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Article 35

Revitalizing a Counseling Training Clinic: Meeting Community and Student Needs

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Abstract

Training clinics are integral to comprehensive preparation within counselor education programs. This article will describe counselor education training clinics, review research that guides the development and growth of clinics, and detail experiences to rebuild a clinical mental health counseling presence within two university-supported clinics. Efforts such as interdepartmental collaboration, social justice programming, and practical strategies to revitalize the clinic will be discussed.

Keywords: counselor education training clinics, pastoral counseling, clinical supervision

Many counselor education programs offer clinical training to practicum and internship students via on-campus counseling training clinics (Ametrano & Stickel, 1999; Hittner & Fawcett, 2012; Lauka & McCarthy, 2013; Myers & Smith, 1994). Lauka and McCarthy (2013) described counselor education and supervision training clinics as "a counseling instruction environment that offers clinical and field experiences; provides services to actual clients; parallels, in many ways, typical counseling settings; and may be located on a university campus or in the community" (p. 109). Lauka, McCarthy, and Carter (2014) underscored the value of the training clinic function to bridge the gap between didactical instruction and clinical practice.

The physical layout of a counselor education training clinic is unique to each campus but generally contains a designated waiting room area, several individual

counseling rooms, space for group counseling, office space for faculty and clinical supervisors, a student workroom, and a chart/file room (Granello, 2010; Holden & Kern, 1996). Training clinics utilize multiple technologies such as electronic student skills assessments, electronic client management software, T.V. monitors, digital cameras, computers, and DVDs/CDs (Granello, 2010; Lauka et al., 2014). Supervision methods in training clinics include live supervision, live observation, monitoring, co therapy, walk-ins, phone-ins, and consultation breaks (Young, Lindsey, & Kolodinsky, 2010).

Myers and Smith (1994) provided one of the first comprehensive overviews of the counselor education clinic training model examining research related to psychology training clinics. They described challenges related to identifying the training clinic's purpose, ethical and legal concerns regarding meeting both the training needs of students and providing quality client care, and clinic administrative hurdles such as the role of the clinic director and supervisory responsibilities. The three areas Myers and Smith (1994) mentioned are potential impediments to the success of training clinics. In an effort to determine the status of existing clinics, Myers and Smith (1995) published the results of a national survey of 216 counselor education program on-campus training clinics. Overall, 128 programs reported maintaining a departmentally sponsored, on-campus, counseling training clinic. The majority of these respondents described training as the main purpose of the clinics in either practicum or internship placement. Over half of the respondents reported also utilizing client data for treatment and outcome research. A majority of the training clinic facilities were shared with other interdepartmental disciplines. Approximately one third of the programs funded a clinic director that oversaw clinic operations. Myers and Smith (1995) also found information on the types of services provided, most frequent clinical issues encountered, the number of clients served, recordkeeping procedures, financial information, and types of recruitment and marketing activities utilized. The researchers concluded that training clinic professional standards need to be formally established by the Association of Counselor Education and Supervision (ACES) to ensure that clinics align with the Council for Accreditation of Counseling and Related Education Programs (CACREP) 1994 standards.

Lauka et al. (2014) undertook an updated national survey of counselor education training clinics. Despite a relatively low response rate (11%) with 29 respondents, information gleaned proves valuable to understand the current status of training clinics. Findings noted that significant variability exists in how training clinics operate, the staffing structure, the number and types of clients seen, and community and university relationships. Survey respondents reported the role of the clinic director and funding as the most prominent challenges facing clinic operation and maintenance. The 2014 survey also identified potential areas of training clinic growth to include collaboration and partnerships with community mental health agencies and non-profit organizations. The researchers emphasized the need to further examine the role of the clinic director to better understand how they may be supported in their duties. In addition, they recommended a replication study be undertaken because of the low response rate. Like Myers and Smith (1994, 1995) Lauka et al. (2014) also noted that the 2009 CACREP standards do not require on-site clinics and guidelines for those programs that operate clinics are lacking. Since the 2014 survey, the most recent 2016 CACREP standards also do not require on-site training clinics.

Many counselor education programs continue to support, fund, and oversee such clinics (Mobley & Myers, 2010). In the absence of standards, Myers and Smith (1994, 1995) recommended that ACES develop guidelines specifically addressing training clinic operations; however, no such efforts have been undertaken (Lauka & McCarthy, 2013). Hence, counselor education training clinics continue to operate with myriad standards and purposes. To address the lack of uniformity, Mobley and Myers (2010) issued comprehensive recommendations for counselor education training clinics on eight subject areas: 1) role of the clinic director, 2) training and orientation for the clinic director, 3) research on clinic operation, 4) ACES-sponsored dialogue between faculty and clinic directors, 5) CACREP standards for clinical training revision, 6) the development of uniform policies and procedures for clinic operation, 7) clarification of supervision roles and supervisor qualifications, and 8) dual leadership from clinic directors and counselor education faculty to develop CACREP standards. Lauka and McCarthy (2013) utilized Mobley and Myers' (2010) guidelines to further explore the benefits of standardized counselor education guidelines to promote training efficacy and prevent ethical and legal violations. While the recommended guidelines are critical for the continued expansion and use of training clinics, further examination of the standards are beyond the scope of this article. The next section will focus more specifically on the experience of strengthening an existing counselor education training clinic.

Clinic Development and Growth

Loyola University Maryland, a Jesuit University, opened the Loyola Clinical Centers (LCC), interdisciplinary training clinics, in two campus locations in 2003. In January 2016, Dr. Branco began her role as the clinic director for the Pastoral Counseling (PC) Department. The PC director's duties include overseeing the PC program in the LCC, supervising six to eight student interns in the LCC, collaborating with the other department clinic directors, teaching a two and two course load within the Pastoral Counseling Department, and serving on departmental and university committees. The following section will describe the programmatic and departmental challenges that Dr. Branco encountered during the first year. Descriptions of solutions addressing the identified challenges will also be reviewed. Please see the appendix for a chart detailing the following information.

Challenges and Proposed Solutions

Within the first 3 months, Dr. Branco identified the following challenges: difficulty in recruitment and retention of department interns to serve in the LCC, intern commitment, limited community awareness of the LCC, and the pastoral counseling title. Dr. Branco embarked on a literature review of counselor education training clinics to seek research and anecdotally based strategies for the PC department to develop an active presence in the LCC.

Intern recruitment and retention. In January, five students were registered as LCC PC interns. Within one month, two out of the five students withdrew from their role at the LCC, citing lack of time as a result of already serving at an external internship site. The remaining students had one to two clients each.

Proposed solution. CACREP 2016 standards require students to complete both a 100-hour practicum and 600-hour internship. The PC department requires a 2-year, four-semester, clinical training commitment that combines the practicum and internship hours. Using this knowledge Dr. Branco began procedures to formally develop the clinic as a first-year internship site for PC students. However, this would not be implemented until fall 2016. During the interim spring and summer time frames, Dr. Branco recruited three additional PC interns who needed supplemental clinical hours. Other recruitment efforts included visiting practicum and internship clinical group supervision classes, issuing a PC LCC newsletter, and providing LCC information sessions to students and department faculty.

The number of clinical services provided in the academic year of 2014 through 2015 totaled 64 hours with nine registered clients. The number of clinical services during the 2016 academic year totaled 249 hours with 37 registered clients. The significant increase in clinical services and clients reflected the literature (Lauka & McCarthy, 2013; Mobley & Myers, 2010; Myers & Smith, 1994, 1995), emphasizing the importance of maintaining a designated role for the clinic director to fully focus on student training and client care.

Intern commitment. Prior to the training clinic's conversion to a formal internship site, many PC students used the clinic to supplement their clinical hours or broaden their experience base. Unfortunately, the lack of formal structure presented multiple limitations, including restrictive PC intern availability to meet with clients, occasional poor performance, and overall weak commitment to the program. The PC clinic program in this context was ripe for ethical errors and poor client care (e.g., potential client abandonment, inconsistent client scheduling).

Proposed solution. To address these concerns, Dr. Branco sought approval from her department chair to develop the LCC into a valid internship site for first-year practicum students to achieve their clinical training. Each student would work in the clinic for a total of 10 to 12 hours weekly and be supervised by Dr. Branco, a doctoral graduate student assistant, and a doctoral counselor education and supervision student needing to fulfill supervision internship hours.

When considering programmatic strategies that would meet the student's training needs and correspond with the Jesuit mission of the University, research related to social justice and community efforts was explored. Niegocki et al. (2012) described the joint efforts of a counselor education and counseling psychology class to develop a resource guide within their community clinic. Similarly, the PC LCC interns will work with the Speech Language and Hearing Sciences department to develop ongoing support groups and community resources for caregivers of persons experiencing primary progressive aphasia, a communication disorder resultant of stroke or other brain injuries. In addition, efforts to address disparity in mental health counseling access to marginalized communities (Yznaga, 2010) led to a collaboration with a local, all girls, scholarship-sponsored, Catholic middle school. This collaboration resulted in the development of LCC off-site school-based services, where the interns provide mental health counseling for the students. At the start of the fall semester, the PC LCC internship program had three full-time first-year clinical interns, one doctoral student intern, and five part-time second-year interns. In addition to doubling the PC intern presence in the LCC, this

combination of interns provided for ample clinic coverage to meet clients' scheduling needs and offered a range of intern experience levels.

Limited community awareness. Local community agencies and current students in the PC department had limited awareness of the existence of the LCC on campus. Hence, outreach and marketing strategies needed to be considered for client recruitment and community engagement.

***Proposed solution*.** Hittner and Fawcett (2012) reported on their unsuccessful marketing strategies of in-person meetings offering brochures to community agencies during their first year of developing a counselor education training clinic. Given this information, Dr. Branco elected to work with the university's marketing department to create large postcard advertisements, a much less expensive investment than brochures. The postcards were distributed by the U.S. Postal Service to local mental health, human service, and crisis agencies. However, Dr. Branco did hold in-person meetings with key referral sources to describe the clinic's mission and services. To address awareness within the department, the LCC PC program sponsored a series of doctoral student-led seminars that offered continuing education credits for students and faculty. Future plans include strategic e-mail marketing and revising the LCC Web site to better promote the PC program within the LCC.

Pastoral counseling title. Pastoral counseling is a frequently misunderstood subfield of professional counseling. Misperceptions include popularly held beliefs that pastoral counseling is equivalent to Christian counseling and is performed by clergy such as priests, nuns, and pastors. Pastoral counseling developed from religious and faith backgrounds tending to parishioners' emotional and spiritual needs (Snodgrass, 2015); however, through the decades, pastoral counseling evolved to incorporate psychological training. In 1997, the department sought and achieved CACREP accreditation to offer master's-level clinical mental health counseling and doctoral level counselor education and supervision. Although the department has achieved standardization via CACREP, the pastoral counseling title remained. The specialty clinical training in theological anthropology, spiritual integration, and spiritual development remains a unique and highly sought after aspect of the program.

Despite the specialized clinical focus and CACREP accreditation in clinical mental health counseling, the pastoral counseling title, at times, impacted client recruitment and referrals. Anecdotal reports suggested that clients seeking appointments were deterred by the title and feared evangelizing or proselytizing. On occasion, the front desk administrative staff would refer prospective clients to the psychology department if the client did not specifically indicate a spiritual concern. One potential client asked if a pastoral counseling intern would be willing to work with a client with a diverse sexual orientation. To be certain, the pastoral counseling title often would be the reason clients sought out services to address questions of faith or spirituality, but overall, the title tended to narrow the client referral base.

Proposed solution. Dr. Branco initiated multiple attempts to clarify the role of pastoral counselors. These included attendance at the monthly LCC leadership meetings where accurate information about services was relayed. Dr. Branco spoke to all department interns at the LCC spring and fall Interprofessional Service half-day conference to promote awareness of pastoral counseling services. Perhaps the biggest impact factor was the university's approval of a program name change from pastoral to

clinical mental health counseling to align with CACREP terminology. Once this change was official, all the promotional materials for the PC presence in the LCC were revised to Clinical Mental Health Counseling (CMHC). Potential clients and referral sources are now informed that in addition to traditional professional counseling services, the CMHC interns have unique training in spiritual integration within a counseling relationship; however, this specialty is not imposed but rather may be requested. It remains to be determined if the name change will result in additional client recruitment.

Emerging Concerns and Future Research

While initial challenges to the LCC CMHC clinic growth have been addressed, other limitations that many training clinics encounter will need further examination. These include low client retention and/or early termination rates (Daneker, 2009; Lampropoulos, Schneider, & Spengler, 2009), determining appropriate client fees (Clark & Kimberly, 2014), technology and supervision practices (Jencius, 2010), and clinic promotion of social justice activities (Yznaga, 2010). Future research for the LCC could include analysis of client satisfaction and counseling outcome measures (Miller, 2010), development of a welcome and what to expect in counseling video to promote client retention (Daneker, 2009), implementation of live supervision technology based on best practices (Jencius, 2010), promotion of the growth of off-site clinical services to underserved populations, and exploring community and university partnerships (Bell, Neale-McFall, Alessandria, & Hamilton, 2013). Lauka et al. (2014) suggested future research examine the role and responsibilities of clinic directors. Their 2014 survey results are the most recent to date on the status of counselor education training clinics, yet the response rate was low, with only 29 respondents. The members of the ACES-affiliated Clinic Director and Placement Coordinator Interest Network (CDPCIN) should undertake an updated survey with an enhanced recruitment strategy to aid in the development of uniform training clinic standards.

Summary

Counselor education training clinics are vital components of comprehensive counselor programs. Myers and Smith (1994, 1995) issued exploratory data on the status of clinics within counselor education over 20 years ago. Since then, guidelines and standards have been proposed (Lauka et al., 2014; Mobley & Myers, 2010) but not formalized by CACREP or ACES. This article described how one clinic director within a CACREP-accredited clinical mental health and counselor education and supervision program pursued efforts to revitalize a stagnant program; hence, findings cannot be generalized to other counselor education training clinics. Efforts such as formalizing the clinic as a practicum/internship site assisted with intern recruitment, retention, and quality of counseling. The program's previous title, pastoral counseling, was officially changed to clinical mental health counseling to mirror the department's CACREP accreditation status. While there is speculation that the name change will result in increased referrals, this remains to be determined. Overall, it is recommended that the 2014 counselor education training clinic survey be replicated to aid in developing formalized and uniform standards for counselor education training clinics.

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Appendix

2016 Loyola Clinical Centers: Clinical Mental Health Counseling*

Identified Challenge	**Proposed Solution**	**Proposed Outcomes**
Intern Recruitment & Retention	Interim intern recruitment Intradepartmental outreach	Recruit three interim interns Increase faculty awareness
Intern Commitment	Formalized internship site Interdepartmental collaboration Off-site clinic services	Increase clinical services Provide group counseling and resource information Develop middle school based mental health counseling program
Community Awareness	Postcard marketing In-person meetings with key referral sources CEU Events**	Overall increase in awareness and referrals
Pastoral Counseling Title	IPS*** presentations Interdepartmental leadership participation Name change to clinical mental health counseling	Provide more accurate definition and scope of services to increase referrals
**Formerly Pastoral Counseling* ***Continuing Education Unit* ****Interprofessional Seminar*		