop assuming that paraprofessionals are not following scientific recommendations. They do to some degree.

Steve Lee (UCLA): If there are a number of activities to incorporate in training, something has to give. Could we cap the number of hours that students are engaged in specific activities to provide a more circumscribed experience that would allow for more time to engage in these suggested activities. He and Darby put together a joint statement to emphasize to practicum sites where students train, all the activities that the UCLA students complete and capping the number of hours that UCLA students could spend on practicum activities.

Bob Levenson: Need more accessible needles; need to know what needles are doing; need dashboards to be able to tell what has gotten better; Example CDC has dashboards. He feels it changes behavior. He feels that if we are going to move the needle, it needs to be something that we watch that shows progress.

Bethany Teachman at University of Virginia: There is a fundamental question that we need to target. What is the sphere and scope that psychological science should be impacting? Can think about a common set of fundamental competencies that we need to establish for folks and then allow for specialization (e.g., clinical practice, clinical science educatory model, clinical science policy). Dashboard focused on clinical competencies, and impact (are people getting services, to what are extent are we seeing use of evidence-based care among paraprofessionals). We need more humility in what we are doing. We are not as far along as we think we are. There needs to be a dramatic change in how we think about partnering with the community.

Indiana: He underscores the need for D&I research. We are the ones that select students so are you going to select the person that cares more about public health or the person doing mechanistic science.

Elephant in room is if we want to move the needle, we need to focus on policy to improve treatment accessibility and train students to do this work.

1) Collect data on cases trainees are treating; 2) for Masters level program, we could create dual training models, but also thinking about not stigmatizing clinical work. We need to think about the real financial incentives for going into private practice. This might mean pushing for higher salaries for trainees.

Edward: Why do we operate differently from professions that have more paraprofessionals who have circumscribed roles. This might provide an "army" of staff who can provide services under a psychologist's license.

She is wondering about how we can improve culturally appropriate assessment; If we do not know what we are treating, this may affect efficacy. We need to promote training assessment. This is an increasingly concerning area of weakness, particularly differential diagnosis with cultural sensitivity

Are goals of psychological clinical science about mental health or mental illness?

Lisa: From NIA; If you do not know the mechanism; She is calling for integrating mechanism of action that will help us administer interventions.

From perspective of Wash U, focused more on research, she thinks spending more time focused on clinical work to engage with the community would be helpful. She has learned more from her practicum training than her research in terms of social determinants of health and barriers to health.

He does not think we should abolish internship, but should we should make it optional. Would it be valuable for every program to have a statement about how the program aims to decrease burden of mental illness.

University of Oregon: Bringing practitioner element down to the lower levels of training. Effort to bring practitioner training to Bachelor's level at her University. Applied practitioner training has historically been for Masters level or higher, but Bachelor's level workforce is a huge untapped resource.

Example from Autism field is providing ABA therapy at undergraduate level, although they are woefully underpaid.

It is hard to partner with community mental health. How do we do this effectively? It is not easy.

Need to bridge clinical and research together. They have journal clubs and read articles and notice that the findings do not apply to the patients they are seeing in clinic. Need to train clinicians how to be researchers.

She wonders what should we train for to make a dent? If we want to move the needle, are we willing to work in a multidisciplinary structure to resolve social problems. Psychologists have a role to play but do not play it. There are bigger problems than mental health.

Retire the 50-minute therapy hour; could need less time for some patients and more time for other patients.

Summary

At the heart of this there are two fundamental points: Have humility about what we know and do not know and the way we approach significant hurdles we are trying to move the needle on.

We need to consider what are goals are for training in psychological science: Reducing burden of mental illness, and promoting mental health, with an emphasis on prevention.

Cannot keep adding to training program activities because students can only do so much. So we could make internship optional, which would provide more time for students who are interested in policy as a specialization, but for those who do want to do clinical work, we should not marginalize that or stigmatize that.

To make a dent, we need a larger workforce. This might include training community mental health professionals (could train students to do this). We could think about creating masters programs or bachelor's programs to allow for a larger workforce. But some things are easier to do with a masters.

We do need to focus on social problems (places to live, having a job) that impede intervention success.

Daniel (Arizona): We can partner with the professional schools who are putting out most of the clinicians to embed more clinical science by teaching courses or offering training.

We can make day-to-day decisions to prioritize efforts that have greater public health potential.

We should consider who we are hiring on to our faculty. Their DEI statement should be one of the first documents we examine.

Measurement: need dashboards to monitor progress with concrete, measurable goals identified.

Need to consider the students we select, and take into account more than research prowess.

Each program should have a statement in their materials about what they are doing to move the needle.

To build on Lorenzo's point, we need to think about changing promotion and tenure practices to push D&I and not focus so much on publications and manuscripts.

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.