# Evaluating CS 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:** Ann Kring
**Scribe:** Loretta Hsueh

**Describe intended product of the workgroup:**

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

**Main Notes Area**

How can we tell whether clinical science training is effective?

- Biggest issue: What is the operational definition of "effective?" Effective for who? Students, faculty, community, policymakers?
- Another perspective on effectiveness: Are our graduates being both scientists and practitioners, in their work?
- How to measure knowledge generation across so many different research areas (in a way that doesn't fall into the trap of counting citations, h-index, etc.)

Recognize diverse and equally important outcomes:

- We need fewer students in academic careers and more students going out to public-serving roles (e.g., practice, training practitioners, program evaluation), basically, students with adequate clinical science skills to go out to the communities and serving them
- So one metric of effectiveness is whether students are engaged as clinical scientists *and* directly serving the community in some way
- Are they doing supervision? Training and dissemination? Are those services getting to communities most at need?
- Need to do a better job of training students in the realms in which clinical science can be practiced– not academic *or* practitioner but a variety of other careers
    - One solution: Having faculty who represent a broader swath of clinical science (not just research, not just practice, but policymakers, community folks, etc.)
- Is the emphasis on hours and internship a disservice to students? More emphasis on *practice of clinical science* in and of itself
- There are so many avenues to effectiveness that it is concerning to try to constrain an effectiveness definition

- Instead, can we recognize the “needs” (e.g., mental health burden) and see how well programs are targeting those needs even if locally
- What about hearing from consumers? What are the most important metrics for them? Students, community members, faculty, patients

Local strategy for measuring effectiveness:

- What about clarifying the goals of each program– why is it that every program has the same set of goals? Is this necessary/effective?
    - *Then*, how do you evaluate those?
- No comprehensive set of targets that we can actually measure– we have lots of different programs with different strategies, can we standardize in order to have mega-dataset?
- Create “profiles” of competencies (e.g., this program is good at CBPR, other program is good at child assessment)
- We should have a stage in common/foundation of what “clinical science” program should be doing at a minimum, *then* programs can specialize
    - E.g., we (this program) target policy, we target assessment
- When we get to specialized goals, what do we need to see in terms of system-level impact? For example, if you say you target policy as a department, how would you measure policy movement? There *has* to be evidence of societal impact but different needles for different goals

Pooling data strategy:

- Can we come together as an Academy to try to track the development of clinical competencies throughout the program?
    - When go to internship, also be tracking competencies in new areas
- Student outcomes are *already* collected for APA accreditation but what if we had an open data/mega data set where we deposit the same data, deidentified?
- But if these data are part of accreditation data (the floor, the safety net) how does this help us push the ceiling? What can we do to elevate where we are?
- There are already points of time when students are evaluated; this could be an opportunity to collaborate with students to figure out, Which direction do you want to do now? How do you create that individualized plan? Students change their mind over time commonly.
- Follow-up data (from PCSAS accreditation) would be helpful to have as an Academy as well
- Generally speaking, programs are collecting what APA is telling you to collect, and in order to collect what programs actually want to collect, would need so many resources
    - However, COA already has a ton of data that they haven’t shared, the dataset likely exists
- Could we link graduate training program data to internship data? They’re not talking to each other
- Correction: The datasets… kind of… exist

    - For example: If PCSAS collects data every 10 years, it's everyone you've trained over 10 years, not people who are 10 years out (messy)-- we need data that match the research question (i.e., following single graduate years and years out)
    - Problem with accredited data: Not a ton of variance… of course we want to pass

<u>Being aware of potential pitfalls:</u>

- If we were to evaluate this in the same way we evaluate anything else in clinical science: How would people respond to the idea that we randomize students to different training models? What is the appetite? Or it could be smaller such as, what if this program does 10 hours vs other program does 20 hours?
    - But what are the ethical issues, protecting students, getting other faculty on board
- Another problem is we don't have a baseline. Each program is convinced we are measuring the things we think are relevant, but there is no cross-talk. If we had a baseline number of variables that we can all agree on, then we can start answering questions.
- Keep in mind the students. Whatever we do needs to minimize the risk to students (the biggest pitfall to "randomizing" students)

<u>How do we do the data coordination?</u>

- Critical questions: Who's funding it? Who's running it?
- What we coordinate is the pitch to NIH, to CHIA, people who are interested in training and education, wherever there is a business case
- What role can our larger professional organizations play in this? APA, APS– well connected organizations who have a business case to do this research
- What if we start small: Agree on small # of metrics, follow longitudinally, spearheaded by one of the larger professional bodies?

<u>Is there another field that does this really well?</u>

- UK program is an example (ask Bethany Teachman exactly what)
- Schools of Education– let them study our programs, all of these students need dissertations after all

**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.*

- How do we get the message across that internships aren't looking for the hours that students think they need?
- Idea: To get away from hours, what about a checklist of "I did 10 assessments" "I did 500 direct intervention hours" and then have that certified by DCT instead of tracking every hour