

CLEARvoz Journal

Vol. 1, No. 1, January 2014, pp. 19-34

Establishing Innovative Student Training Clinics for Counselor Educators and Marriage and Family Therapists

Kyle Weir, L. Marinn Pierce, and Chris Lucey

California State University, Fresno

Abstract

Universities have a rich opportunity to make an impact on their communities where poverty and barriers to mental health access exist. A training model is outlined for universities with graduate programs in counselor education and/or marriage and family therapy. Specifically, establishing a university-associated community-based student training clinic to service the mental health needs in impoverished communities helps fulfill the mission of service to the community most universities espouse. The article addresses such aspects as: student training, university support, financial implications, recruitment and retention of minority faculty and students, mentoring, and enhancing faculty scholarship.

Keywords: Student Training Clinics, Counseling, Community Service, Mentoring, Supervision, Equity, Mental Health

Establishing Innovative Student Training Clinics for Counselor Educators and Marriage and Family Therapists

Fresno Family Counseling Center (FFCC) was created to provide low-cost, high quality counseling services to residents of the county and the surrounding areas. In return, the California State University - Fresno's Marriage and Family Therapy Program is able to provide highly structured, intensely supervised training in marriage, family, and child counseling. FFCC advances the university's goal to collaborate with the community with activities beneficial both to the community and the university. Fresno Family Counseling Center provides a full range of counseling services to assist individuals and families in addressing issues related to school, social, marital, and family adjustment. We provide a supportive environment that fosters the discovery of workable solutions to personal and family challenges. Our team approach is brief and highly effective. Fees at Fresno Family Counseling Center are substantially lower than those of other non-profit mental health agencies in the area, making it an invaluable resource for the community without which the majority of families would not be able to obtain services.

Student training clinics, like FFCC, operated by counselor education (CE) or marriage and family therapy (MFT) programs in the United States can serve many useful purposes for universities and their local communities. Such clinics provide valuable pedagogical experiences for the students and professors, benefit the people in the community or region they serve, offer significant recruitment and enrollment benefits for prospective students, and can be a fertile ground for scholarly inquiry and research agendas (Hertlein & Lambert-Shute, 2007; Mittal, 2003; Mobley & Myers, 2011; Myers, 1994; Weir, Lee, Canosa, Rodrigues, McWilliams, & Parker, 2013). As faculty are progressively and incrementally expected to increase their teaching, scholarship, and service productivity by the institutions they serve, university-associated community training clinics can be an extremely beneficial tool to enhance all three of these professorial aspects of their work.

Educational leaders and university administrators of graduate level counselor education and MFT programs will likely find that supporting such student training clinics in the community is a distinctly effective tool in achieving several goals. Such clinics can be utilized to effectively reduce equity discrepancies in mental health needs within the university's local communities, significantly increase the quality of teaching and mentoring students in training in graduate CE/MFT programs, and enhance faculty scholarship through increased opportunities to explore clinical effectiveness and outcome research. These clinics can provide unique capacities to benefit students, faculty, the university, and the community at large.

Literature Review

The use of university-based and university-associated community-based student training clinics for practicum and field placement/internship level students has been explored moderately in other disciplines such as psychology, school psychology, and social work (Funderburk & Fielder, 2013; Keys, 2013; Levinson et al., 2010; Rudd, 2004;

Sells, Smith, & Moon, 1996; Whitehead, 2009), but relatively few studies have been conducted in the related fields of MFT and CE programs' usage of university-based training clinics and university-associated community-based student training clinics (e.g. Chernail, Sommers, & Benjamin, 2009; Clark et al., 2011; Dakin & Wampler, 2008; Strohmer et al., 2003; Tsai & Ray, 2011). Most of the MFT and CE specific studies cited above consisted of efficacy and outcome research. While clinical outcomes are central to the mission of these clinics, this emphasis on clinical effectiveness is only one of many benefits that may be derived from the efforts of such clinics. Largely unexamined are the significant benefits to the students, faculty, and the university, in addition to the significant benefits to the clients served.

Additionally, studies regarding the recruitment of students to clinical programs show that the presence of a university-based training clinic or university-associated community-based student training clinic is a significant factor in the student's selection process of graduate study. Hertlein and Lambert-Shute (2007) researched factors influencing student selection of MFT programs. The six factors they studied were *faculty* (personality, notoriety, faculty research interests, and faculty clinical work), *teaching* (opportunities to teach or be a teaching assistant, class size, and specific classes available to teach), *research* (opportunities for research, mentoring of faculty vs. self-directed research, thesis or dissertation derived from faculty research, and the presence of a wide range of responsibilities on research teams), *clinical work* (presence of a university-based clinic, flexibility in choosing modality, type of clients, amount of supervision, internships, working with a particular program model, and opportunities to facilitate therapy groups), *funding* (being fully funded throughout the program length vs. partially funded, ability to select position for which you are funded, and opportunities for other funding outside the department or program from the larger university), and *personal fit* (location, rigor of program opportunities for social interaction, diversity, flexibility with family duties, similarity of religious philosophy, student culture, and employment opportunities for a partner) (Hertlein & Lambert-Shute, 2007). Students entering master's level programs ranked *clinical work* number *two* out of the six factors pertaining to their program selection and doctoral students ranked it number *four* of the six factors (Hertlein & Lambert-Shute, 2007). Of the "clinical work" factor sub-categories, the presence of a university based clinic ranked number *one* with 44.9% of the responses of master's students indicating this was a significant factor in their decision-making process for selecting a program (Hertlein & Lambert-Shute, 2007). For doctoral students in MFT programs, Hertlein and Lambert-Shute (2007) indicate that students ranked the presence of a university-based clinic as their number *one* priority regarding clinical work (40.9%). Clearly, from Hertlein and Lambert-Shute's study (2007) one can conclude that the presence of a university-based clinic or other similar community-based student training clinic associated with the university can be a substantial recruitment tool that may often be underutilized in the recruitment of graduate students. Students clearly wanted such a clinic experience as part of their graduate level study. Furthermore, Mittal (2003) suggested that such clinical work is a factor in recruiting international students, as well as recruitment of people of color within the United States (Culver, 2012; Hardy & Keller, 1991; Wilson & Stith, 1993), thereby assisting universities and colleges in their commitment to reducing inequities by their efforts to recruit and retain strong students from diverse backgrounds.

Case Example: A Model of Success and Meaning

Fresno Family Counseling Center (FFCC) is a model for establishing a university-associated community-based student training clinic. Established in 1985, the clinic has been serving a community with both urban and rural (specifically agricultural) districts for 28 years in the Central Valley of California. This region has been ranked the absolute lowest in the nation in 2008 on the American Human Development Index by the Social Science Research Council's "Measure of America" (Doyle, 2008; Social Science Research Council [SSRC], 2013). This index combines data on education, health, and income. Since 2008, the region continues to remain among the lowest rankings in the nation indicating a community where significant poverty, disparity, and poor health and educational attainment dominate. In the midst of this inequity, Fresno Family Counseling Center continues to provide crucial mental health services through a combination of self-support and moderate, fiscally-responsible assistance from the university.

History of Fresno Family Counseling Center (FFCC)

Fresno Family Counseling Center was initially established in 1985 by Dr. H. Dan Smith as the Clovis Family Counseling Center, a collaborative effort between Clovis Unified School District (CUSD and California State University, Fresno (CSUF). The school district provided the facilities for the clinic and the students in the Counselor Education program at CSUF provided the therapy sessions as part of their practicum experience while being supervised by the licensed faculty. The university also provided the technical equipment necessary to monitor and supervise sessions in accordance with the professional ethical guidelines. All members of the community were welcome to engage in treatment, however, families who lived in that school district and attended those schools within the district were given priority scheduling and a reduced fee in the already affordable sliding scale fee structure. Thus the collaboration was mutually beneficial to both the university and the local school district and their families.

The decision was made to locate the counseling center out in the community rather than on the university campus. The reasoning for this decision was primarily to reduce barriers of access to mental healthcare services. Like most universities, parking permits are required on campus and community members sometimes feel uncomfortable in an "ivory tower" setting. The commitment to be associated with the university, but located off campus within the community neighborhoods (thereby increasing access to mental health services by the community members), continues to be a guiding principle in the clinic's work to date. The current location was selected based on several factors that include affordability (rent), access to public transportation, and centrality of location in the city to maximize community access to care. It is still within a reasonable driving distance from the university for faculty and students, and parking is open and free. Though the clinic was later affiliated with another school district and renamed Fresno Family Counseling Center. Since 2007 FFCC has been functioning as an independent organization with primarily self-support funding. The clinic continues to be affiliated solely with the university and primarily self-supporting with only modest costs to the university for administrative assistance and technical equipment.

Practicum Process

While it is common for CE programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) to have one semester of practicum and two semester of field placement/internship for their students, this CE

program is unique in its approach. Students complete their practicum coursework over two semesters and intensive supervision is provided to increase therapeutic skill capacity, as well as enhanced personal and professional growth opportunities for the students. The first semester of practicum involves the student learning to structure a clinical session, practice the core conditions and skills of a basic Rogerian counseling model (congruence, empathy, acceptance, unconditional positive regard, reflection, reframing, and non-judgmentalism) (Rogers, 1961). This first semester involves only individual client sessions so that the student-trainees are not overwhelmed by the multiplicity of interactions and issues of couples or family therapy. This initial practicum occurs on-campus and involves providing sessions to students in a discipline-related undergraduate course who receive course credit (and personal growth experience) for participating as clients. All standard ethical practices are followed and appropriate supervision is provided. The practicum faculty to student ratio is 1:6 for a four-unit/credit load course. During these sessions with individual clients, the new student-trainees are provided live supervision from a supervisor behind a one-way mirror. Additionally, the sessions are recorded digitally and a dual channel feedback microphone system is employed so that the supervisor and other students observing behind the mirror can hear the session and record feedback for the trainee directly onto the digital recording (Smith, 1989). This technology allows the trainees to download the session with video and audio of the session with the client, with voiced-over audio from the supervisor and observing peer students. The students use encrypted USB devices to save and later view the sessions after class. This technological usage of digital recording with dual channel feedback systems is a unique hallmark of our training model. It has since been replicated by a small number of other universities, but it remains a cornerstone of our training program. Additionally, students are expected to take a five-minute break halfway through the session and reflect in the privacy of the observation room with the supervisor and reflecting team of peer-trainees on the session at hand. This practice ensures that the trainee receives feedback partway through the session and can make corrections to their approach, seek crucial answers to questions they had not considered, and can seek help when stuck or confused. At all times, the faculty supervisor has the option of knocking on the door and entering the session to address any crises or other issues that may be beyond the scope of competence of the trainee. After the clinical sessions for the day are concluded, the students and the faculty supervisor debrief and discuss the case in a group supervision hour immediately following.

The second level of practicum involves a similar process of digital recording with a dual channel feedback system, live supervision, and post-session group supervision, but the difference in this second semester of practicum is that the student-trainees work off-campus at the university-associated, community-based student training clinic that is operated completely by the faculty and students of the CE program (MFT option). Here trainees use clinical theories and models relevant to family systems approaches (e.g. Structural Family Therapy, Experiential Family Therapy, and Solution-Focused Therapy, among others). These are clinical theories that have demonstrated effectiveness with clients of poverty and color and are easily learned by the students under careful supervision. Fresno Family Counseling Center is the heart and core of the training program. All students serve at least one semester as practicum trainees at the community clinic. In this second practicum semester, students are asked to provide clinical treatment

to a wide variety of families, couples, and individuals, with a myriad of presenting problems. The faculty to student ratio is 1:8, but the course is a six-unit/credit load course.

Equitably Serving the Community

Serving the mental health needs in one of the most impoverished, poorly educated, and underserved communities, particularly in terms of mental health services, in the nation has its challenges. Combined with those difficulties are the compounding challenges of serving a culturally diverse community with significant language barriers to education, economic, and healthcare resources. Universities can become the greatest community asset to overcome these challenges. Because universities attract students from various, diverse cultural groups and also have student training programs that require students to engage in service-learning experiences, practicum courses, and field placement/internships, MFT/CE programs and their student-trainees can provide a diverse, trained, and free or low cost human resource who can work to ameliorate these some of these social issues.

The clinic served 425 sessions in the academic year 2005-2006. In the 2012-2013 academic year, the clinic produced over 9,000 sessions to families in the regional community. As of October 2013, the center is currently treating 327 cases and on-target to exceed 10,000 sessions this year. The current racial composition of the clientele at FFCC is represented in Table 1.

Table 1

Ethnicity of Clients

Ethnicity <i>N</i> = 327	%
Latino/Chicano	50.5
White	41.3
African-American	3.6
Bi-racial	2.1
Other	0.4

As noted in Table 1., FFCC serves a diverse cross-section of the community. The gender composition of the clients is 42.44% male (188 out of 443 persons currently being served) and 57.56% female (255 out of the 443 persons currently being served). In terms of treatment modality, FFCC provided a full-range of counseling services. See Table 2 for a breakdown of treatment modality provided.

Income strata are described in Table 3, which highlights the poverty among clientele seeking services at the center.

Table 2. *Treatment modality N = 327*

	N	%
Individual Child Counseling	25	7.7
Individual Adult Counseling	129	58.7
Couples counseling	65	19.9
Family Counseling	33	10.1
Group Counseling	12	3.6

Table 3. *Income Strata of Clients*

Under \$10,000	26.6
\$10,000 - 19,999	20.8
\$20,000 – 29,999	14.4
\$30,000 - 39,999	8.6
\$40,000 – 49,999	8.9
\$50,000 – 59,999	4.2
\$60,000 - 69,999	2.9
\$70,000 – above	3.9
Unemployed	4.2
Not reported	5.5

When examining the income levels of the families served by FFCC through the perspective of the Federal Poverty Level (FPL), the average family of 4 people would qualify for government funded healthcare services at the 133% mark of the FPL or \$31,322 (Families USA, 2013). Thus the clients who are unemployed or whose combined household income is less than \$30,000 is fully 66% of the clients served at FFCC. ***Two-thirds*** of the clients served are impoverished and would normally qualify for government health insurance but cannot be adequately served by the local mental health care system providers due to budgetary constraints and other barriers to access. Thus FFCC plays a critical role of ensuring that those who would otherwise go un-served or underserved by an overburdened mental health care system actually get competent mental health care through the university-associated, community-based student training clinic. This places the university in a vital position to step into the breach and provide desperately needed mental health services to the community and make a difference in the region. It is a strong example of fulfilling the university’s vision to “improve the quality of life in the region and beyond” (Fresno State, 2013), and is a model that can be replicated by other universities.

Teaching and Mentoring Students

Students at the university often represent the diversity found in the local community. Many students are the first in their family to attend college at any level, let

alone at the graduate level. Graduate students and faculty in the CE program represent the ethnic diversity of the university campus and local community. Recruitment of people of color to the graduate program in the counselor education program currently include:

The CE graduate full-time faculty is comprised of White males (3), White females (2), Latino males (2), Asian females (2), and a Black male (1). Approximately 300 graduate students were enrolled in the CE program during the 2011-2012 academic year and included American Indian (1%), Asian (9%), Biracial (1%), Black (5%), White (30%), and Latino (52%) students. It should be noted that a significant number of counseling students were first generation college students, and most ethnic students were bilingual, fluent in English and their native languages. The ethnic diversity of the CE student body is representative of the community at large; the 2010 US Census data reveals the local community comprised of American Indian and Alaska Native persons (2%), Asians (9%), Biracial/Multiracial persons (2%), Blacks (6%), Whites (35%), and Latinos (49%) (US Census Bureau, 2010). In terms of student gender, the CE program male to female ratio is 1:7.

Such student body composition statistics are reflective of similar matriculation of students over the last decade due to recruitment efforts to enhance diversity within the program. This highly diverse student population presents a unique opportunity for the students, faculty, and clients served by the clinic. Addressing diversity and equity issues at the level of the student population has granted the CE program and clinic a rich resource for providing mental health treatment to families in the community. Because the ethnic, language, socio-economic background, and other critical aspects of diversity are salient with the student population (and are reflective consistently of the diversity within the local community region) and armed with their didactic training in the CE program, these students have the language skills, cultural competency, empathic attunement, and clinical skills to competently treat the mental health and family therapy needs of the clinical population they serve.

Mentoring the students through supervision is an added benefit of the clinic. Through individual, triadic, and group supervision, the student-trainees at the clinic get frequent, in-depth contact at least weekly (if not more often). These important mentoring relationships grow stronger through the intense, close contact of supervision. Because of the serious nature of the clinical cases they treat, the student-trainees and the faculty supervisors must develop a bond of trust as they collaboratively work as a team to provide excellent quality of care.

Lastly, as traditional universities find themselves competing with other types of educational systems (e.g. on-line colleges and universities, for-profit educational systems, and specialized off-site cohort programming), traditional universities have a strong core competency that can translate into a key competitive advantage regarding counselor education training. Counseling primarily occurs in a face-to-face context. People want the privacy and personal connection with their therapist or counselor. In an isomorphic manner, learning to be a counselor or therapist requires training that emphasizes these same personal, face-to-face skills (Weir, 2009). While much technological innovation in the counselor education field is exciting and helpful, the field will likely continue to emphasize personal, face-to-face skills in its training processes for the foreseeable future. Having a university-based or university-associated, community-based student training

clinic such as FFCC provides exceptional preparation of student-trainees for field placements, internships, and eventual careers. Educational institutions without the extensive practicum training approach described in this study are at a severe disadvantage. Employers and field placement supervisors of counselors and therapists in the local region consistently report through employer survey data and advisory board reports that they desire to have well-trained students who have had the prior experience of clinical training in a setting such as FFCC.

It is this crucially valuable experience in student training clinics during the practicum and field placement/internship coursework that provide traditional MFT/CE training programs with a decisive advantage. Thus traditional universities can utilize their clinics as a key factor in recruitment, retention, and job placement, which further attracts the best, brightest, and more diverse students to the program. In the age of higher education innovation and competition (Christensen & Eyring, 2011), traditional universities must compete with other forms of educational systems. University-based and university-associated community-based student training clinics are a powerful core competency lending significant competitive advantage to traditional universities who maintain such clinics.

Enhancing Faculty Scholarship

In addition to service to the community and quality teaching and mentoring experiences, university-based and university-associated, community-based student training clinics are excellent environments for conducting research and enhancing faculty scholarship. In one example from Fresno Family Counseling Center, a faculty member conducted a two-year study to test the efficacy of an innovative, integrative model of play therapy for adoptive families in the community. The project involved all three aspects of professorial expectations: service to the community by providing sessions, teaching students a new model of play therapy (through an elective course taught over four semesters), and scholarship through a research team who eventually published the findings (Weir, Lee, Canosa, Rodrigues, McWilliams, & Parker, 2013). This “win-win-win” combination of teaching, scholarship, and community service allowed faculty members to combine three aspects of their retention, tenure, and promotion activities into one project, thus enhancing their capacity to accomplish more in less time and energy output. As faculty are continually expected to accomplish more and more with less and less resources, student training clinics offer a solution of efficient productivity with vast potential. Investing time, energy, and financial resources in student training clinics preserves the facility and environment where such tri-fold teaching, scholarship, and service can be more affordably, efficiently, and productively accomplished. As administrators are forced to make difficult budgetary decisions, cutting investment in student training clinics is often much more expensive than it initially appears. Well-managed, cost-effective student training clinics make sound financial sense; the return on investment (in the form of faculty productivity) an administrator receives from such clinics have the potential to be quite valuable resource instruments for such educational goals as faculty publications, quality education, and visible community service (which development officers can easily tout in their efforts to acquire external funding from significant donors).

Funding Concerns and Capacities

There are three crucial financial aspects to consider: administrative support, self-support, and external funding. These financial capacity decisions must be made in the context of a culture of commitment to equity, service, and collaborative support. There must also be a sound grasp of financial management, operational planning, and capacity building by administrators and faculty supervisors. An honest evaluation of these principles and skills must be made in advance to ensure success.

Administrative Support – Initial start up costs are probably the most significant barrier to such a venture. Acquiring space from the university or leasing space in the community has an initial cost, coupled with the technology equipment, office supplies, and furniture. However, university administrators with clear foresight are likely to provide such resources because they can envision such counseling clinics as fulfilling the university's larger missions of teaching, scholarship, and service in a cost-effective program that will eventually lead to self-support and possibly revenue provision. In cases where faculty may not have all of those initial necessities due to difficult budgetary constraints at the university, beginning with community collaborations (such as school systems, healthcare initiatives, or other non-profits) can be an excellent way to commence the clinic project. These initial community collaborations were the approach this clinic took many years ago by partnering with local school systems.

Fresno Family Counseling Center has been fortunate to have administrative support from the administration of the Kremen School of Education and Human Development (KSOEHD). The administration provides the salary for one office manager, the technology equipment (video cameras, microphones, monitors, headphones, etc.), and the faculty necessary to keep the operation functioning. The college-level administration has also advocated for summer field placement coursework for FFCC trainees even in lean budgetary times so the center can remain open year round.

Even in humble beginnings, dedicated and committed students and faculty can practice therapy and generate modest revenue streams that can be grown over time (e.g. in the past we were given access to two portable classrooms on an elementary school campus, a house was rented by a school district for the clinic, and later a substance abuse clinic formed a partnership with us whereby they offered adjoining office space in exchange for couple and family therapy services for their recovering clients before we could eventually afford to self-support the clinic in professional office suites – each of these phases marked crucial steps in the eventual development of the clinic and its reputation in the community). Once the project commenced and clients began to be seen, a very small revenue stream emerged that could be cultivated and grown.

Self-Support – Despite the vast poverty in the community, it is been the center's practice that every client must pay something for sessions so clients will value the work that they are doing in session with the student-trainee. Though the current sliding scale is extremely affordable (the scale begins at \$30 for the first session and \$20 for subsequent sessions). In reality, the average client pays between \$15-\$20 per session. In some case of extreme emotional and/or family crisis coupled with dire financial distress, supervisors approved a fee as low as \$1-\$5 dollars based on income and defined by the sliding fee structure. The key to self-support is a balance of fee structure and volume, rather than fee structure alone. Expanding the number of treatment rooms, the number of students in the program and at the clinic, and the number of faculty teaching coursework at the clinic (in

some cases as much as half of the weighted teaching units of the expected faculty workload) allowed for the expansion of client volume to the point where the clinic can pay its own rent, have an alarm system, maintain necessary office supplies and file storage, and the other necessary operating expenses. This modest revenue stream from the services offered essentially can support the clinic's basic operating costs. At our university, accounts housed in the university's foundation charge a modest 8% from the revenue acquired and provide indirect financial supports for the university, school or college, and department within which it is located.

Dedicated faculty and students are essential. The students are a vital human resource for the provision of sessions. Without their uncompensated services that they provide in practicum and field placement/internship courses, the clinic would not be financial solvent. Their dedication and social advocacy for the impoverished, disenfranchised, and underserved in the community is exceptional.

Students are required to carry a load of three to four clients for practicum level students and 15-20 for field placement students at the clinic. They are also required to provide a minimum of 10 hours per semester of volunteer time outside of their assigned class times in service to the center, often in the form of outreach, cleaning, filing, data entry, or other similar activities. The result is a significant sense of ownership and commitment on the part of the students. Upon moving to the current location, the students moved the boxes and equipment, built walls to partition larger rooms into two smaller treatment rooms, painted, decorated, and helped set up the environment. The students answer the phones and handle intakes. The center is open 9 am to 9 pm 7 days a week and students always are committed to do whatever is necessary to keep the center open. The KSOEHD administration provides funds to offset the costs for one office manager, who oversees day-to-day operations, conducted file audits, and provides essential coverage during normal business hours. Approximately 40 students are placed at the center at the field placement/internship level in any given semester with either 24-40 additional practicum students present on their scheduled days. This volume of students is essential for the volume of clients that is required for self-support.

In addition to faculty workload being devoted to the center, most faculty actively provide additional supervision outside of their assigned course duties without compensation. It is not uncommon to provide uncompensated, unaccounted for (in terms of faculty workload expectations) hours of supervision and service in the amount of 4-10 hours per week for the good of the clinic. The dedicated faculty and enthusiastic, committed student collaboration is the heart of why the center is so successful.

External Funding – The center currently is poised to make inroads into greater sources of support from the donors in the community and from grant sources. The local minor league baseball team does an annual fundraiser where a portion of the sales of ticket proceeds for a game are given to community causes. The center was successfully able to be the chosen the beneficiary one year. When a retired faculty member passed away, his estate left a generous contribution to the clinic. The university president and the university's office of development have begun making connections and soliciting support from key community donors for whom family therapy, children's mental health, and other related mental health services are near and dear to their hearts with the intent of securing donations and future endowments to support the center's operations and future growth.

Grants have been modest, but timely and well appreciated. Faculty have written and received in-kind training grants, research grants, and grants for specific services rendered to support the operations of the center. Currently, the center is undergoing a comprehensive data analysis of clinical outcomes in order to pursue larger external funding opportunities from both government and private funding sources.

Marketing – Modest marketing efforts have been utilized to expand services. Students and faculty volunteer in community outreach opportunities such as health fairs, school career nights, and local community events. The brochures handed out at such events seem to be a key, effective marketing tool. The center also maintains a website, and faculty and students make presentations to local organizations, another effective outreach effort. Faculty members sit on panels, advisory committees, and boards relevant to the clinic's work in an effort to inform other community leaders of our efforts. The result has been a strong reputation for the center of providing quality mental health care at extremely affordable prices to community. Finally, word-of-mouth referrals from both community professionals and clients familiar with the clinic's work is the greatest marketing resource. By providing quality care at the center, the respect and reputation of FFCC increases further generating new clients.

Conclusion

Operating a university-based or university-associated community-based student training clinic for counselor education and MFT programs can be a very powerful tool in achieving educational goals of equity, service, mentoring, teaching, and faculty research. Educational leaders who support this model of tri-fold focus on enhancing faculty productivity in teaching, scholarship, and service through the use of student training clinics will likely find that such efforts provide significant benefits to the most needy in the community, as well as provide a means of benefiting the university, college/school, and departments where such programs are academically located.

For colleges and universities seeking to implement this training model, some implications are worth mentioning. Garnering widespread support from the department faculty and the school or college administration is essential. It is crucial to ascertain that the key decision-makers, as well as the implementers of the student training clinic model, share a clear vision and precise set of expectations from the outset. Starting with either modest financial investment or through community partnership collaborations can be effective, and the clinic can be cultivated and grown until it is largely self-supported. Waiting for massive capital outlays or until significant external funding is obtained is not always necessary. Rather, overcoming the initial inertia of the organizational founding is the key. It is easier to obtain funding for a small, but competent clinic that is already operating than for a dream clinic that exists in theory but not in practice. Additionally, having dedicated faculty, supervisors, and student-trainees who are willing to sacrifice because they believe in the cause of servicing the impoverished and breaking down barriers to mental health access is essential. Finally, having a training model built on simple, but effective clinical theories (e.g. Rogerian, Structural Family Therapy, and Solution-Focused Therapy, among others) that are brief, empirically-supported, and can readily be learned and implemented by beginning-level trainees under the type of intense supervision described in this model is a requisite for success in this endeavor.

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