Presidential Address
APA, Division 37, Society for Child and Family Policy and Practice
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As Division 37 embarks on its 30th year—and we will be celebrating that anniversary next year, during Patrick Tolan's presidency in 2008, it is important for us to look to the future and directions that are converging to chart our paths.

Our Division has been at the forefront of advocacy, and now thanks to the task force, we have completed an advocacy training project, that is available on our website. Because of my special interest in training and supervision, I have been particularly intrigued by why advocacy is not generally taught in college or graduate school in psychology. Especially intriguing are the data APA cites about how psychologists in general are so reticent to advocate— We donate the least to political causes—in comparison to doctors, dentists, nurses, and many other professions.

We do not cultivate relationships with politicians to advocate for our profession or even for the most part for causes that are near and dear to us—Yes Division 37 is an exception, and other divisions are also beginning to advocate, but it is far from widespread or substantial.

Why is this?

First we encounter reticence on the part of practicing professionals to change

Michael Roberts wrote, "Changing clinical psychology may be likened to turning an ocean liner; it takes a plan, care, patience, and time. The inertia of the status quo prevents inappropriate sudden movements in the progress of the field while also unfortunately impeding appropriate and innovative adaptation to changes in the environment and within the field itself. Fortunately, clinical psychology as a ship can maneuver more than if it were a railroad train held rigidly in its direction by tracks." (Roberts, 2005; p. 1081)

So this could be a factor. We have long struggled with ambivalence about impacting public policy (or not) and the fear that doing so would somehow soil or tarnish the research or the motivation for having done the research. The "hat" issue has been foremost: what multiple roles will the psychologist be playing to research and then advocate? Grisso and Steinberg remind us that this is what Urie Bronfenbrenner described as being caught between a rock (science) and a soft place (advocacy). Scientists are concerned that results would be sullied by intent to "be on the side of the children." The result of this tension is disengagement ((DeLeon, Loftis, Ball, & Sullivan, 2006), and the lack of commitment to children in public policy (Portwood, 2006) and mental health planning.

Whether social policy and advocacy should be a topic in psychology training has been controversial. Our own Division 37 and the Section on Child Maltreatment have been and continue to be at the forefront of advocacy training, integration, and practice. The fact is that advocacy has not been a subject in the majority of professional psychology graduate training programs (Friedman, 2007; Newman, 2004) and is neglected in internship and postdoctoral work as well. Recently, there have been multiple sources of support for increased attention to advocacy and policy in graduate curricula. Friedman reminds us that greater focus on policy in graduate training is

consistent with the recommendations of the taskforce on training psychologists to provide services to children and adolescents (Roberts, Carlson, Erikson, Friedman, LaGreca, Lemanek, et al, 1998). The taskforce advocated training in systems of care and an increase in responsiveness of community and service systems to the needs of children, adolescents, and families. In 2004, the National Council of Schools and Programs of Professional Psychology (NCSPP) passed a motion including advocacy as a professional value and attitude in psychology training. They stated, "Advocacy as a professional value and attitude promotes the knowledge and skills of the professional psychologist toward promoting the interests of individual clients, systems of care, public health and welfare issues, and/or professional psychology itself." (NCSPP, 2004). But still, Friedman states that most current Ph.D. programs in psychology offer no courses on policy, systems, and only minimal exposure, if any, to these. And undergrad curricula do not either.

The role of "social interventionist" is an ethically explicit role within psychology. The Preamble to the American Psychological Association's Ethical Principles and Code of Conduct (APA, 1992, 2002) states: (Psychologists)… "strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness."

The narrow focus and methodologies of much psychological research can limit scientific conclusions to the seemingly obvious such that absolutely verifiable conclusions contain little or no useful information or application or guidance. Part of what is at issue is the empiricist approach which excludes anthropology and more holistic approaches.

Regarding the content of pre-internship training, Kaslow, Pate, and Thorn (2005) commented on the discrepancy between the APPIC definition of practicum activity defined as actual clock hours in direct service to clients/patients) and training directors' description of practicum hours in which about half of the sample included advocacy as an appropriate practicum activity. Recent critiques describe "silo training" (Harowski, Turner, LeVine, Schank, & Leichter, 2006) suggesting that current curricula neglect multidisciplinary team approaches and relationship to the real word and particular skills that are necessary for functioning.

Advocacy need to be Interdisciplinary and interprofessional –such collaboration may run counter to "professionalism" or professional as expert as is imbued in trainees (Walsh, Brabeck, & Howard, 1999). Graduate programs typically do not promote interdisciplinary or collaborative approaches Walsh et al., 1999). This stance promotes competitiveness between professions and erects barriers which are potentially detrimental to provision of services to children.

There are also research obstacles. Not only do studies need be carefully designed, research questions posed in ways that are fair and even handed, statistical analysis and description of such that is understandable, responsible, and reflective of a balance and fair test of the hypotheses—this is a heavy burden for the responsible researcher.

There is the fear that researchers will be carried away and overstate data—in the context of deep felt political or social beliefs or values. Maintaining a balance and wearing the two hats is a gigantic task.

So my interest is in how to bring advocacy more to the forefront of training. The scope of graduate training is broad, diverse and crowded. Increasingly new areas are being added or their omission is being noted.

Candidates include

Diversity in every aspect and multiple identities

Supervision—increasingly noted as pivotal in EBTs

Advocacy which is generally noted as important (NCSPP)

But generally not addressed

PTSD and trauma – assessment and treatment co-occurring or as a precursor of the presenting problem

Contextually sound Evidence-based treatments, validated and relevant to minority children, youth, and families

Risk assessment and emergency psychology

The world of academics is changing to competency-based—on the belief that it is possible to determine what competencies an individual should have to practice Competence is defined as knowledge, skills, and attitudes.

In most of psychology we have excelled in training in knowledge and skills but have been deficient in attitudes or values—viewing them as out of the realm of education As competency-based approaches spread, they have become standard of practice for medicine, psychiatry, family practice, dentistry, increasingly psychology, marriage and family therapy, nursing, social work, and are spreading through other areas
Why the movement to competency based training—a subject about which Dr. Edward Shafranske and I wrote a book?

Competence is easier to define in its absence than its presence (Kitchener)
Let me tell you a little story about competency, lack of competency, and what the effects can be. Internationally, it revolves around the issue of revalidation. In U.K., a series of White Papers have been written (Shipman, Ayling, Neale, Kerr/Haslam), outlining a series of egregious acts performed by physicians. For example–for example in Shipman, it had been identified that Dr. Shipman was prescribing huge amounts of narcotic drugs for the size of his practice, and routine checks led to inquiry, but he assured the investigators that he had a very chronic, elderly practice and it was warranted…the numbers kept rising, Ultimately it was determined in fact HE had a significant narcotic addiction himself, he was briefly censured, and moved to another area of U.K. where he set up practice again, unsupervised. This time he did home visits to elderly and developed a thriving practice, but it became noted that he had incredibly high death rates—which if questioned he attributed to the population he was serving. There was no follow through on this or previous complaints. His demise came as he visited the mother of a prominent barrister only minutes after the two had had a phone conversation and the mother had told the daughter how very chipper she felt and all of her plans for travel and fun. Minutes later she was dead. Investigation revealed that Shipman killed a minimum of 215 patients in over 23 years—and led to the conclusion that doctors can work for 30 years with no formal reassessment of their competence, clinical skills or performance—in contrast to airplane pilots who would be assessed 100 times during a similar working life. Shipman had a substance abuse problem himself, and an attitudinal problem as well about the elderly with whom he practiced.

The General Medical Council which oversaw physicians was labeled "toothless" and responsibility has been shifted from the profession to another board—to cover medical and non-medical professionals—councils to be appointed not elected, reducing natural sympathy to professional interests, competencies will define appointments, regulatory councils will be smaller, more consistent in size and role, and more accountable to parliament.

Outcome was revalidation, and recertification…a positive affirmation of entitlement to practice rather than just absence of concern. Recertification will apply to specialist doctors and GPs. Further specific remedial actions would be tied to any complaint or safety incident. A further part of the recommendation was that responsibility for setting educational standards for non-medical professionals should remain with their respective councils—but that it may be desirable to have a single body responsible for setting the standards for undergrad and postgrad education and continuing professional development for doctors, change should be introduced in such a way as to preserve the expertise and experience of the present organizations that undertake its role. For psychologists, they are in the process of determining which roles should eventually be statutorily regulated…including requirements that the profession has a discrete area of activity, defined body of knowledge, evidence-based practice code of conduct and disciplinary procedures.

How does this affect us? Well an incredible recent study of practicing physicians demonstrated that those who received disciplinary referrals to the medical board—were significantly more likely to have been irresponsible, unresponsive to corrective feedback than a matched set of peers.

Generally COMPETENCE—how we can transmit competencies to our students

Clinical Psych is engaged in the Benchmarks process to identify
Readiness for practicum
Readiness for internship
Readiness for entry to practice

This could result in increased accountability—ensuring that what we are teaching is effective, that students/supervisees emerge with a set of skills/knowledge/ values/attitudes. Foundational and functional competencies were derived from Rodolfa et al.'s competency cube.

Advocacy is neither a foundational nor function competency

Foundational Competencies

Reflective practice-self-assessment

Scientific knowledge-methods

Relationships

Ethical-legal standards-policy

Individual-cultural diversity.

Interdisciplinary systems

Functional Competencies

Assessment-diagnosis-case conceptualization

Intervention

Consultation.

Research/evaluation

Supervision-teaching

Management-administration

To access Benchmarks: http://APAOutsidbe.apa.org/EducCSS/Public

Much of this relates to the future directions of Division 37, now that we have a new name and have become a society which means we can attract members from multiple disciplines. I would suggest that as in other behavioral areas, we focus inadequately on attitude/values—to advocate one must possess a set of values and attitudes. Within Div 37 we value and hold in high esteem, prioritize children and families. We think implicitly about social justice and value it.

Sometimes we assume our students hold these same attitudes
But increasingly we learn that biases are incredibly powerful…Physicians who did not believe they held racial biases in fact exhibited racial bias in their treatment decisions—unbeknownst to them—and they were shocked to learn in a study done (Banaji—Harvard psychologist) that unconscious bias affect treatment decisions such as whether to prescribe clot-busting drugs.

A new look at advocacy in the context of ethics and professional practice needs to be taken to prepare our students for this new approach. It may require an attitudinal change—not amongst those of you here…as you are Div 37 members

When I do workshops on supervision I encourage greater self-disclosure among faculty/supervisors regarding values/attitudes, diversity factors, and general biases, worldview, etc. This is HIGHLY controversial.

Maybe more controversial than modeling advocacy—
As we move into era of EBT we increasingly realize that there is much more to therapy or intervention than a book or list of directives…we are increasingly understanding the role of the supervisor as one who moves through a progression of teaching, structuring, modeling, critiquing, advocating and using critical thinking skills related to the area of

practice, monitor, oversee, regulate, evaluate, provide feedback and direction, even stepping in to assume responsibility as viewed needed.
Some may wear multiple hats and supervise, mentor, advise, co-author , teach, etc.
Division 37 needs to advocate for advocacy. We need to move towards instilling advocacy as a competency, and towards ensuring the values and attitudes associated with it are taught.