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A Guide for Starting a Specialty Training Clinic: An Alcohol Treatment Program as an Example

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Abstract

Since the Boulder conference more than 50 years ago, clinical psychology has been moving towards empirically based techniques and methods. Considerable research has been conducted and a multitude of studies have documented support for empirically supported treatments (ESTs). However, the literature on implementing ESTs in real-world settings is relatively limited. The absence of practical guidance poses a particular problem for students in clinical psychology training programs that emphasize training and competency in ESTs. This article describes the development of an alcohol specialty clinic within a clinical psychology training program from the first conceptualizations to establishment of a referral base and provision of services. At each step, integration of science and clinical practice is discussed. Future directions and suggestions for developing training clinics are provided.

Keywords

Alcohol treatment; Specialty clinic; EST; clinical training

Introduction

The Clinical Science Model

Dating back to the 1949 Boulder Conference (American Psychological Association, 1950), clinical psychology has advocated for scientific knowledge as the basis for clinical practice. McFall (1991) finely honed this long-espoused value in his “Manifesto for a psychological clinical science,” in which he argued that science-based practice was the “only legitimate form of clinical psychology” (p. 76), and suggested that the primary goal of doctoral training should be to train clinical scientists.

To train graduate students within the newly emerging clinical science model, Calhoun, Moras, Pilkonis, and Rehm (1998) recommended grounding in four major elements: (a) empirically supported assessments and treatments; (b) conceptual bases of psychopathology; (c) common therapeutic skills; and (d) competence in at least one empirically supported treatment (EST). Inspired by those recommendations, a number of graduate training programs began to shift their psychology clinics to provide more training in ESTs. For example, Cukrowicz et al. (2005) reported that transition to an EST-based clinic resulted in

more positive clinical outcomes, and a six-year follow-up study of their clinic (Cukrowicz et al., 2011) reported continued evidence of better client outcomes than prior to the transition.

The newly developed Psychological Clinical Science Accreditation System (PCSAS) includes an explicit expectation that graduate training programs train clinical students “to a professional level of competence in the most cost-effective, efficient, empirically supported procedures for the assessment and treatment of specific populations and problems” (PCSAS, 2011). As an indicator of this goal, programs are evaluated on whether students “receive individualized on- or off-site training whereby they gain direct, first-hand, mentored experience with specific science-based procedures and with populations or problems that are relevant to ensuring their competence in core areas of clinical science application”—i.e., “assessment, diagnosis, prevention, treatment, supervision, and program evaluation” (PCSAS, 2011). Clearly, the EST movement continues to gain ground within clinical psychology, as manifested through this ideal model of focused training.

One strategy for providing the training advocated by the PCSAS is the specialty clinic. Simply put, a specialty clinic provides psychological services within a circumscribed area, disorder, or cluster of disorders; thus, the specialty clinic affords training in the evidence-based assessment, diagnosis, and treatment of a restricted range of clinical presentations or populations. By limiting the range of services provided, comprehensive training can be provided using the best and most current empirical knowledge. Although there is considerable enthusiasm about the specialty clinic as a training vehicle, professional literature on the development of such models is limited. In one of the few detailed descriptions of the development of a specialty clinic, Levenson, Cowan, and Cowan (2010) reported the steps they took to develop a clinic for parenting skills training. Their qualitative report indicated considerable enthusiasm with their experience developing and sustaining this clinic. Based on this report, it is clear that not only working within a training clinic, but also the act of creating a training clinic can provide students with an opportunity to learn how to incorporate empirically based clinical training into the provision of psychological services.

Challenges of Integrating Empirical Findings with Real-World Community Practice

Despite an increase in the use of ESTs in clinical practice, several barriers exist for the widespread implementation of ESTs. Specifically lacking is research that demonstrates the efficacy of ESTs with diverse populations and in varied settings. In response to these limitations in scientific knowledge, a number of approaches to this dilemma have been proposed. For example, the APA Presidential Task Force on Evidence-Based Practice (2006, p. 273) suggested a focus on evidence-based practice (EBP) in psychology, defined as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.” The EBP model emphasizes equal consideration of evidence derived from research, clinical experience, and client preferences; it stands in contrast to models that give primacy to research evidence in decision making (e.g., McFall, 1991). One implication of EBPs is that research evidence must be integrated with the other two components for treatments to be applied successfully in community settings. Specialty training clinics committed to ESTs must grapple with the inherent tension between a commitment to science as the basis for practice and the limitations of scientific knowledge that prompted the alternate EBP approach.

At a more applied level, the adoption and implementation of ESTs can be hindered by barriers at all levels of community practice. These include lack of awareness about ESTs, limited time and funding, inability to access empirical literature because of limitations in technology or skills, few training resources, and lack of buy-in or leadership (e.g., Falzon, Davison, & Bruns, 2010; Iowa Consortium, 2003; Rosenberg, 2009). Although most clinical

psychologists report utilizing ESTs within their own clinical work, those practices are not universal, and are influenced by factors including work setting, clinical experience, and theoretical orientation (Berke, Rozell, Hogan, Norcross, & Karpiak, 2011). To this end, clinical science training programs offer a unique opportunity to circumvent many of these barriers, thus improving clinical psychologists' implementation of ESTs, because students are familiar with current research, actively seek new clinical experiences, are open to multiple therapeutic methods, can be trained and supervised by expert researchers and clinicians, and often are immersed in a culture that supports ESTs (e.g., Norcross, Hogan, & Koocher, 2008).

Purpose

A faculty member and group of graduate students at the University of New Mexico (UNM) Department of Psychology collaborated to develop a specialty clinic within the department's Psychology Clinic—dubbed Alcohol Treatment at UNM (*@UNM*)—to provide treatment for people with alcohol-related concerns and alcohol use disorders (AUDs). The role of this specialty clinic was to provide graduate students with: (a) experience in clinical program development; (b) training in the provision of empirically supported assessments and treatments for AUDs; and (c) experience offering assessment and treatment services to a diverse surrounding community. The *@UNM* clinic used a flexible EST approach to define its empirically supported treatments and methods. The approach taken by *@UNM* is that empirical evidence should be the primary characteristic guiding clinical work, but individual characteristics (e.g., diversity issues, client preferences) deserve consideration in treatment planning and implementation, particularly when an empirical evidence base is lacking.

Although a wealth of scientific literature on empirically supported assessments and treatments exists for AUDs, our group identified two major gaps: lack of a template for the development of a specialty training clinic, and limited availability of models and data for adapting ESTs for AUDs for a diverse client population. The goals of the present paper are to provide “how-to” steps for developing a specialty training clinic and offer an example of the integration of empirical research and clinical practice within this setting.

@UNM Training Model and Objectives

The UNM doctoral training program in clinical psychology espouses a clinical science training model. The program holds APA accreditation, and the decision to develop specialty clinics was motivated partly in accordance with APA standards and recommendations. Within the department, multiple faculty members specialize in the treatment of alcohol problems. Additionally, UNM is home to the Center on Alcoholism, Substance Abuse, and Addictions (CASAA), an established addictions research institute with a significant focus on treatment research. Thus, the environment was conducive to the development of a specialty clinic focused on treating alcohol problems.

After discussion with departmental faculty, a steering committee was formed and began meeting on a bi-weekly basis to formalize the aims for *@UNM*. This committee consisted of nine students, the *@UNM* faculty director, and the general clinic director. The overarching goals of *@UNM* were to provide: (a) clinical training in ESTs for alcohol problems, (b) state-of-the-art services to the local community for the treatment of alcohol problems, and (c) training opportunities suitable for students with varying levels of clinical experience using a vertical training model. All services provided by *@UNM* are evidence-based, and specific assessments and treatments were selected based on the availability of empirical support for their utility and efficacy, along with perceived community need for given services (e.g., family-based approaches, brief interventions).

Development of the @UNM Clinic

The initial direction and structure of @UNM was guided by a handbook and checklist of start-up tasks produced for a specialty clinic previously established by the senior faculty member (B.S.M.) at another institution. The @UNM steering committee used this addictions clinic handbook to identify content areas to consider in the development of a specialty training clinic, including: (a) a clinic philosophy and mission statement, (b) student expectations and requirements, (c) a supervision model, (d) clinical service procedures, (e) clinical emergency procedures, and (f) community referrals. The steering committee then adapted, modified, or replaced individual sections consistent with the needs of the @UNM clinic to produce @UNM's own operations handbook. This process included consideration of the clinic's role in the larger treatment community. Steering committee members expressed their ultimate vision for the clinic, and from those formative ideals, created a mission statement centered on the concept of an individualized, collaborative, and empirically based approach to treatment. Of note, this philosophy was markedly different from many established treatment agencies in the community. Students also managed meetings, assigned tasks, and identified instruments with strong psychometric properties and clinical utility for the intake assessment. At all stages, faculty members advised and provided institutional support.

The scope of treatments provided was limited to those for which graduate students were able to receive competent supervision in EST modalities; community treatment needs necessarily were balanced with practical considerations. For example, clients requiring services beyond the scope or capacity of a behavioral outpatient alcohol clinic (e.g., medical detoxification, primary non-alcohol substance use disorders, severe co-occurring psychopathology) were to be referred to other treatment facilities (with the option of returning for services when stable, if appropriate). Finally, congruent with @UNM's conceptualization of AUDs not as a disease but as a spectrum of complex disorders with multiple etiologies and courses, a stepped-care model of individualized treatment was selected so the @UNM clinic would be responsive to clients with varying levels of presenting problems and symptom severities (e.g., clients needing only a brief intervention, or those seeking extended treatment) would be appropriate for the clinic. By accepting a range of clients, the clinic could address a spectrum of treatment needs in the community and provide training experiences with diverse clients.

Once a formalized clinic identity was established, considerations about the @UNM public image and relationships to other treatment agencies in the community arose. Tasks included: (a) choosing a descriptive and memorable name, (b) creating a clinic logo, (c) preparing a brochure to help with recruitment efforts, and (d) solidifying relationships with other treatment agencies identified during the informal assessment of community needs. From conceptualization to service initiation, completing this organic and iterative process took less than a year.

@UNM Clinical Services

Intake screening—The primary goal of the intake screening is to establish the eligibility of those seeking treatment at the clinic. Potential clients were to be included if they met criteria for at-risk alcohol use. Psychotic or dangerous (to themselves or others) clients were to be excluded in order to ensure cases appropriate for a training clinic. Additionally, a decision to exclude clients with a non-alcohol substance use disorder was made, primarily due to limitations of clinic resources (e.g., lack of medical staff and inability to provide pharmacological interventions). However, use of other drugs would not automatically render clients ineligible for services, provided alcohol was their primary problem. For example, a client who also is concerned about his marijuana use or a client distressed by her occasional

use of cocaine when drinking may be considered for treatment. @UNM has discussed the possibility of extending services to appropriate individuals with primary non-alcohol substance use problems in the future if demand exists. A set of questions to be administered by telephone was compiled from existing measures with strong reliability and validity: three quantity/frequency questions from the AUDIT to screen for at-risk alcohol-related use (Bush et al., 1998); ten questions from the ASSIST to probe for at-risk substance use (WHO ASSIST Working Group, 2002); four questions from the SCID-C to probe for psychotic features, three questions on prior psychiatric diagnosis, medication and hospitalization, and one question to probe for risk of self harm (First, Spitzer, Gibbon & Williams, 1996). The goal of the phone intake is for the screener to determine appropriateness of fit and, if eligible, to immediately schedule the initial evaluation. As risky drinking often affects families, and services for concerned family members can provide both support to them in their own right in addition to facilitate drinkers' entry into treatment, @UNM decided to serve this population as well. A parallel screening form was developed for family members of risky drinkers, and other-oriented treatments are offered through @UNM.

Assessment—The intake assessment consists of a standardized battery of structured interview instruments, paper-and-pencil measures, and a semistructured clinical interview. The goals of the assessment are to determine the severity and patterns of alcohol use, assess negative impacts of drinking, gather information relevant to determining appropriate treatment options, and engage the client in ongoing treatment. The steering committee selected the following measures to assess those areas: Form-90, Structured Clinical Interview for DSM Disorders: Module E (SCID-E), Drinker Inventory of Consequences (DrInC-2R), Health Status Questionnaire (HSQ-12), Important People Interview (IPI), and the "Readiness Ruler" (see Table 1 for additional information).

Potential assessment measures were identified by reviewing the empirical literature (e.g., Green, Worden, Menges, & McCrady, 2008). Instruments were selected based both for their strong psychometric properties (particularly relevant for measures assessing diagnostic criteria such as the SCID-E, Form-90) and their clinical utility. When multiple measures of similar psychometric quality and clinical utility were identified for the same purpose, practical considerations (e.g., cost, administration time) determined the final selection. Because no instrument for quickly identifying important components of cultural identity was available, an instrument, entitled the "Me Wheel," was developed in-house. This instrument, modeled after the "menu of options" (Rollnick, Mason, & Butler, 1999), is a pictographic wheel with an element of identity (e.g., religion, race, sexual orientation) listed on each spoke; clients are asked to circle any that are "important in the context of their assessment and treatment." The semistructured clinical interview allows clients to provide their own perspectives of drinking and other concerns as well as provides assessors the opportunity to observe the client's presentation. Finally, the Outcome Questionnaire 45 (OQ-45), a well-validated tool for assessing treatment progress, was selected as an assessment to track clients' weekly progress.

Case Formulation and Treatment—After each assessment, the student-clinician writes an integrated report based upon clinical observations and assessment results. Reports summarize clinically relevant aspects of clients' presentation and provide tentative case formulations and treatment recommendations, which are discussed, reformulated, and used to select treatment modality by the treatment team during supervised weekly staff meetings. This process promotes critical thinking about case formulation and involves students at all levels of clinical experience.

A two-step process was used to identify the treatments offered through @UNM (see Table 2 for ESTs offered). First, the steering committee examined the literature on alcohol

treatments with strong empirical support, including consulting relevant research articles and book chapters (e.g., Hallgren et al., 2012; Miller & Wilbourne, 2002) and reviewing the recommendations of consensus panels (e.g., National Registry of Evidence-Based Practices and Programs, <http://www.nrepp.samhsa.gov/>; APA Presidential Task Force on Evidence-Based Practice, http://www.div12.org/PsychologicalTreatments/disorders/substance_main.php). Next, the committee further narrowed down those offered by considering practical limitations of @UNM (e.g., expertise of supervisors) and investigation of community need (e.g., offering couples therapy due to few local providers of such services).

Although many comparable ESTs exist for AUDs, literature to guide specific matching of clients to particular treatments remains sparse (e.g., McCrady, Haaga, & Lebow, 2006). Thus, matches were estimated based upon factors such as severity of alcohol use, motivation for changing drinking, and existing social network supportive of changing drinking behaviors. For example, if a client expresses ambivalence about changing drinking, motivational interviewing (MI; Miller & Rollnick, 2002) might be used. If a client is sufficiently motivated, but lacks the skills to initiate or maintain a change, cognitive-behavioral therapy (CBT; Epstein & McCrady, 2009) might be implemented. If a client has already made changes in drinking but struggles with maintenance of the change, a relapse prevention approach (Marlatt & Donovan, 2007) might be employed. If a client is unable to identify other reinforcers to replace the positive effects of alcohol, the Community Reinforcement Approach (CRA; Meyers & Smith, 1995) might be used. A client who is experiencing relationship problems due to drinking, and has a willing significant other, might be offered Alcohol Behavioral Couples Therapy (ABCT; McCrady & Epstein, 2009). Concerned family members of individuals not engaged in treatment might be offered Community Reinforcement and Family Training (CRAFT; Smith & Meyers, 2004). Once an appropriate treatment is identified, a graduate-student therapist and faculty supervisor are then assigned based on availability and training or expertise in the selected EST.

UNM Psychology Clinic Resources—@UNM benefitted from a variety of organizational resources. For example, @UNM was developed with the support of the larger UNM training program, and thus, was conceptualized under the umbrella of the existing general psychology clinic and designed to be congruent with existing policies and procedures. Physical space was provided within the general clinic, which is located in its own building on the edge of the UNM campus; clients need not walk across campus to get to the clinic or encounter the student body to access services. Also, the clinic provides free, on-site parking and is easily accessible via public transportation. Moreover, UNM as an institution holds a strong reputation within the community as a major service provider across a range of disciplines.

@UNM procedures for determining client fees mirrored those already in place for the general clinic, including a sliding scale for determining fees. Clinic fees are funneled back into the clinic to obtain resources such as treatment manuals and assessment instruments. As faculty members, supervisors do not receive their salaries through clinic funds. This flexibility in billing often removes financial difficulties as a barrier to access to services, but prevents the clinic from accepting third-party payers (e.g., private insurance, Medicare). However, the clinic sets fees for clients with insurance to equal their co-pay. Additionally, this arrangement obviates potential conflicts in terms of third-party payment for services to patients who are concerned family members, rather than the drinkers themselves.

Finally, @UNM had the advantage of being able to co-opt a number of standard clinic policies pertaining to the day-to-day logistics of running a psychology clinic. For example, @UNM therapist safety was ensured by adopting the general clinic policy of only

conducting intakes during regular business hours when other clinic staff are present. Based on the client population served by @UNM, additional precautions were taken by informing all clients during the phone screening that they must be sober for all appointments and a test of blood alcohol content would be administered to ensure compliance.

Ongoing Training and Supervision Model

After the assessment battery had been finalized, training in the instruments commenced. For some instruments, such as the AUD module of the SCID, training took place in regular staff meetings and utilized didactic presentation by the supervising faculty member followed by role-playing among student clinicians. Development of the telephone screening underwent several rounds of role-playing and revisions in these meetings as well. Other training occurred in a more formal setting. For example, initial training on the Form-90 required a day of intensive formal training offered by CASAA staff. Ongoing training has utilized these resources, with plans to invite guests for further specialized training in other ESTs for AUDs. In addition, student clinicians were encouraged to independently seek out trainings in ESTs for AUDs. As @UNM is a training clinic, students were not expected to pay for training experiences. In some cases, training opportunities were obtained at no cost (e.g., as a professor emeritus, Dr. William Miller provided a free motivational interviewing workshop to the department). Funds for other training experiences were obtained through local resources (e.g., clinic funds). External funding also was sought when possible (e.g., @UNM recently applied for a Clinical Scientist Training Initiative grant through the Society for a Science of Clinical Psychology).

Weekly staff meetings were designed to operate as a forum for group supervision regarding client intake, assessment, and case assignment. The agenda for these meetings is to discuss telephone screening calls, review assessment reports, assign clients to student clinicians, address clinical issues relevant to the group (e.g., how to handle an intoxicated client), and offer updates on ongoing therapy cases with a focus on case conceptualization.

Early in the planning stage, UNM faculty members specializing in the treatment of AUDs were identified and contacted regarding their willingness to serve as supervisors for therapy cases. Four faculty members agreed to serve as regular supervisors for the clinic. Identified supervisors bring a wealth of experience in working with varied populations, such as court-mandated and ethnically diverse clients, and as seen by the list of treatments offered (Table 2), have expertise in a wide range of ESTs.

Consistent with the identity as a training clinic, @UNM offers increasing levels of clinical experience and maximizes student involvement by specifying roles for students at every stage of the graduate program in both the development process and service delivery. Novice students get training in “early-entry” experiences such as telephone screening, scheduling, and sitting in on case assignment and conceptualization meetings. Less experienced students may observe more advanced students conducting assessments and delivering treatment. As students progress in the clinic, they adopt roles as assessors or therapists after sufficient general training in the UNM graduate program, in conjunction with specialized training in the procedures of @UNM. More advanced students also can receive higher-level experiences, such as peer supervision and training. As mentioned previously, all students also are involved in group learning experiences.

A primary goal of any training clinic should be to establish clinical competency of its students. @UNM determines initial level of student competence based on a few criteria. One of the main criteria used to determine clinical competence is number of years in the clinical training program. This includes consideration of: (a) coursework completed, specifically courses directly related to clinical practice, and (b) previous clinical experience. In addition,

@UNM utilizes regular role-playing, when possible, to establish competency in clinic protocols (e.g., phone screening, assessment administration). Finally, supervisors provide close monitoring of therapy, typically listening to recordings or therapy sessions, and supervisors also complete annual evaluations of their supervisees' clinical skills and competency.

Establishing a Reputation in the Community and Establishing a Referral Base

With the procedures and the clinic handbook nearly finalized, the steering committee decided that designing a brochure for the clinic would help to bolster its identity, and be a tool for client recruitment. Included in the brochure were: (a) the clinic's mission statement, (b) available treatment options (e.g., individual, group, couple, family), (c) description of the clinical supervisors and nature of a training clinic, (d) payment information, and (e) contact information.

After finishing the brochure, the next step was to establish a consistent stream of client referrals. The client recruitment process began with contacting local substance abuse treatment agencies, with the goal of offering an alternative referral source for agencies in need. Student clinicians contacted community agencies—including a university health clinic, a substance use inpatient facility and detoxification center, outpatient substance-use agencies, and community treatment funding sources—to conduct brief presentations about @UNM to the staff, and provide clinic brochures. To supplement this approach, recruitment efforts were expanded by posting brief advertisements in the Craigslist "General Community" section and in the classified section of a local newspaper; and distributing information and @UNM brochures to local food banks, emergency-room staff, and adult-probation sites.

Even with extensive efforts by the clinic members to increase recruitment, it was difficult to achieve a steady flow of treatment referrals. In the 14 months since @UNM opened in March 2011, there have been approximately 50 calls from individuals seeking treatment, which resulted in 35 phone screens, 18 assessments, and 13 clients actively engaging in treatment. Individuals who called but did not begin treatment either were ineligible for clinic's services (e.g., seeking detoxification), or did not appear for the initial assessment despite repeated attempts to contact.

Next Steps: Solidifying @UNM Procedures and Expanding Services Provided

Although the foundation of the @UNM clinic is well established, recruitment of new clients has been slower than anticipated. Given @UNM's ability to treat additional clients, this presented an unforeseen problem that is being addressed through additional recruitment strategies, including public service announcements on local radio, a clinic web site, and more consistent contacts with referral sources.

Another promising source of referrals for @UNM is Access to Recovery (ATR), a grant program funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. ATR is a voucher-based system that provides low-cost, sliding-scale services to low-income individuals seeking substance use treatment services. It is likely that participation in the ATR program will expand the clinic's ability to provide ESTs to the community by offering another option to reduce the financial burden of receiving services.

Along with increasing referral rates comes the ability to expand services beyond individual treatment, such as group therapy. With four regular supervisors (each able to oversee up to 3 cases) and 6 students providing individual therapy (each with a caseload of 2 clients), the capacity for @UNM is roughly 12 individual clients. Offering group sessions (e.g., early

recovery, continuing care) will allow @UNM to expand its client capacity and provide services more efficiently than through individual sessions with multiple clients.

Another possibility is to expand services to include individuals who prefer treatment in Spanish. Over a quarter of New Mexico's population speaks Spanish at home (MLA Language Map Data Center, 2000), and offering services in Spanish would allow @UNM to reach clients who might otherwise receive inadequate or no treatment. Empirically supported assessment materials available in Spanish have been collected, and other documents are being translated. In addition, the @UNM clinic is collaborating with the Psychology Clinic's new Multiculturalism and Diversity specialty clinic to ensure that the best measures are selected. In the future, the ability to provide services will depend on the availability of clinicians and supervisors fluent in Spanish.

As the clinic grows, emphasis will be placed on monitoring both individual and aggregate client outcomes through the client screening and assessment variables already being collected systemically. As outlined during the development process, two strategies will allow for systematic evaluation of services. First, all clients receive the same intake assessment, allowing for evaluation of outcomes based on baseline characteristics. Second, consistent and repeated administration of the OQ-45 to all clients at the beginning of every session not only helps clinicians track and monitor clients' session-by-session progress during therapy, but also allows for the evaluation of aggregated outcomes of the @UNM clinic. Such outcome data are being collected to promote evaluation of the program as a whole, as has been done in other clinics (i.e., Cukrowicz et al., 2005; 2011), in order to monitor and improve general provision of clinical services. Although the only repeated assessment planned initially is to track in-treatment change via the administration of the OQ-45 at all sessions, @UNM has discussed the possibility of implementing a more comprehensive follow-up assessment strategy. This would likely include a shortened assessment based on the initial assessment battery at fixed time points (e.g., at the end of treatment and/or another predetermined post-treatment time period) to evaluate long-term gains.

Looking Back: Lessons for the Future

As the development of @UNM was a student-driven initiative, it is important to offer a critique of the process of establishing @UNM within a larger context for anyone interested in developing a specialty clinic. The template provided in this paper describes one type of clinic, that of a training clinic within a doctoral clinical psychology program. Thus, the demands and needs at another institution may differ markedly. For example, the client recruitment strategy for @UNM was implemented intentionally in a piecemeal fashion so as to avoid being overwhelmed in the early stages. With the advantage of hindsight, we could have been more aggressive in our initial recruitment strategy. This could have involved establishing stronger referral contacts with community providers and utilizing multiple information sources (e.g., the internet) earlier on. Along this line, we did not conduct a formal local needs assessment; doing so might have forged stronger relationships with referral sources, broadened our visibility, and created a partnership that would have created a more consistent client flow.

Conclusion

The empirical literature on developing an EST-based specialty clinic is scant, which is problematic within a clinical-science model that uses empirical evidence as the basis of decision-making. This manuscript provided a step-by-step guide to developing such a clinic using a flexible EST approach. We believe the benefits of the @UNM training model are numerous. First, it aligns with the clinical science approach and is consistent with APA

guidelines for scientific clinical training. Second, the clinical experiences available through @UNM encourage students to critically examine the relevant literature and think analytically and flexibly in providing services to the community. Third, as a specialty clinic, @UNM also provides students the opportunity to gain competence in the treatment of a problem that affects most communities: alcohol use disorders. Finally, the @UNM clinic was largely a student-led endeavor. Although the faculty, institutional resources, and institutional perspective influence what is possible within a clinical training program, the process of developing a specialty clinic allows students to actively determine the course of their education. Investment in the current science of research and practice will ensure not only that students will receive a comprehensive education, but also that they will leave graduate school with the skills necessary to identify strengths and weaknesses of current clinical practices and further the field. We hope that the literature will someday contain many other examples of specialty clinics to expand the framework for other clinical scientists, and to foster an ongoing synthesis of research findings and community needs.

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Table 1**Baseline Assessment Battery**

Instrument	Purpose	Clinical Utility	Authors (Year)
Form-90	Assessment of daily drinking	Identifies drinking patterns and features in the past 90 days	Miller & Del Boca(1994)
SCID-E	Diagnostic instrument for AUDs	Provides diagnosis of presence and severity of an AUD	First et al. (1996)
DrInC	Measure of alcohol-related consequences	Gives clients feedback about alcohol use within their lives	Miller et al. (1995)
IPI	Assessment of social support for sobriety and for continued drinking	Determines support from family and friends for sobriety vs. continued drinking	Clifford & Longabaugh (1991)
HSQ	Assessment of mental and physical health, and quality of life	Screens for physical and mental health issues pertinent to AUD treatment	Radosevitch & Pruitt (1995)
OQ-45	Ongoing assessment of symptom distress	Tracks clinical progress across treatment, beginning at intake	Lambert et al. (2004)
Readiness Ruler	Assessment of client motivation for change	Provides information on client's intrinsic motivation	Rollnick, Mason, & Butler (1999)
Me Wheel	Assessment of for facets of client identity	Guides treatment formulation	Developed by @ UNM

SCID = Structured Clinical Interview for DSM Disorders, AUD = alcohol use disorder. DrInC = Drinker's Inventory of Consequences, IPI = Important People Interview, HSQ = Health Status Questionnaire, OQ = Outcome Questionnaire.

Table 2

Treatment Modalities Offered

Treatment Name	Brief Description	Author(s), Year
Alcohol Behavioral Couples Therapy (ABCT)	Conjoint cognitive-behavioral approach, built on the assumption that intimate partner interactions and couple behavior can trigger drinking and reinforce change.	McCrary & Epstein (2009)
Cognitive-Behavioral Treatment (CBT)	Goal oriented treatment to teach coping skills for dysfunctional thoughts, emotions, and behaviors.	Epstein & McCrary (2009)
Community Reinforcement Approach (CRA)	Behavioral approach built on functional assessment of a client's drinking behavior and the use of positive reinforcement and contingency management for non-drinking.	Meyers & Smith (1995)
Community Reinforcement Approach and Family Treatment (CRAFT)	Behavioral approach designed to empower family members to help get their loved ones into treatment and provide better family coping skills	Smith & Meyers (2004)
Motivational Interviewing (MI)	A brief, client-centered, directive treatment approach useful in working with clients who are ambivalent about changing a targeted behavior.	Miller & Rollnick (2002)
Relapse Prevention	A cognitive-behavioral approach with a goal of identifying and preventing high-risk situations that may lead to alcohol or substance-use relapse.	Marlatt & Donovan (2007)