



Office of Statewide Health Planning and Development

HEALTH PROFESSIONS
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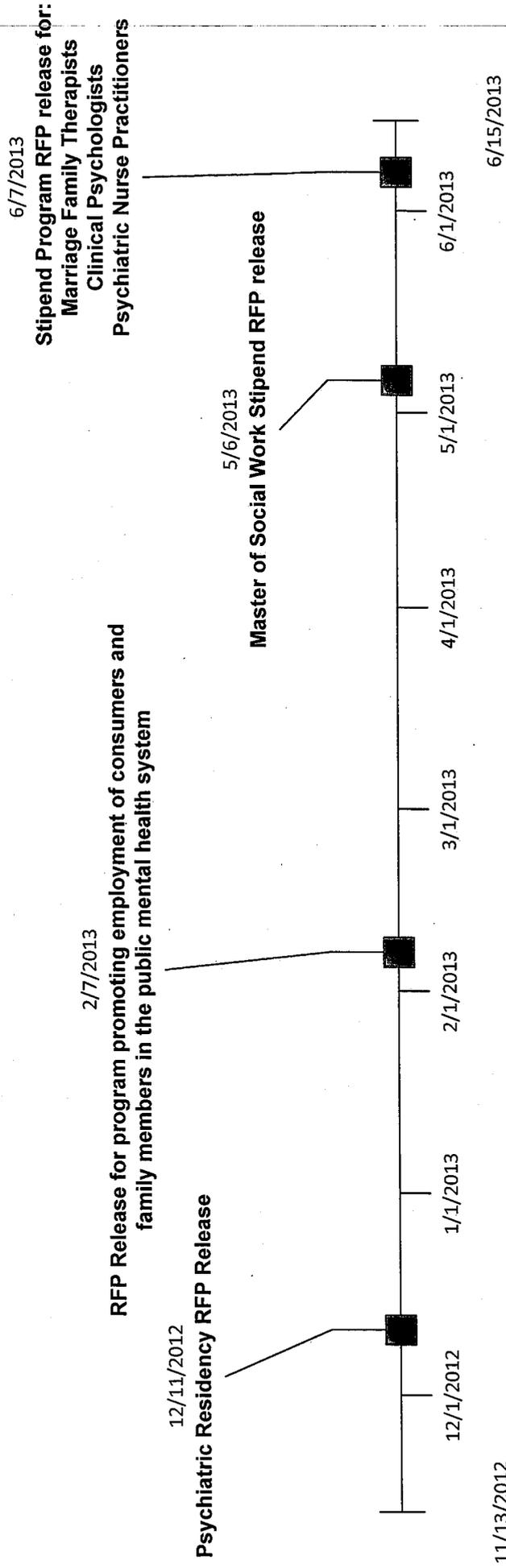
**Workforce Education and Training (WET)
Advisory Committee**

**December 3, 2012
1:00 PM to 5:00 PM**

**400 R Street, Suite 471
Sacramento, CA 95811
Teleconference Number: (877) 213-1782
Participant Code: 439482**

| Item | Subject | Contact |
|------|---|---|
| 1 | Welcome and Introductions | Lupe Alonzo-Diaz |
| 2 | Administrative <ul style="list-style-type: none"> • Review Purpose of Meeting and Agenda • Review Minutes from Last Meeting • Present MHSA WET Team | Inna Tysoe |
| 3 | Status of MHSA WET Transfer to OSHPD/Health Professions Education Foundation <ul style="list-style-type: none"> • Review Contractors Meet and Greet Discussion • Review Master Schedule for Release of RFPs | Linda Onstad-Adkins |
| 4 | Presentation on DHCS Business Plan Regarding Workforce Findings | To Be Determined |
| 5 | Panel Presentation on Existing WET Programs <ul style="list-style-type: none"> • Financial Incentive Programs: Stipends and Loan Repayments | Panelists will include administrators of stipend programs and Mental Health Loan Assumption Program |
| 6 | Review Proposed Work Plan for Developing Five-Year Plan <ul style="list-style-type: none"> • Identify Resources from WET Advisory Committee members to support development of plan. | Sergio Aguilar |
| 7 | Updates by WET Advisory Committee Members on Their WET-Related Activities | Advisory Committee Members |
| 8 | Public Comment | Lupe Alonzo-Diaz |
| 9 | Adjournment | Lupe Alonzo-Diaz |

Workforce Education and Training Requests for Proposal Release Timeline



6. Workforce Capacity

- Need expanded MH & SUD workforce
- Staff competency is needed for MH/SUD/PC integration; cultural & linguistic needs; and special populations
- A single state agency for certification/ credential approval process is needed for SUD counselors
- Peer & family certification programs are needed

Workforce Capacity

Next Steps

- Project staff to review stakeholder input to identify specific workforce capacity issues
- Project staff to develop recommendations
- Recommendations sent out for stakeholder review
- Comments from stakeholders incorporated into recommendations



Office of Statewide
Health Planning and
Development



HEALTH PROFESSIONS
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Workforce Education and Training Program

Advisory Committee Meeting

Mental Health Loan Assumption Program

Presentation

December 3, 2012



Mental Health Loan Assumption Program

| Applications | | | | | |
|--------------|----------|--------------|------------------------|--------------|------------------------|
| Fiscal Year | Counties | Received | \$ Requested | Awarded | \$ Awarded |
| 2008-09 | 43 | 1,236 | \$15,047,225.57 | 288 | \$2,285,277.15 |
| 2009-10 | 52 | 1,498 | \$12,683,961.79 | 309 | \$2,469,239.30 |
| 2010-11 | 50 | 1,009 | \$10,030,983.35 | 474 | \$4,523,757 |
| 2011-12 | 55 | 1,659 | \$16,581,901.02 | 661 | \$5,365,680 |
| 2012-13 | 53 | 1,824 | \$18,049,953.76 | TBD | TBD |
| Total | | 7,226 | \$72,394,025.49 | 1,732 | \$14,643,953.45 |

| Applicants Awarded | | | |
|--------------------|-------------------|---|---------------------------|
| Fiscal Year | Under-Represented | Speak a Language In Addition to English | Consumer or Family Member |
| 2008-09 | 71% | 68% | 29% |
| 2009-10 | 62% | 63% | 35% |
| 2010-11 | 72% | 59% | 35% |
| 2011-12 | 71% | 60% | 53% |
| 2012-13 | TBD | TBD | TBD |

12/3/2012



Mental Health Loan Assumption Program

From Fiscal Year 2008/2009 to Fiscal Year 2011/2012:

- 5,402 applications requesting \$54,344,071.73 were received and 1,732 individuals were awarded \$14,643,953.45
- Applications received increased from 43 to 55 counties
- 62% of applicants awarded spoke at least one language in addition to English
- Amount of applicants awarded increased by 130%
- The number of applicants awarded increased from 29% to 53% for mental health consumers or family members of mental health consumers

Fiscal Year 2012/2013:

- \$ 10 million dollars allocated for awards
- 1,824 applications requesting \$18,049,953.76 were received
- The final number of awards will be finalized by December 2012 and awardees notified in January 2013

12/3/2012



HEALTH PROFESSIONS
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CALIFORNIA DEPARTMENT OF
MENTAL HEALTH

Mental Health Loan Assumption Program 2011/2012 Cycle

Qualified Awardees may receive up to \$10,000 in educational loan repayments from the Mental Health Loan Assumption Program in exchange for working or volunteering 12 consecutive months in a hard-to-fill/retain position in the Public Mental Health System. Funded by Proposition 63, the Mental Health Services Act. For a copy of the application visit www.healthprofessions.ca.gov.

Eligible Professions include but are not limited to:

- Licensed Marriage & Family Therapists
 - Marriage & Family Therapist Interns
 - Licensed Clinical Social Workers
 - Associate Clinical Social Workers
 - Licensed Psychologists
 - Registered Psychologists
 - Postdoctoral Psychological Assistants
 - Postdoctoral Psychological Trainees
 - Licensed Psychiatrists
 - Registered Psychiatrists
 - Licensed Psychiatric Mental Health Nurse Practitioners
 - Certified Psychiatric Mental Health Nurse Practitioners
 - Registered Psychiatric Mental Health Nurse Practitioners
 - Peer Counselors
- Counties may determine if other professions fit their hard-to-fill/retain criteria



To be eligible to participate in the MHLAP, applicants must:

- Have valid legal presence and ability to work and provide care in the state of California, and
- Have no outstanding service obligation to an entity other than the Foundation, and
- Submit a complete application that is postmarked on or before December 10, 2011, and
- Be verified by the County Mental Health Director/Designee in applicant's county of employment, and
- Have a current, full, permanent, unencumbered, unrestricted health professional license, registration or waiver
- Have outstanding educational debt from a commercial or governmental lending institution, and
- Work or volunteer in the Public Mental Health System for a minimum of 20 hours per week

Contact the Health Professions Education Foundation at www.healthprofessions.ca.gov or (800) 773-1669

Application Postmark Deadline: December 10, 2011

Applications with required documents postmarked after 12/10/11 will not be reviewed. Faxes and emails will not be accepted.

This program is supported by funds secured from the MHSA in partnership with the California Department of Mental Health.



Mental Health Loan Assumption Program Contacts

Margarita Miranda, Program Officer
(916) 326-3696
margarita.miranda@oshpd.ca.gov

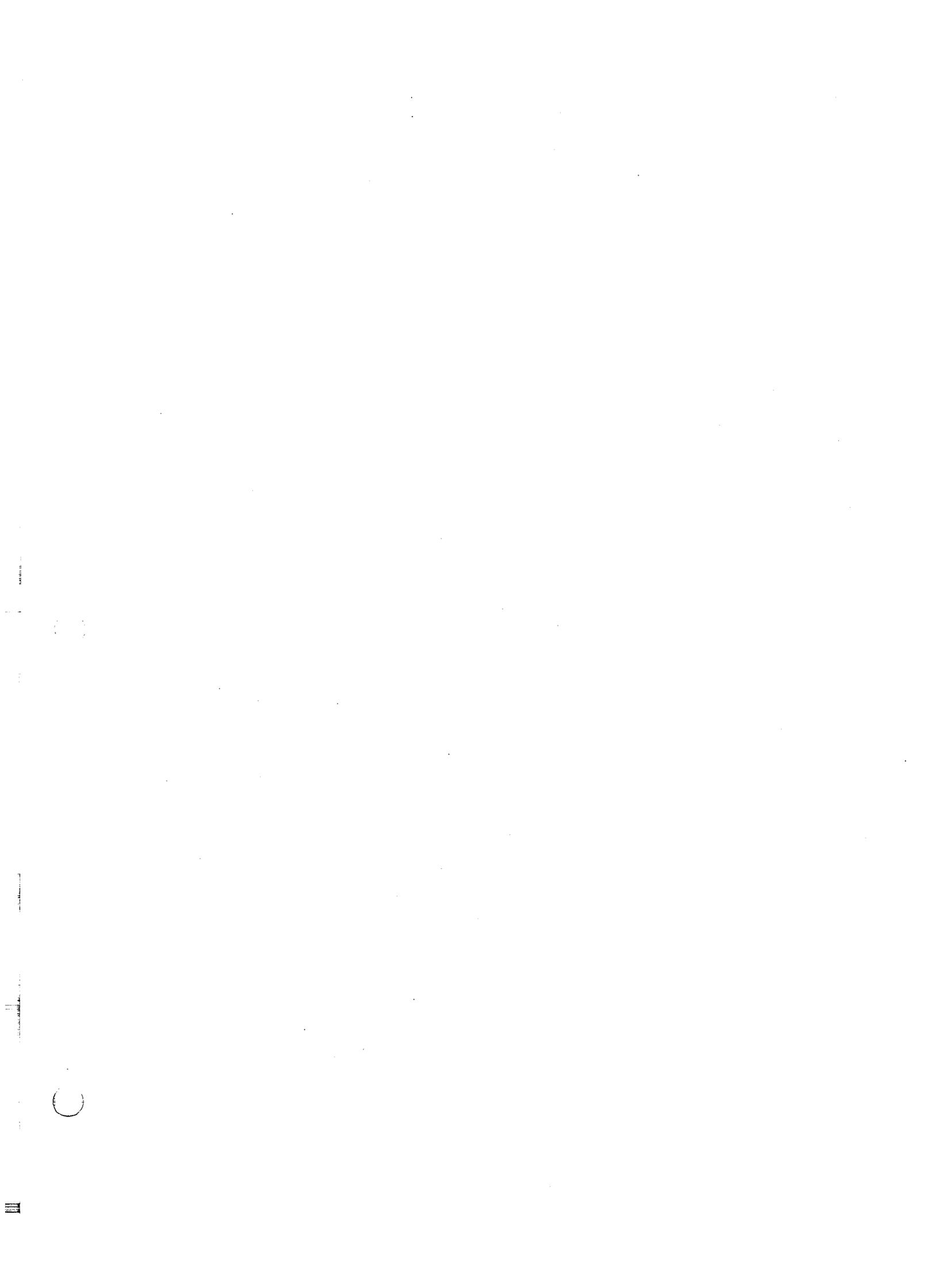
Brent Houser, Program Officer
(916) 326-3655
brent.houser@oshpd.ca.gov

Kulwinder Kaur, Program Officer
(916) 326-3644
kulwinder.kaur@oshpd.ca.gov

Linda Onstad-Adkins, Director of Programs Administration
(916) 326-3695
linda.onstad-adkins@oshpd.ca.gov

Health Professions Education Foundation
Office of Statewide Health Planning and Development
400 R Street, Sacramento, CA 95811

12/3/2012



CALIFORNIA EDUCATIONAL MFT STIPEND PROGRAM

The MFT Consortium of California advances the high quality of academic preparation and clinical training of students entering the marriage and family therapy profession. The overall objective of the MFT Consortium of California is to promote the adaptation of academic curriculum and the application of clinical training that best prepares its students for both private practice and public mental health service as licensed professionals. Schools with MFT graduate programs participate in their regional MFT Consortium; some regional consortia include as members agencies that provide practicum training to MFT students. There are eight regional MFT consortia with a total of 91 school members, which is 94% of the MFT graduate programs in the state. Participation in a regional consortium is voluntary and no fees are collected. Each consortium has a host school that schedules regular events using its own resources.

The California Educational MFT Stipend Program is funded through the Mental Health Services Act (MHSA) and its objective is to address the statewide workforce need for mental health practitioners in underserved communities.

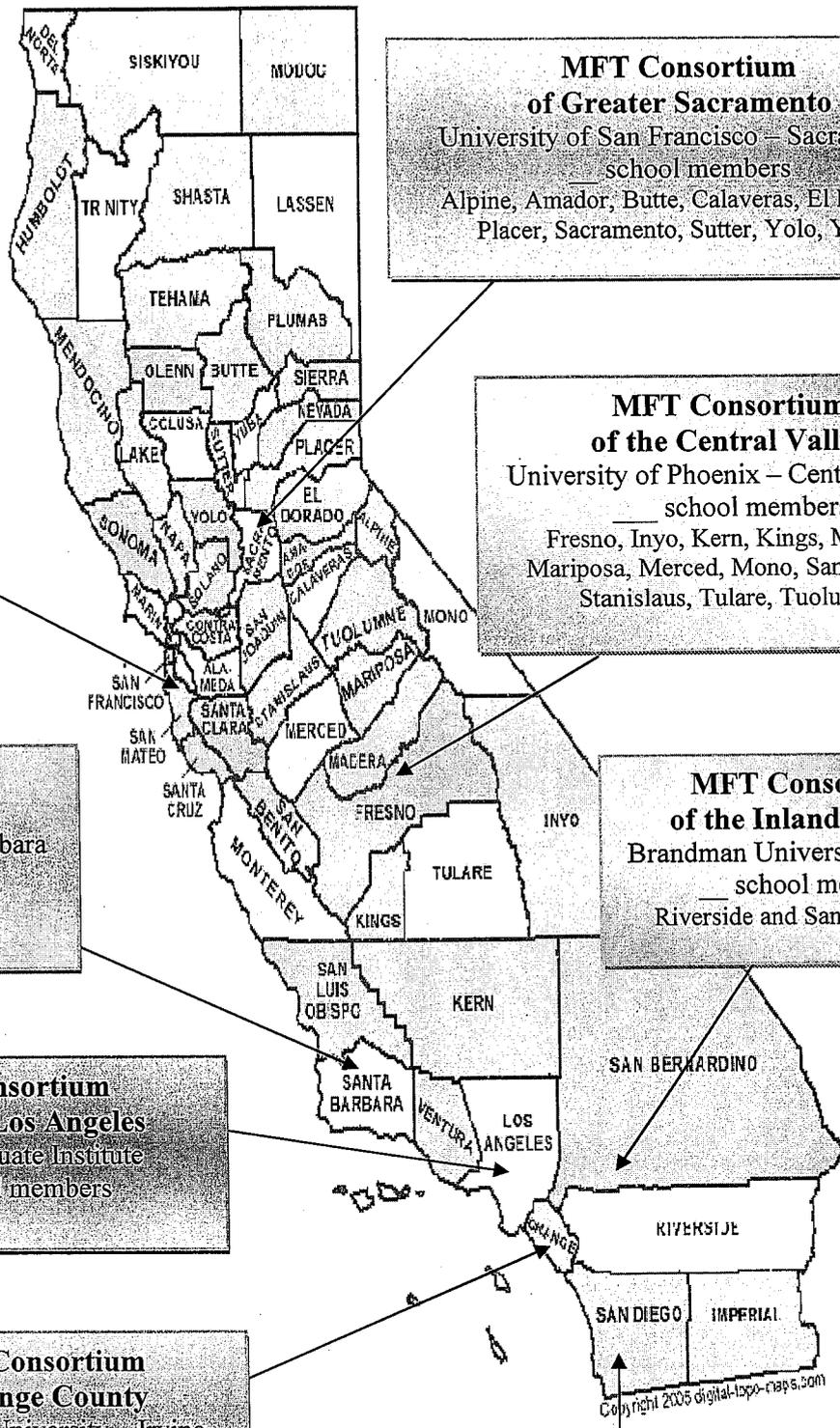
MHSA

The mission of the Mental Health Services Act, enacted in 2005, is to transform California's public mental health delivery; in part, with mental health professionals dedicated to community service and to the care of those living with mental illness, by inspiring hope in their recovery, focusing on their personal strengths, respecting their cultural perspectives and learning from their lived experiences as consumers.

The goal of the State's Educational MFT Stipend Program is threefold: 1. to recruit MFT graduates with the capacity to serve the culturally diverse needs of persons in mental health care, 2. to prepare recruited MFT graduates in the delivery of mental health services that promote wellness, recovery and resilience, and 3. to recruit into MFT academic programs individuals who have experience in the public mental health system as clients or family members of clients. The ultimate objective of the MFT educational stipend program is to promote public mental health as a career option for those entering the MFT profession. Towards that end, the stipend program promotes curriculum development in MFT graduate institutions that prepares MFT graduates for public mental health practice.

The MFT Leadership Collaborative, consisting of the host schools of the eight regional MFT Consortia and the Executive Directors of the MFT professional associations (CAMFT and AAMFT-CA), provides guidance and oversight on the effective implementation of the statewide stipend program. The stipend program has been administered by Phillips Graduate Institute (Chatsworth) since 2008 and has a stipend coordinator in each regional consortium that supports the schools' efforts to recruit, inform and advise their students on the stipend program. The coordinators conduct annual orientations to school representatives in preparation for stipend recruitment, assemble a Stipend Awards Council responsible for reviewing applications and selecting recipients, identify public mental health positions that fill the needs of the counties in their region, and monitor stipend recipients' compliance to their payback agreement. Through the partnership of the MFT Leadership Collaborative, the regional MFT Consortia and Phillips Graduate Institute the MFT Consortium of California is able to serve the workforce needs of 45 counties.

The MFT Consortium of California



MFT Consortium of the Bay Area
 California Institute of Integral Sciences
 ___ school members
 Alameda, Contra Costa, Humboldt, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma,

MFT Consortium of Greater Sacramento
 University of San Francisco – Sacramento
 ___ school members
 Alpine, Amador, Butte, Calaveras, El Dorado, Placer, Sacramento, Sutter, Yolo, Yuba

MFT Consortium of the Central Valley
 University of Phoenix – Central Valley
 ___ school members
 Fresno, Inyo, Kern, Kings, Madera, Mariposa, Merced, Mono, San Joaquin, Stanislaus, Tulare, Tuolumne

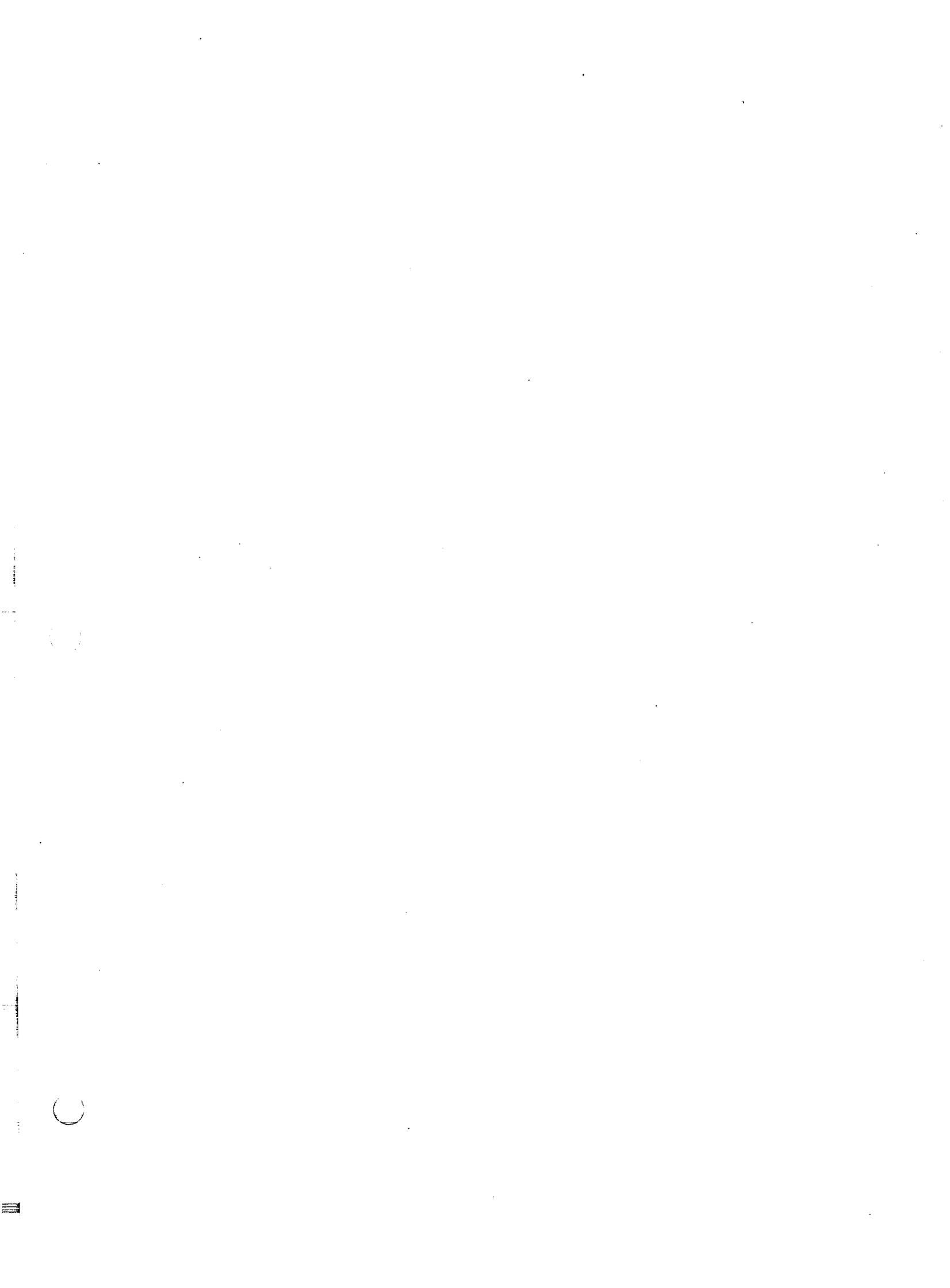
MFT Consortium of the Central Coast
 Antioch University – Santa Barbara
 3 school members
 San Luis Obispo, Santa Barbara, Ventura

MFT Consortium of the Inland Empire
 Brandman University – Ontario
 ___ school members
 Riverside and San Bernardino

MFT Consortium of Greater Los Angeles
 Phillips Graduate Institute
 ___ school members

MFT Consortium of Orange County
 Pepperdine University – Irvine
 ___ school members

MFT Consortium of San Diego and Imperial Counties
 University of Phoenix – San Diego
 ___ school members





MFT CONSORTIUM OF CALIFORNIA

The MFT Consortium of California (Consortium) in partnership with the California Association of Marriage and Family Therapists (CAMFT), the American Association for Marital and Family Therapy, California Division (AAMFT-CA), and Phillips Graduate Institute (Chatsworth) has effectively implemented and delivered since 2008 a statewide MFT Stipend Program under the workforce, education and training endeavors of the Mental Health Services Act (MHSA). The Consortium consists of eight regional MFT consortia that include as members the schools in its region with graduate programs in marriage and family therapy, and, in some regions, the agencies that provide practicum training to MFT students.

Here is a brief summary on the Consortium's advancements in its statewide recruitment of qualified MFT graduate students for public mental health practice. Under a state contract administered by Phillips Graduate Institute, the Consortium awarded 60 stipends in FY 2009-10 and FY 2010-11, and 84 stipends in FY 2011-12 and FY 2012-13.

1. Successes

- a. Increased the number of counties serviced by the Consortium and the statewide stipend program from 19 to 45
- b. Increased the number of MFT graduate programs recruiting students for the stipend program from 59 to 91
- c. Increased the number of annual applications by qualified MFT students for the statewide stipends from 281 to 530
- d. Assisted the schools in the implementation of an academic curriculum that promotes the values and principles of the MHSA and best prepares MFT students for public mental health practice

2. Outcomes

- a. Increased the number of students enrolled in MFT schools with previous employment in public mental health care
- b. Increased the number of stipend recipients with the lived experience as consumers or family members of mental health care
- c. Increased the number of stipend recipients with capacity to provide clinical services in a second language
- d. 92% of the FY 2009-10 and 2010-11 stipend recipients successfully completed one year of public mental health services as an MFT Intern
- e. Survey results indicate that 57% of the stipend recipients who completed payback obligation plan to continue to be employed in public mental health in the long term (5 or more years) and 40% plan to continue to be employed in public mental health service in the short term (2-3 years).

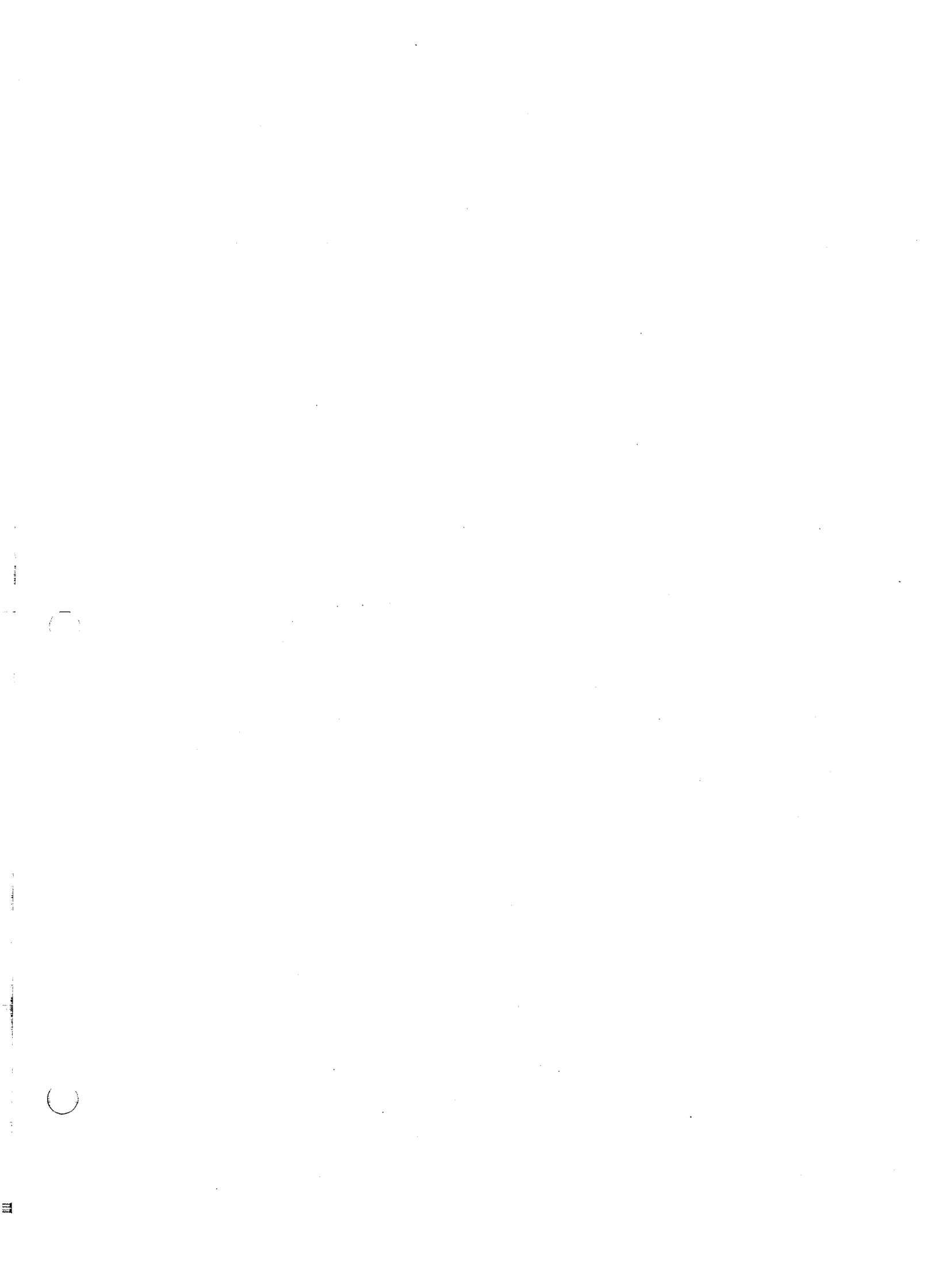
3. Challenges

- a. How to allocate the number of stipends awarded per region.
The MFT Leadership Collaborative* was instrumental in determining the number of stipends each region would award based on the following: the number of counties served by that region, the counties' workforce needs, poverty levels, and percentage of households primarily using a non-English language

- b. How to prepare the schools in the recruitment of its students.
In order to prepare the numerous schools in recruiting and informing their students on the stipend program and the application process, each regional consortium host school held annual Stipend Orientations for its educators. At least one representative from each school was required to attend the orientation.
 - c. How to verify that student-applicants were eligible.
In order to assure that students applying for the stipends were enrolled in the school, in good student standing and in their last year of graduate study, the application form required the signature of the school's stipend representative.
4. Lessons Learned
- a. The collaborative spirit of the MFT educators in sharing their best academic practices. This was evident when the schools prepared to amend their programs in compliance with a new curriculum that promote recovery, wellness and the instruction of those with the lived experience of mental illness. Through regional consortium meetings, AAMFT-CA sponsored Educators Forums, and planned workshops educators presented their curriculum plans, community mental health concentration programs and course syllabi.
 - b. The interest of MFT students in public mental health practice and community service. Although traditionally the MFT schools attracted students with career plans for private practice, the stipend program demonstrated that there is a large segment of MFT enrollees with considerable interest in public service, public justice and public care to those that most need it.
 - c. The considerable experience in community service and mental health care of those enrolled in the MFT programs. The applications submitted for the stipend program revealed how much previous experience and commitment these students had in public service.
5. Current 5-Yr Plan
- a. Consulting school members in the successful adaptation of the state licensing board's 60 unit curriculum that infuses the principles of the MHSA
 - b. Developing academic specialization and practicum training that best prepares students for integrated health care

*The MFT Leadership Collaborative consist of the host schools of the eight regional MFT Consortia, the Executive Directors of the MFT professional associations (CAMFT and AAMFT-CA), and Phillips Graduate Institute (Chatsworth), the administrator of the stipend program. The Collaborative has provided since 2008 guidance and oversight on the effective implementation of the statewide stipend program. Here are the eight regional consortia along with the host schools:

| | |
|---|---|
| MFT Consortium of Greater Sacramento | University of San Francisco, Sacramento |
| MFT Consortium of the Bay Area | California Institute for Integral Studies |
| MFT Consortium of the Central Valley | University of Phoenix, Fresno |
| MFT Consortium of the Central Coast | Antioch University, Santa Barbara |
| MFT Consortium of Greater Los Angeles | Phillips Graduate Institute |
| MFT Consortium of the Inland Empire | Brandman University, Ontario |
| MFT Consortium of Orange County | Pepperdine University, Irvine |
| MFT Consortium of San Diego/Imperial Counties | University of Phoenix, San Diego |



Public Psychology: A Competency Model for Professional Psychologists in Community Mental Health

Joyce P. Chu and Luli Emmons
Palo Alto University

Jorge Wong
Asian Americans for Community Involvement, San Jose,
California

Peter Goldblum, Robert Reiser, Alinne Z. Barrera,
and Jessica Byrd-Olmstead
Palo Alto University

Recent attention to gaps and inadequacies in U.S. community mental health systems has revived efforts to improve access and the quality of mental health care to underserved, diverse, rural, and seriously mentally ill populations. The importance of elements such as evidence-based practice importation, needs assessment and evaluation, and mental health care disparities in this effort calls for innovation and leadership from professional psychologists. Yet, psychologists have been diminishing in representation from public mental health settings, and there have been limited efforts to comprehensively define the competencies required of practice in the public psychology specialty. This article presents the unique functional and foundational competencies required of psychologists to lead a transformation in the public mental health system. These public psychology competencies provide a foundation for professional psychologists to meet the challenges of a changing public mental health services context and promulgate effective evidence-based community systems of care. With education and training efforts, exposure to the public psychology competencies established in this study can aid in the transition of more psychologists into the public sector.

Keywords: community mental health, public psychology, competencies, diversity, serious mental illness

Editor's Note. This is one of 8 accepted articles received in response to an open call for submissions on Opportunities Arising Out of Challenges in Professional Psychology.—MCR

JOYCE P. CHU received her PhD in clinical psychology from the University of Michigan. She is an assistant professor and the director of the Diversity and Community Mental Health program at Palo Alto University. Her areas of research and practice include Asian American mental health, suicide and depression in ethnic minority adult and geriatric populations, community mental health training, and the development of culturally congruent service options for underserved communities.

LULI EMMONS received her PhD in clinical psychology from the Pacific Graduate School of Psychology. She maintains an independent practice in Berkeley, CA and is an associate professor and vice president of the Office of Professional Development at Palo Alto University. Her professional interests include community mental health and professional psychology education and training.

JORGE WONG received his PhD in clinical psychology from the Pacific Graduate School of Psychology. He is the director of Behavioral Health Services at Asian Americans for Community Involvement (AACI) in San Jose, CA. His professional interests include ethnic minority health, policy development, leadership, advocacy, healthcare compliance, and ethics. He serves on numerous oversight and policy development committees at the county and state level.

PETER GOLDBLUM received his PhD in clinical psychology from the Pacific Graduate School of Psychology. He is a professor, the director of the Center for LGBTQ Evidence-Based Applied Research (CLEAR), and the director of the LGBTQ program at Palo Alto University. His areas of research and practice include gay men's health, sexual minority suicide,

development of clinical measures of sexual minority stress, and psychological health of older sexual minority adults.

ROBERT REISER received his PhD in clinical psychology from the Pacific Graduate School of Psychology. He maintains an independent practice and is an associate professor and the director of the Kurt and Barbara Gronowski Psychology Clinic at Palo Alto University. His areas of research and practice include developing and transporting evidence-based treatments into real-world practice settings, cognitive-behavioral therapy, evidence-based supervision, and the treatment of bipolar disorder in community mental health settings.

ALINNE Z. BARRERA received her PhD in clinical psychology from the University of Colorado, Boulder. She is an assistant professor at Palo Alto University. Her areas of research and practice include immigrant, Spanish-speaking individuals with mood disorders and designing and testing depression programs for underserved populations.

JESSICA BYRD-OLMSTEAD is currently a doctoral candidate and will receive her PhD in clinical psychology from Palo Alto University in 2012. Her areas of practice and research include substance use disorders, forensic assessment, adolescent mental health, and public policy.

THIS PAPER WAS SUPPORTED in part by California's Department of Mental Health Mental Health Services Act, Proposition 63. We are grateful to Larry Beutler, PhD, Carol Kerr, PhD, and Lou Moffett, PhD, who played essential roles in developing these training competencies. We also thank William Froming, PhD and Allen Calvin, PhD for their leadership at Palo Alto University in supporting the Diversity and Community Mental Health Emphasis Area.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Joyce Chu, Palo Alto University, 1791 Arastradero Road, Palo Alto, CA 94304. E-mail: jchu@paloalto.edu

The President's New Freedom Commission on Mental Health (2003) uncovered abundant gaps and inadequacies in the United States community mental health (CMH)¹ systems, and proposed a strategy to improve the quality of mental health care. With their unique combination of expertise in research/analytical skills, clinical skills, and teaching/training, professional psychologists are poised to rise to these challenges of the changing public mental health context with innovation and leadership (Reddy, Spaulding, Jansen, Menditto, & Pickett, 2010; Roe, Yanos, & Lysaker, 2006). Yet, psychologists are currently underrepresented in CMH settings (Levant et al., 2001; Reddy et al., 2010; Roe et al., 2006; Shore, 1992), highlighting a need to train and recruit psychologists for work in the public sector where a majority of the nation's mentally ill are served. A comprehensive definition of the competencies required for practice in the public psychology specialty is needed to create a foundation for practitioners interested in working in public psychology and for education and training endeavors. Limited efforts to delineate public psychology competencies currently exist.

This article defines the unique competencies required of psychologists to work and lead a transformation in the public mental health system. These competencies delineate public psychology as a specialty of professional psychology with distinct roles and responsibilities, and will be beneficial for psychologists interested in serving underserved diverse communities with mental illness in the public mental health field.

Public Psychology: A Description and Need for Defined Competencies

The CMH movement of the 1950s through '80s signified a transition in the United States from an institution- to community-based public mental health system where the nation's most chronically mentally ill, indigent, and culturally diverse populations would be served (Pollack & Feldman, 2003; Stockdill, 2005). The professional psychologists that spearheaded the CMH movement became known as public psychologists. Public psychology has been defined as a derivation of community psychology (Imber, Young, & Froman, 1978) or of public health (Zimet & Harding, 1993), and typically refers to mental health services of the publicly funded sector rendered in a variety of settings including community, county, and state hospitals and clinics, correctional settings, and other social service organizations. Public psychology refers to the professional practice of school, counseling, and clinical psychology with some of the most seriously mentally ill, indigent, and marginalized individuals in society. The complex needs and challenging environments of underserved communities require public psychologists to serve in multiple roles, from administrator in a county-contracted CMH center to researcher performing community program evaluations.

Out of the CMH movement, public psychology gained ground as a distinctive and legitimate subfield of professional psychology. Yet, a search of the current literature yields no comprehensive definition of public psychology, nor does the American Psychological Association (APA) recognize public psychology as a distinct specialty (APA, 2011). APA defines a specialty as

a defined area of psychological practice which requires advanced knowledge and skills acquired through an organized sequence of

education and training. The advanced knowledge and skills specific to a specialty are obtained subsequent to the acquisition of core scientific and professional foundations in psychology (APA, 2008).

The development of a public psychology specialty would require several steps: the organization of interested psychologists into advocacy groups to promote the specialty within professional psychology and the larger mental health establishments, recognition of the specialty by accrediting organizations, and recruitment of existing psychologists and students into the specialty. The definition of distinct competencies of public psychology is an important and arguably foundational first step in its recognition as a specialty. Currently, there have been few efforts to delineate such competencies.

Without circumscribed public psychology competencies, many psychologists have not been formally trained for CMH careers and therefore have not systematically acquired the competencies needed to practice or play leadership roles in the public sector. For example, research indicates that psychologists in CMH typically acquire leadership skills "on-the-job," which can lead to variability in job performance or qualifications (Perlman & Hartman, 1987). Other investigators have identified a lack of formal training programs in CMH- or serious mental illness-related careers (Reddy et al., 2010; Roe et al., 2006). Scholars have argued that increased exposure to key competencies at early stages of professional training will ease and encourage the transition to related roles as students choose their career paths (e.g., Clements, 1992). Indeed, research in organizational psychology has found that exposure and previous experience with a concept both increase openness to change and increase the likelihood that such change will be adopted (e.g., Axtell et al., 2002). As such, the absence of a defined set or formal training around public psychology competencies has contributed to declining representation of psychologists in the public sector since the 1960s.

Psychology's Decline of Representation in Public Psychology

In 1960, approximately half of all psychologists worked in CMH clinics and hospitals (Norcross, Karpiak, & Santoro, 2005). In contrast, current data indicate that professional psychologists are underrepresented in the public sector (Levant et al., 2001; Reddy et al., 2010; Roe et al., 2006; Shore, 1992). APA's, 2010 demographics showed that only .3% of Division 12 (clinical psychology), .7% of Division 17 (counseling psychology), and .1% of Division 16 (school psychologists) associates, members, and fellows identified as community psychologists (APA Center for Workforce Studies, 2010). A 2002 survey by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that less than 15% of psychologists practice in CMH clinics and hospitals. Moreover, even though public sector psychologists are more likely to assume leadership than front-line clinician roles (Reddy et al., 2010; Wall, 1984), most leaders in the public sector are not psychologists. In a search of the National Association of State Mental Health Program Directors' 740 mem-

¹ This manuscript utilizes the terms public psychology, public sector psychology, community mental health, and public mental health interchangeably.

bers holding leadership positions in public mental health, only 5% were psychologists (NASMHPD, 2011).

As psychologists have been declining in public mental health representation, the CMH service context has been changing rapidly, contending with such issues as shrinking funding sources, shifts in treatment philosophies and models, and pressures for evidence-based program outcomes. The general competencies of professional psychology do not prioritize many of the key skills and knowledge base needed to keep pace with these changes. Yet, with training and increased attention to the competencies required for service and leadership in public mental health, psychologists can employ their combination of analytical, training, and clinical skills to rise to the new CMH challenges and establish areas in which psychologists provide unique "value added" to the system. The changing public sector context presents an exciting time of both challenge and opportunity, and professional psychology's response will determine its role in the future of services for a majority of the nation's diverse, marginalized, and seriously or chronically mentally ill population.

The Present Study

Despite a clear opportunity and need for professional psychology leadership, a lack of clearly defined public psychology competencies has posed barriers for professional psychologists whose interests may align with public mental health. The purpose of this article is to define the distinct competencies of public psychology as an important step in establishing a renewed need for professional psychologists in community mental health.

In 2005, Rodolfa and colleagues established the Cube Model, a three-dimensional conceptual framework defining competency domains expected of professional psychologists in a particular area of practice. Within Rodolfa's competency framework, foundational competencies are the building blocks of the activities of public psychologists, and therefore represent the foundational knowledge, skills, and attitudes of CMH. Foundational competencies create the underpinnings for functional competencies, or the multiple roles and areas of professional functioning that psychologists assume in CMH settings (Rodolfa et al., 2005). The third dimension establishes that foundational and functional competencies are attained and maintained throughout multiple stages of career development (doctoral education, internship/residency, postdoctoral supervision, residency/fellowship, and continuing competency). The public psychology competencies developed in this article describe the functional and foundational competencies that establish a conceptual framework for training and the practice of professional psychology in CMH. These public psychology competencies intersect with stages of professional development and are mapped onto an adapted version of Rodolfa's Cube Model in Figure 1.

Methods

Phase 1: Identification of Competencies via Literature Analysis With Expert Consultation

To identify the unique competencies of public psychology that supplement the general competencies of professional psychology, several sources of information were consulted and synthesized. A comprehensive literature review of CMH-related articles, public

health and community psychology textbooks, and web-based searches of the services currently offered in CMH organizations were conducted to create an initial list of 14 unique foundational competencies and six functional competencies (described later in this article) required of professional psychology in the public sector. This list was then reviewed by a team of five psychologists who have CMH work experience, to both expand and refine an initial list of public psychology competencies.

Phase 2: Prioritization and Refinement of Competencies via Stakeholder Input

Participants and Procedures

The aim of the second study phase was to create a final list of public psychology competencies truly representative of stakeholder expertise in CMH. Professional psychologists with public sector work experience were surveyed for feedback via online questionnaires assessing the importance of the initial list of foundational and functional competencies. Stakeholder feedback informed further refinement and prioritization of the competencies identified in the first phase of the study. Competencies rated as important for public psychology work were retained in the final list of competencies. Feedback was also used to refine descriptions and definitions of each competency and identify any missing from the initial list.

Inclusion criteria for survey participants included identification as a professional psychologist (including clinical, counseling, and school psychologists) and having work experience in a CMH setting. Respondents included 73 psychologists with an average age of 44.65 (standard deviation [*SD*] = 11.47) years and 11.69 (*SD* = 9.84) years of CMH work experience. Participants reported having worked in a variety of CMH settings (76.71% in nonprofit community-based organizations, 54.79% in county mental health organizations, 34.24% in county hospitals) in a number of different roles or capacities (95.89% as clinicians, 64.38% as supervisors, 53.42% as administrators, 38.36% as consultants or trainers, 30.14% as researchers, 17.81% as policy advocates). The sample was 65.75% female and 34.25% male and included 47.95% Caucasian, 35.62% Asian American, 9.59% Latino/a, 5.48% mixed race, and 1.37% African American individuals.

Measures

A questionnaire was developed to assess respondents' ratings of how important the 14 foundational and six functional competencies are to work by professional psychologists in CMH settings. Functional competency items asked "How important is it for public sector/community mental health psychologists to be able to serve in the role [of a particular functional competency]?" Foundational competency questionnaire items listed the name and a brief description of each competency and asked "In the variety of roles that psychologists may hold in community mental health, how important is it for them to know the following competencies or functions?" All items were rated on a 6-point Likert scale with 1 = *very unimportant* to 6 = *very important*. Respondents were also asked to describe "any other competencies you believe are important for public sector psychologists to know."

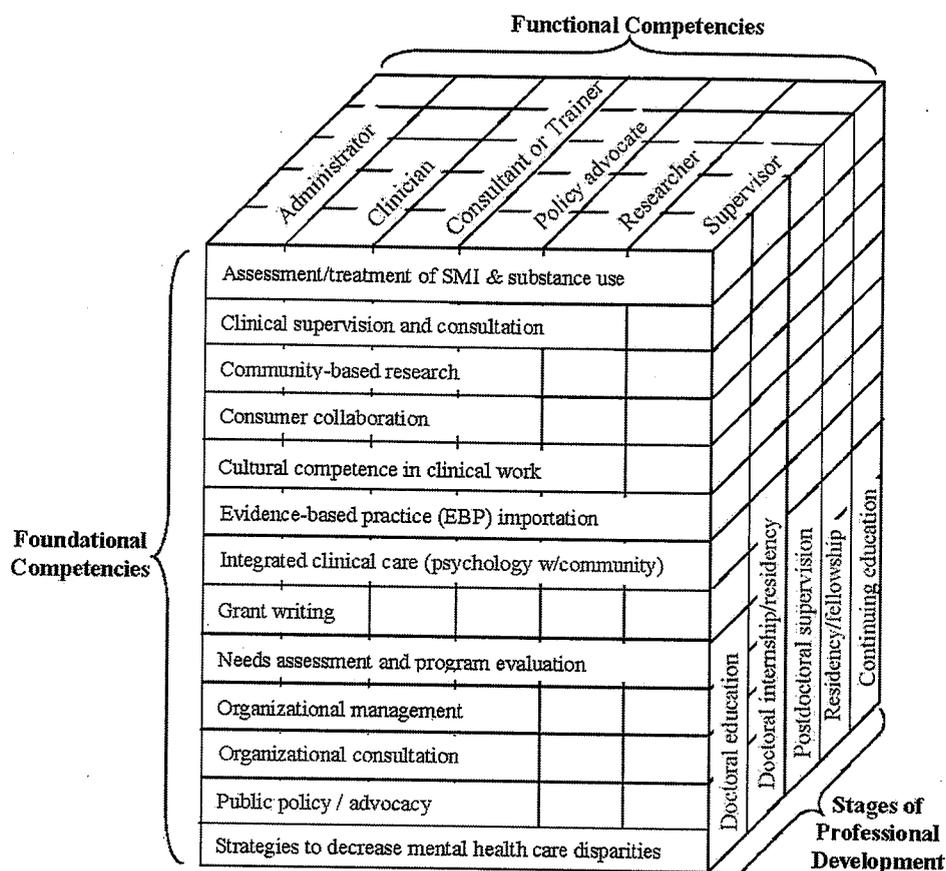


Figure 1. Intersecting competencies of public psychology. Note: Adapted from Rodolfa et al.'s (2005, p. 350) Cube Model for general professional psychology competencies.

Results: The Foundational Competencies of Public Psychology

Survey results indicated that the foundational competencies developed via literature review with expert consultation were well-identified, with all 14 foundational competencies yielding average ratings of 4.75 = important, or higher (see Table 1 for all competency ratings). There were no additional competencies identified by respondents that were not already encompassed by the original list. These final 14 foundational public psychology competencies are listed in Table 1 and defined and described below. For expediency, descriptions of competencies related to similar overarching themes are combined in the ensuing discussion.

Evidence-Based Practice (EBP) Importation

In the late 1990s, professional psychology began to emphasize evidence-based practices (EBPs) tested in controlled settings (e.g., Chambless & Hollon, 1998). Though many of these EBPs show promising efficacy data, they have not been well-integrated into the public sector where provision of EBPs is lacking and culture change toward adoption has been slow (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009; Frueh, Grubaugh, Cusack, & Elhai, 2009; Stahmer & Aarons, 2009). Consequently, one major short-

coming of mental health care in America is that most people do not access or benefit from empirically tested psychological treatments (President's New Freedom Commission on Mental Health, 2003). Given that approximately 58% of U. S. mental health services are funded publicly (Mark et al., 2007), increasing access to effective treatments in the public sector can be viewed as a national priority. In fact, two stated goals of the 2003 Commission are to disseminate EBPs utilizing public/private partnerships to steer implementation and to expand the number of clinicians available and able to provide EBPs.

With their analytical, clinical, and training skills, professional psychologists are poised to meet the challenges of EBP implementation. For example, the nascent yet rapidly developing science of translational research can guide efforts to effectively transport EBPs from experimental into community-based settings (Aarons et al., 2009; Stirman et al., 2010). Typically, professional psychologists are at the forefront of this research and are among the few practitioners trained in EBPs. Psychologists can then employ their teaching skills to train the public sector workforce in these treatments (Roe et al., 2006).

The foundational competency of EBP importation includes being able to transport, train, and implement EBPs into CMH settings while responding to the challenges of importation. Such challenges

Table 1
Foundational and Functional Competencies of Public Psychology: Ratings of Importance to Community Mental Health Work (N = 73)

| | <i>M</i> | <i>SD</i> |
|--|----------|-----------|
| Foundational competencies | | |
| Cultural competence in clinical work | 5.81 | .70 |
| Integration of traditional psychology with community clinical care | 5.68 | .72 |
| Assessment/treatment of serious mental illness | 5.64 | .56 |
| Clinical supervision and consultation | 5.60 | .79 |
| Assessment/treatment of substance use disorders/dual diagnosis | 5.58 | .60 |
| Strategies to decrease mental health care disparities | 5.52 | .71 |
| Consumer collaboration | 5.27 | .90 |
| Needs assessment and program evaluation | 5.22 | .82 |
| Public policy/advocacy | 5.17 | .86 |
| Organizational management | 5.11 | .79 |
| Evidence-based practice importation | 5.11 | 1.09 |
| Community-based research | 4.90 | .95 |
| Organizational consultation | 4.82 | .96 |
| Grant writing | 4.75 | 1.01 |
| Functional competencies | | |
| Supervisor | 5.64 | .56 |
| Clinician (direct service) | 5.63 | .77 |
| Administrator (program manager, director, or other) | 5.49 | .78 |
| Policy advocate | 5.30 | .81 |
| Consultant or trainer | 5.23 | .95 |
| Researcher (including program evaluator and grant writer) | 5.21 | .94 |

Note. All competency items were rated on a 6-point Likert scale with 1 = very unimportant, 2 = unimportant, 3 = somewhat unimportant, 4 = somewhat important, 5 = important, and 6 = very important. Competencies are listed in order of rated importance from most to least important.

may include negotiating multiple stakeholder perspectives, resistance to change, lack of community buy-in, or insufficient infrastructure to support training and outcome tracking.

Integration of Traditional Psychology With Community-Based Clinical Care

Professional psychology has traditionally focused on individual psychotherapies like psychodynamic, cognitive-behavioral, and client-centered treatments, whereas CMH has moved toward system-, strength-, consumer-, or recovery-based practice orientations (e.g., Doughty, Tse, Duncan, & McIntyre, 2008; Frese & Davis, 1997; Onken, Craig, Ridgway, Ralph, & Cook, 2007). These departures in emphasis have widened the gap between treatments professional psychologists are trained to provide versus practices utilized in the public sector. Recently, many community approaches to care such as Assertive Community Treatment, systems-oriented approaches, or consumer-collaborative care have had a growing base of evidence suggesting their utility and effectiveness in public mental health settings (e.g., Bronfenbrenner, 2005; DeLuca et al., 2008; Frese & Davis, 1997).

As such, knowledge and skill in community-based practices are important for public psychologists providing clinical services or training, to effectively bridge the gap between traditional psychology and community approaches to care. Consistent with wellness and recovery community movements which emphasize working equally with and empowering clients (Onken et al., 2007), con-

sumer collaboration is a key component to integrated psychology/community care. Consumer collaboration requires that one possesses a collaborative attitude and values client input in shaping the direction of research and clinical services.

The foundational competency of integrated traditional with community-based clinical care involves applying and integrating community-based treatment approaches (e.g., systems, wellness and recovery, empowerment, consumer-based approaches, strengths-based, or wraparound) with more traditional psychology approaches (e.g., cognitive-behavioral therapy, psychodynamic, or client-centered) to enhance treatment efficacy with effectiveness in the community. Such integrated care may involve negotiating community referrals and resources and working with interdisciplinary teams. The foundational competency of consumer collaboration is an essential component of integrated care and includes being able to understand, address, and respond to the needs of multiple stakeholders in the community mental health system (e.g., clinicians, managers, administrators, clients, and family members).

Cultural Competence and Strategies to Decrease Mental Health Care Disparities

A formidable challenge in CMH comes from the need to eliminate mental health care disparities for underserved communities including ethnic and sexual minorities, refugees, immigrants, rural communities, older adults, individuals with disability, indigent communities, and individuals with limited English proficiency. Seminal reports by the U.S. Department of Health and Human Services (2001), the President's New Freedom Commission on Mental Health (2003), and Healthy People 2020 (Office of Disease Prevention & Health Promotion, 2010) confirm disproportionate access to mental health care for ethnic minorities in the United States, establishing the reduction of mental health care disparities as a national priority. Given that ethnic minorities are overrepresented in low-income, vulnerable populations, the mission to eliminate disparities is situated largely in the public sector (U.S. DHHS, 2001).

With the diversity of client populations in public mental health, cultural competence in clinical work is of paramount importance for CMH work and is defined as the ability to integrate cultural competence and diversity (including the need for language-matched services) into case formulations and treatments. Recruitment of public psychologists representative of the diverse communities and language proficiencies served in the public sector may also help in fulfilling the needs of culturally competent care.

Beyond cultural competence within the provider/client relationship, cultural competence on a larger community or organizational level is needed to ameliorate the problem of disparities in underserved communities. For example, reduction of mental health care disparities requires skills in community outreach, engagement, and stigma reduction (Corrigan, 2004; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007). The foundational competency of strategies to decrease mental health care disparities involves the ability to develop and implement innovative solutions to work with/engage underserved communities and reduce disparities.

Organizational or Systems Change

In its attention to inadequacies in the U.S. CMH system, the 2003 Commission on Mental Health called for a transformed system of care, identifying the fragmented mental health service delivery system as a major obstacle to adequate care for individuals with mental illness. Care systems are often disjointed with clients given palliative or acute crisis care without adequate preventive or maintenance treatment to avert relapse. In addition, many systems are not interconnected or able to provide the type of coordinated care needed to transition individuals with serious mental illnesses back into the community and eventually to recovery (President's New Freedom Commission on Mental Health, 2003).

System transformation requires the foundational competencies of needs assessment and program evaluation to identify needs in the community, inform service priorities, and collect and use outcome data to improve programs and analyze change (Cohen, Adams, Dougherty, Clark, & Taylor, 2007; Whealin & Ruzek, 2008). Professional psychologists are distinctly qualified with clinical and analytical skills to investigate systems based on identifiable clinical outcomes and to provide leadership to implement recommendations for improvement (Reddy et al., 2010).

Psychologists can also undertake administrative and managerial roles that are responsible for systems-level change in the public sector (Perلمان & Hartman, 1987). In fact, as reimbursement structures change with direct clinical services increasingly provided by Masters-level clinicians, psychologists are increasingly asked to fill managerial, consultation, or administrative roles (Clements, 1992; Kilburg, 1984). The public psychology foundational competency of organizational management is defined as knowing principles essential to program administration and operations of a community mental health organization (including program development, management, and improvement, medical records, billing, funding, awareness of legislative or fiscal initiatives, hiring personnel, providing leadership and guidance, etc.). The foundational competency of organizational consultation, on the other hand, involves the application of consultation strategies to advise organizations on ways to improve their structure and systems. Such consultation work often involves managing the cultural differences within CMH systems including differences between mental health and substance abuse providers, "guild" concerns, and cultural differences in terms of power, privilege, and status.

It is becoming increasingly common for public psychologists in leadership roles to search for and obtain funding to sustain core clinical services or develop innovative programs. Such requests for funding involve dual functions of: 1) the foundational competency of grant writing, to justify the need for funding, and 2) the foundational competency of community-based research to provide evidence that mental health services are successfully treating clients and meeting community needs. Contrary to more traditional experimental and quantitative research methods, community-based research often involves knowledge of research methods appropriate to and feasible in community settings such as qualitative, mixed methods, community-collaborative, participatory action, or community-based participatory research (Altman, 1995; Davidson, Stayner, Lambert, Smith, & Sledge, 1997; Orford, 2008).

Public Policy/Advocacy

In changing economic times, the landscape of public mental health shifts rapidly. For example, from the original formation of federally-funded Community Mental Health Centers in the 1960s to the Mental Health Systems Act of 1980, funding changed from federal funding to state block grants which increased competition for funds at local levels and contributed to the withdrawal of many mental health professionals from the public sector (Shore, 1992). Currently, most public programs are contending with formidable budget cuts that are reshaping the provision of CMH services (Hodgkins & Karpman, 2010).

Amid these changes, psychologists can play influential roles in public health policymaking to ensure that service priorities are met and professional psychologists maintain roles in the evolving CMH context (e.g., Hinrichsen, 2010; Holtgrave, Doll, & Harrison, 1997). For example, advocacy and public policy knowledge is needed to affect system-wide change on issues such as mental health parity or health care reform for underinsured individuals (Lating, Barnett, & Horowitz, 2010; Levant et al., 2001). In an environment where only 6% or fewer professional psychologists providing direct clinical services are employed in CMH centers or public hospitals (Finno, Michalski, Hart, Wicherski, & Kohout, 2010), public policy/advocacy is needed to ensure that psychologists remain eligible as providers of clinical services under public health plans like Medicare or Medicaid. These unique competencies are not included in core elements of professional psychology training in its current state. The foundational public psychology competency of public policy/advocacy involves applying principles of advocacy and social justice to assure future sustainability of service programs for people with mental illness, and advocating for policy-related issues through local and national organizations.

Other Clinical Care Issues

The clinical issues of serious mental illness (including severe and disabling psychotic and mood disorders) and substance use disorders are particularly common among public mental health clientele. National U.S. data indicate that of four million people 12 or older who received treatment for a substance problem in 2008, 1.8 million—almost 50%—received treatment in state-funded facilities (SAMHSA, 2009; SAMHSA Office of Applied studies, 2010). Additionally, following deinstitutionalization in the 1950s and 1960s, CMH became charged with caring for a majority of the nation's seriously mentally ill (Shore, 1992; Smith, Schwebel, Dunn, & Mclever, 1993), and most people with serious mental illness are now treated in the public sector (Roe et al., 2006). In fact, in a current climate of limited funding, many public sector agencies have had to prioritize treating only clientele with the most severe psychopathology—that of serious mental illness (SMI).

Many of the stated inadequacies and gaps in the U.S. public mental health system pertain to individuals with SMI and substance use disorders. The treatment of SMI in the United States in particular has been discussed as inadequate and a public health problem. One epidemiological study found that only 38.9% of treatments for serious mental illness were minimally adequate, equaling only 15.3% of all individuals with SMI receiving minimally adequate treatment (Wang, Demler, & Kessler, 2002). Clearly, psychologists can play a crucial role in improving care for substance use disorders and SMI in the United States.

The foundational competency of assessment/treatment of SMI includes providing evidence-based treatments for SMI amid challenges of providing effective and continuous care for these clinical issues. The foundational competency of assessment/treatment of substance use disorders involves screening and treating co-occurring mental illness and substance use disorders in collaboration with community settings and consumer-led support groups.

A final clinical care issue foundational to public psychology is that of clinical supervision and consultation. Just as professional psychologists are increasingly filling managerial or administrative roles, they also assume the leadership roles of clinical supervisor or consultant. Indeed, CMH organizations are common training sites for practicum or internship students; 35% (241 out of 682 total) of North American psychology internship training programs accredited by the Association of Psychology Postdoctoral and Internship Centers (APPIC) in 2011 are situated in CMH centers or public hospitals. These trainees are supervised by psychologists employed at their public mental health training sites; yet, the theoretical and technical underpinnings of supervision are not a standard component of general professional psychology training. Many public psychologists learn to supervise on-the-job or through optional continuing education coursework. Thus, the foundational public psychology competency of clinical supervision and consultation is defined as supervision and provision of clinical consultation to clinical trainees utilizing theoretical and applied supervisory techniques.

Results: The Functional Competencies of Public Psychology

Survey results indicated that the functional competencies developed via literature review with expert consultation in the first study phase were well-identified, with all six functional competencies of public psychology yielding average ratings of 5 = important or higher (see Table 1). These final six functional public psychology competencies include a) administrator (program manager, director, or other), b) clinician (direct service), c) consultant or trainer, d) policy advocate, e) researcher (including program evaluator and grant writer), and f) supervisor.

As depicted in Figure 1's Cube Model for professional psychology competencies, foundational and functional competencies intersect and overlap such that any one foundational competency may be required of more than one public psychologist functional role. Table 2 identifies the specific functional competencies that intersect with each foundational competency. Examples are provided of each functional competency to further clarify how the foundational competencies might be implemented in CMH organizations or training and education programs.

Implications for Professional Psychologists

This article established the foundational and functional competencies of public psychology, mapped onto the conceptual framework defined by Rodolfa et al.'s (2005) Cube Model for general professional psychology competencies (see Figure 1). The delineation of public psychology competencies makes a clear argument for public psychology as a subfield of professional psychology with distinct roles and responsibilities. With approximately 58% of all mental health services in the United States funded in the public

sector (Mark et al., 2007), community mental health is a prominent and mainstream area of practice for mental health professionals. Additionally, the growing demand for services responsive to the nation's seriously mentally ill and diversifying communities, along with an increased focus on data-driven treatments and programs, ensure that a need for the public psychology specialty will be ongoing.

Within the past 20 years, public mental health services have evolved to keep pace with changes such as funding mechanism alterations (e.g., managed care), a movement toward integrated care (e.g., integrated mental health with health or substance abuse services), and increased emphasis on recovery-oriented services. Yet, since the CMH movement of the 1960s, more psychologists have moved away from public sector settings and have chosen instead to provide services in private independent practice, counseling centers, or private hospitals (Finno et al., 2010). With decreased psychology representation in public mental health, current CMH organizations are not fully aware of the spectrum of skills psychologists have to offer and therefore do not routinely look to psychologists to fulfill their needs.

The changing CMH context holds both opportunities and challenges for psychologists in the public sector. Professional psychologists need to familiarize themselves with the changes that have occurred in public mental health and also apply their distinct clinical, analytical, and training skills to assume leadership roles in system transformation. The standardization and definition of public psychology competencies advances the establishment of psychologists as qualified professionals to provide the type of leadership, consulting, supervision, direct service, research, or advocacy needed by CMH organizations dealing with new public sector challenges. Subsequently, individual practitioners can utilize the public psychology competencies as a foundation to frame their unique qualifications for specific roles in CMH, and to serve as a springboard for acquisition of skills that will increase their marketability and qualifications for CMH clinical work and leadership positions. In fact, experts in the field have previously brought attention to the natural leadership potential of psychologists, calling for psychology to rise to the challenges of an evolving public sector environment. In 2005, the APA president Dr. Ronald Levant wrote that

it is important that psychology embrace the recovery model and participate fully in the transformation of the mental health system. I would even go so far as to suggest that this is an initiative that psychology is uniquely qualified to lead (Levant, 2005, p. 5).

As recognition of public psychology as a specialty within psychology spreads, we argue that exposure to the public psychology competencies established in this study will aid in the transition of more psychologists into the public sector. Increased visibility of career paths in CMH (whether through coursework, practicum training, or continuing education) will prompt students and professionals to see public sector organizations as logical and viable settings for their careers. Their desire to shape the services and systems of public mental health as leaders in the field may also grow. Indeed, exposure to training and competencies in the general professional psychology field has led to subsequent growth and mainstreaming of areas such as neuropsychology, assessment, or health psychology—areas formerly considered highly specialized,

Table 2

Examples of the Application of Foundational Competencies of Public Psychology Across Different Functional Roles

| Functional role or competency | Applied example of foundational competency |
|-------------------------------|--|
| | Assessment and treatment of serious mental illness and substance use disorders |
| Clinician | Provide evidence-based treatments for serious mental illness |
| Supervisor | Screen and treat co-occurring mental illness and substance use disorders in collaboration with consumer groups Provide clinical supervision for serious mental illness and substance use disorder assessment and treatment |
| | Community-based research |
| Administrator | Use research to inform organizational change and service improvement |
| Clinician | Apply research findings to inform effective treatments for clients |
| Consultant or trainer | Design and implement community-based research for an organization |
| Policy advocate | Use research to leverage policy change or advocacy for an organization |
| Researcher | Design and implement research in CMH organizations to inform service improvement, or to write grants to obtain funding |
| | Consumer collaboration |
| Administrator | Incorporate consumer and recovery perspectives into program structure |
| Clinician | Work with consumers to tailor clinical care |
| Consultant or trainer | Respond to stakeholder needs when providing consultation or training |
| Policy advocate | Work with consumers to tailor policy/advocacy efforts to their needs |
| Researcher | Incorporate stakeholder input into community-based research methods |
| Supervisor | Supervise trainees to work with consumers in tailoring clinical care |
| | Cultural competence in clinical work |
| Administrator | Support cultural competence trainings and service needs |
| Clinician | Recruit clinicians with proficiencies in clients' primary languages Integrate cultural competence into case formulations and treatments Provide treatments in client's preferred language |
| Consultant or trainer | Integrate cultural competence and diversity needs in all trainings |
| Policy advocate | Advocate for policies and programs consistent with the needs of diverse underserved communities |
| Researcher | Incorporate cultural and diversity needs into all research efforts |
| Supervisor | Supervise trainees in integrating cultural competence into treatments |
| | EBP importation |
| Administrator | Provide support for EBP training, implementation, and research |
| Clinician | Obtain ongoing training in EBPs Translate and provide effective EBPs for CMH clients |
| Consultant or trainer | Translate and train in EBPs for CMH settings. Address challenges to EBP importation (e.g., negotiating multiple stakeholders, resistance to change, community-buy-in, and lack of infrastructure to support training and outcome tracking) |
| Policy advocate | Advocate for reimbursements policies consistent with treatment challenges of CMH settings |
| Researcher | Design and implement research to investigate EBP effectiveness. |
| Supervisor | Supervise trainees in implementing EBPs with CMH clients |
| | Integration of traditional psychology with community-based clinical care |
| Administrator | Modify programs based on strengths and limitations of traditional psychology approaches as applied to the complex needs of CMH |
| Clinician | Integrate community and traditional psychology methods in clinical care |
| Consultant or trainer | Attend to needed community modifications when providing trainings |
| Researcher | Investigate the effectiveness of integrated psychology with community approaches in clinical care |
| Supervisor | Supervise trainees in integrating psychology with community care |
| | Grant writing |
| Administrator | Identify and apply for external grant funding to support CMH programs |
| Consultant or trainer | Identify and apply for external grant funding to support CMH programs |
| Policy advocate | Advocate for funding streams consistent with CMH grant needs |
| Researcher | Identify and apply for external grant funding to support CMH programs |
| | Strategies to decrease mental health care disparities |
| Administrator | Support implementation of efforts to engage underserved communities |
| Clinician | Expand and/or modify services to engage and outreach to underserved communities (e.g., stigma reduction programs, bridging mental health with health/social services, culturally adapted treatments) |
| Consultant or trainer | Design innovative programs to effectively serve underserved populations in a CMH organization's catchment area |
| Policy advocate | Advocate for policies that recruit diverse providers that match the language and cultural needs of CMH populations Advocate for funding streams to support innovative programs that decrease mental health care disparities |

Table 2 (continued)

| Functional role or competency | Applied example of foundational competency |
|--|--|
| Researcher Supervisor | Evaluate the impact of CMH programs on mental health care disparities Supervise trainees in engaging/outreaching to underserved communities |
| Needs assessment and program evaluation | |
| Administrator Clinician Consultant or trainer Policy advocate Researcher Supervisor | Provide agency support for needs assessments and program evaluation Administer assessments or conduct interviews for program evaluation Evaluate outcome data to identify agency needs Use data to lobby for or acquire funding for services Employ needs assessment methodologies to inform service priorities Evaluate and use outcome data to improve services and seek funding Supervise trainees on the assessment of service needs and/or implementation of clinical changes |
| Organizational consultation | |
| Administrator Consultant or trainer Policy advocate Researcher | Seek consultation for organizational management issues when indicated Apply consultation strategies to advise on organizational improvements Address cultural differences likely to be experienced in consulting with CMH systems (e.g., differences between mental health and substance abuse providers, 'guild' concerns, cultural differences in terms of power, privilege, and status) Advise organizations on navigation of pertinent policy and fiscal issues Advise organizations on effective collection and use of data |
| Organizational management | |
| Administrator | Apply principles essential to administration and operations of a CMH organization, including program development, management, and improvement, medical records, billing, and funding Recruit, hire, and maintain personnel Develop operational policies and procedures Provide leadership and guidance, i.e. to navigate interdisciplinary teams and organizational cultural differences |
| Public policy/advocacy | |
| Administrator Clinician Consultant or trainer Policy advocate Researcher | Seek consultation from policy or advocacy experts in matters pertinent to managing and sustaining a CMH organization Advocate for client issues through local and national organizations Advise on advocacy/policy pathways as solutions to agency needs Use advocacy/social justice principles to assure program sustainability Advocate for funding/policy-related issues through local and national organizations Disseminate research to inform policy/advocacy implications |
| Clinical supervision and consultation | |
| Supervisor | Supervise and provide clinical consultation to clinical trainees utilizing theoretical and applied supervisory techniques Provide supervision that takes into account cultural competence needs of underserved communities, serious and complex nature of client psychopathologies, clients' social service needs, billing constraints, and community-based approaches to care |

Note. CMH = community mental health; EBP = evidence-based practice. This table is intended to give examples of how foundational public psychology competencies are applied across different functional competency roles of psychologists in community mental health organizations. Its intention is not to provide comprehensive definitions or address every possible example of role functions. Each foundational competency does not necessarily intersect with all six functional competencies; only those functional roles that apply to each foundational competency are listed.

but later integrated as increasingly common functions of professional psychologists.

Education and Training

The translation of public psychology competencies into education and training efforts will be instrumental to professional psychology's success in playing a vital role in CMH transformation. Education and training endeavors will serve as a vehicle for exposure and subsequent openness to public psychology careers by psychologists.

Consistent with developmental models of training, the acquisition of basic competencies should start in graduate doctoral training with refinement during internship and postgraduate education efforts. Alternatively, practicing psychologists interested in acquiring public

psychology competencies may pursue continuing education opportunities. Given both the academic and applied nature of the public psychology field, it is particularly important for training efforts to encompass the intersection of didactic, experiential, and applied research modalities. Additionally, collaborations between academic institutions, CMH organizations, and/or public policy entities may create ideal public psychology learning environments. Finally, recruiting psychologists representative of the diverse linguistic and cultural needs of underserved public sector communities may be particularly important for future training endeavors.

Promising efforts have recently been initiated to provide education specific to public psychology competencies. Palo Alto University in Palo Alto, CA has developed a "Diversity and Commu-

nity Mental Health" emphasis area to their clinical psychology PhD program, and other doctoral programs like DePaul University, George Washington University, Georgia State University, or the University of Illinois at Urbana-Champaign have integrated community tracks or community focuses. These innovations in CMH training are a good indication of changing tides toward increased public sector emphasis in the mental health field.

Conclusion

Psychologists have the potential to bring critical analytical, clinical, and training skills to serve the complex and unique needs of community mental health clients and to provide leadership to address public sector transformation needs. The establishment of public psychology competencies in this article introduces and develops legitimate roles for community mental health psychologists. Additionally, it was argued that such competencies will help to increase the representation of psychologists in public service settings. Applied examples were provided to clarify how competencies might be implemented by psychologists assuming different roles in public sector organizations. Given the breadth of public psychology and its competencies, it is important to recognize that each psychologist will likely fulfill a different combination of roles and may not be competent in every area of public psychology practice. Future education and training efforts are needed to implement and promulgate professional psychologists' acquisition of these functional and foundational public psychology competencies.

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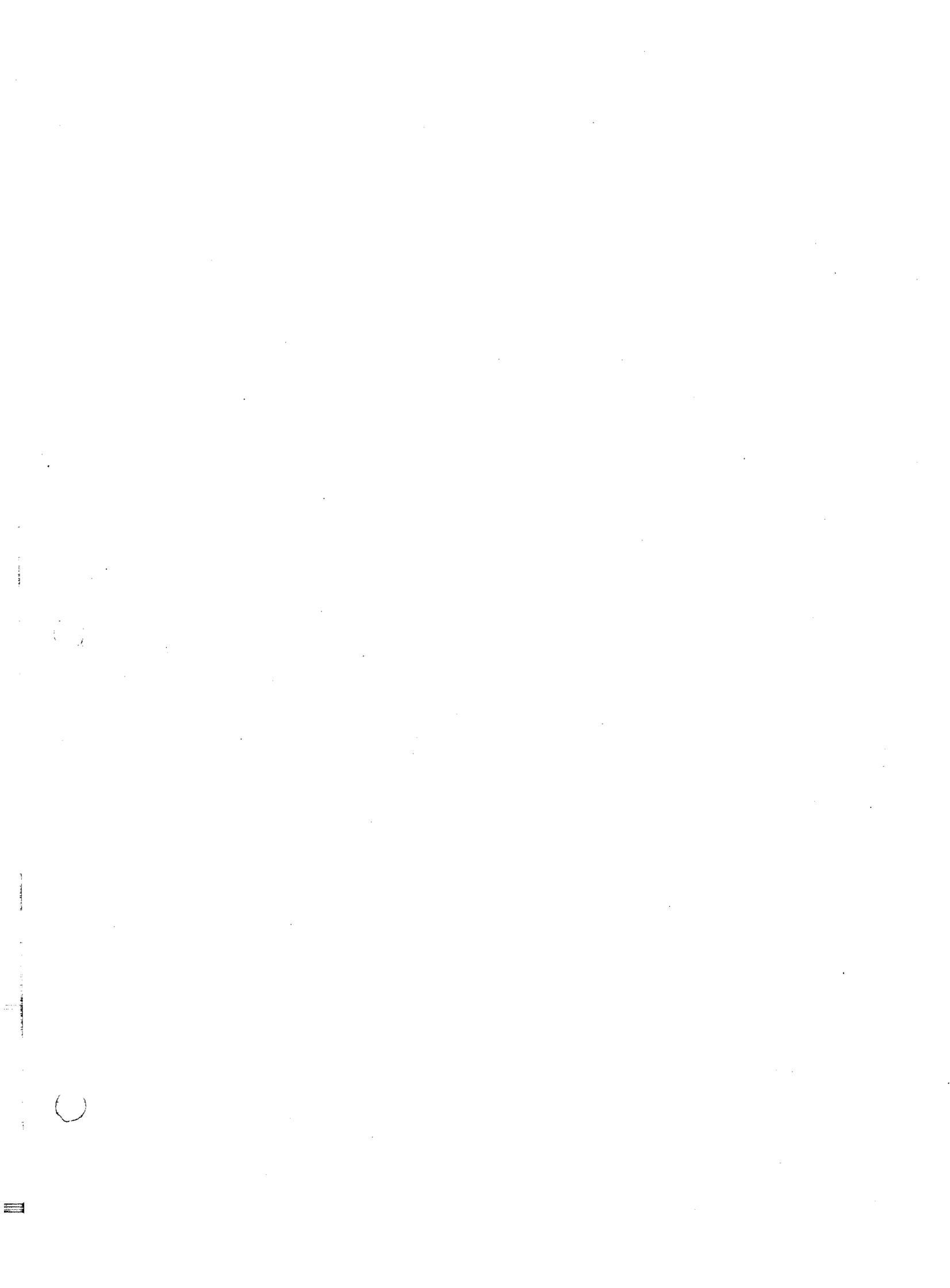
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CalSWEC

California Social Work Education Center

A partnership for Education, Student Support, Training, Evaluation, and Research

Background:

- CalSWEC is the nation's largest collaborative of schools of social work, public agencies, and foundations working together to provide professional education, student support, in-service training, and workforce research.
- CalSWEC has a 20 plus year history of developing professional social workers for public sector practice in the fields of children's service, mental health and aging.
- Originally created as an academic institution and public agency partnership between the University of California at Berkeley's School of Social Welfare, the California Department of Social Services and the County Welfare Directors Association of California, to address the need to produce social work professionals for careers in the public sector serving disadvantaged persons and communities.
- The collaborative now includes all 21 California State Universities and Universities of California with accredited Social Work Programs, California County Mental Health and Social Service departments through CMHDA and CWDA, State agencies, the California Chapter of the National Association of Social Workers, and other professional associations and foundations.
- The CalSWEC partnership facilitates UC Berkeley's mission by integrating education and practice to assure effective, culturally competent service delivery to the people of California through practice and empirically based curriculum development, student stipends, educational support and job placement services.

Mental Health Program:

The CalSWEC Mental Health Program (MHP), through an interagency agreement, with the California Office of Statewide Health Planning and Development distributes MHPA funds each year to 21 schools of social work for stipends for a maximum of 196 students who have an interest in careers in public or contract mental health services. This funding also supports a portion of the operating costs for each program and MHP. MHP has developed and implemented a set of curriculum competencies for public mental health services that are included by each school in academic and field programs for MHP stipend students. Process and outcome studies track program progress and challenges as funding allows.

Results (2005 – 2012):

WET Plan Goal #1: Develop sufficient qualified individuals for the public mental health workforce

1295 stipends were awarded during the past six years; an additional 195 students have received stipends this year, totaling 1495 stipends by 6/30/13.

- Students reside and attend graduate school in all Mental Health Regions:

| | |
|---------------|-----|
| ✓ Superior | 6% |
| ✓ Central | 17% |
| ✓ Bay Area | 24% |
| ✓ Southern | 23% |
| ✓ Los Angeles | 30% |

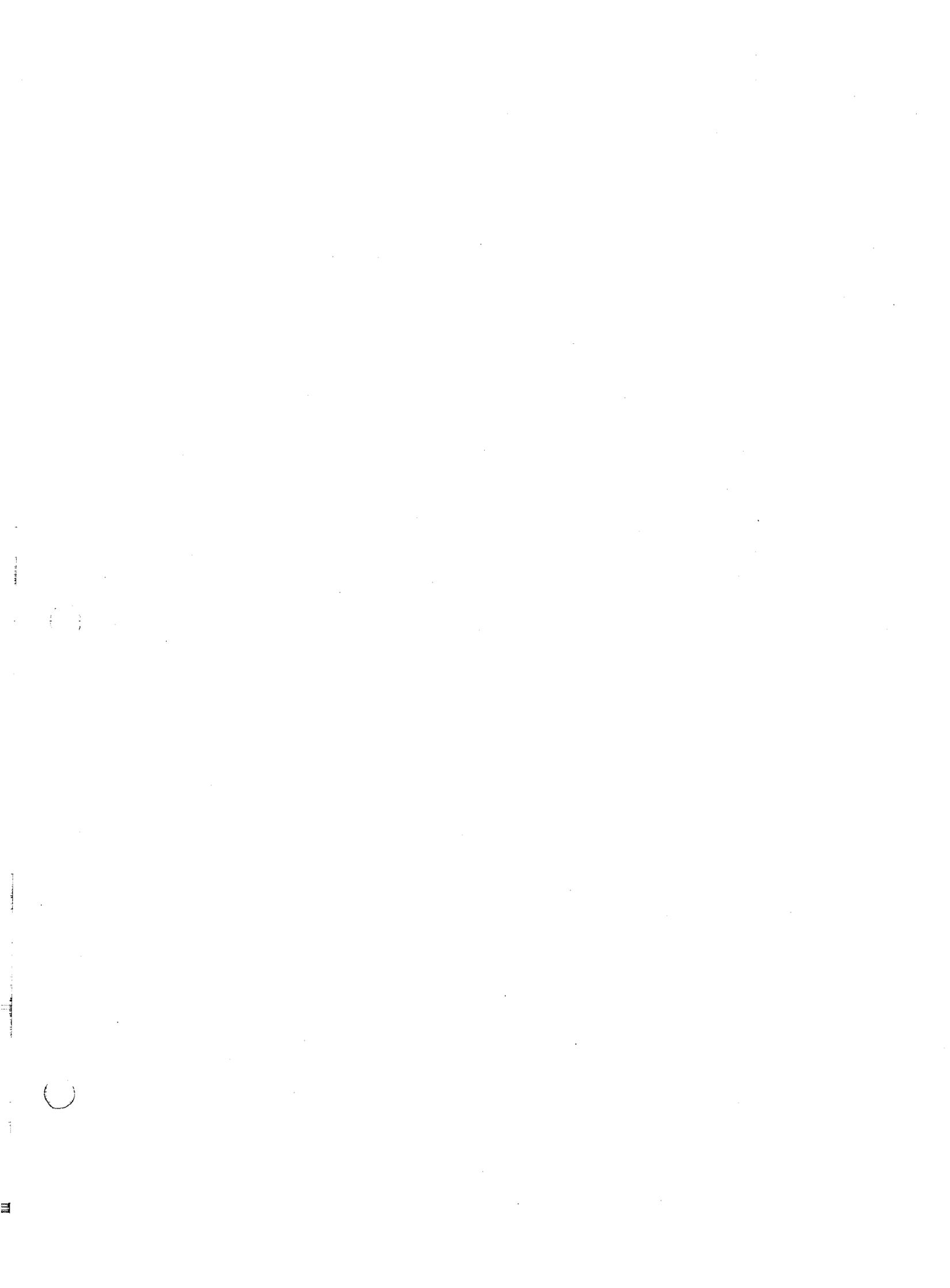
- The cohorts are ethnically and racially diverse:
 - ✓ Minority group members 59%
 - ✓ White/Caucasian 41%
- The majority of graduates speak another language in addition to English:
 - ✓ English/at least one other language 57%
 - ✓ English only 43%
- The majority (89%) of graduates met a one-year payback obligation through employment in a county-operated or contract behavioral health agency. The other graduates met the obligation monetarily.
- Among graduates of 2006 – 2009 cohorts who could be traced, 68% were still in the behavioral health field a year after payback completion, most often at the payback agency.

WET Plan Goal #2: Increase the quality and success of educating and training the public mental health workforce in the expressed values and practices envisioned by the MHSA

An assistant professor and graduate students at CSU East Bay Department of Social Work conducted a content analysis of 115 syllabi submitted by all participating schools of social work. The researchers did a keyword search for these MHSA concepts: evidence-based practices; recovery/wellness/resiliency; consumer empowerment; family member empowerment; trauma; co-occurring conditions/dual diagnosis; and cultural sensitivity in mental health settings. They found that each of the topics was addressed in three to five of the five types of courses offered: first year generalist practice; advanced mental health practice; advanced other practice (e.g. child and family); policy; research.

Many of the competencies, including MHSA-affiliated competencies, also are incorporated into students' learning agreements with their field placements. The findings of the syllabi content study and other surveys of graduates, faculty, and agency supervisors informed the development of a new set of competencies approved by the CalSWEC Board in 2011.

Additional information about the Mental Health Program may be found at <http://calswec.berkeley.edu/mental-health>.



The Public Psychology Doctoral Training Model: Training Clinical Psychologists in Community Mental Health Competencies and Leadership

Joyce P. Chu and Luli Emmons
Palo Alto University

Jorge Wong
Asian Americans for Community Involvement,
San Jose, California

Peter Goldblum, Robert Reiser, Alinne Z. Barrera,
and Jessica Byrd-Olmstead
Palo Alto University

National reports have illuminated problems within the public mental health system such as fragmented care for serious mental illness, mental health care disparities for underserved populations, a dearth of data-driven evidence-based practices, and inadequacies in policy and advocacy work (President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 2001). Chu et al. (2012) established the public psychology competencies that would create the foundation needed for psychology leadership to assist in the transformation of the community mental health system. Yet, systematic doctoral-level training efforts in these competencies appear sparse. This article presents key components of a Public Psychology Doctoral Training Model that trains psychologists in the competencies needed for leadership in community mental health. Key components include the following: (a) a focus on public psychology foundational and functional competencies, (b) collaborative partnerships between academic, community, and county/state/federal entities, and (c) group case-method learning beyond the classroom. The Diversity and Community Mental Health (DCMH) emphasis area is presented as an example, and recommendations are provided for other doctoral programs endeavoring to establish similar programs.

Keywords: community mental health, public psychology, doctoral training, diversity, serious mental illness

JOYCE P. CHU received her PhD in clinical psychology from the University of Michigan. She is an assistant professor and director of the DCMH emphasis at Palo Alto University. Her professional interests include Asian American mental health, suicide and depression in ethnic minority adult and geriatric populations, and community mental health training.

LULI EMMONS received her PhD in clinical psychology from the Pacific Graduate School of Psychology (PGSP). She is an associate professor and vice president of the Office of Professional Advising and Development at Palo Alto University. Her professional interests include community mental health and professional psychology education and training.

PETER GOLDBLUM received his PhD in clinical psychology from PGSP. He is a professor and co-director of the Center for LGBTQ Evidence-based Applied Research (CLEAR), the Sexual and Gender Identities Clinic, and the LGBTQ emphasis at Palo Alto University. His professional interests include the mental health, geriatric issues, suicide, and minority stress of sexual minorities.

ROBERT REISER received his PhD in clinical psychology from PGSP. He is an associate professor and director of the Kurt and Barbara Gronowski Psychology Clinic at Palo Alto University. His professional interests include transporting evidence-based treatments into real-world settings, cognitive-behavioral therapy, evidence-based supervision, and bipolar disorder treatment in community mental health.

ALINNE Z. BARRERA received her PhD in clinical psychology from the University of Colorado, Boulder. She is an assistant professor at Palo Alto

University. Her areas of research and practice include immigrant, Spanish-speaking individuals with mood disorders and designing and testing depression programs for underserved populations.

JORGE WONG received his PhD in clinical psychology from PGSP. He is the director of Behavioral Health Services at Asian Americans for Community Involvement (AACI). His professional interests include ethnic minority health, policy development, leadership, advocacy, healthcare compliance and ethics. He serves on numerous county and state oversight and policy development committees.

JESSICA BYRD-OLMSTEAD is currently a doctoral candidate and will receive her PhD in clinical psychology from Palo Alto University in 2012. Her areas of practice and research include substance use disorders, forensic assessment, adolescent mental health, and public policy.

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CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Joyce Chu, Palo Alto University, 1791 Arastradero Road, Palo Alto, CA 94304. E-mail: jchu@paloalto.edu

Seminal reports on the state of the U.S. community mental health system illuminated a variety of problems with public mental health¹ services provided to indigent, marginalized, and seriously mentally ill individuals (President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 2001). A call for an improved community mental health system of care that provides evidence-based treatments accessible to diverse populations has subsequently brought the need for clinical psychology leadership to the forefront (Reddy, Spaulding, Jansen, Menditto, & Pickett, 2010; Roe, Yanos, & Lysaker, 2006). However, within existing systems of training, there is a lack of coursework relevant to the assumption of these unique public psychology leadership roles (Reddy et al., 2010; Roe et al., 2006).

This article proposes a training model that can be used by clinical psychology doctoral programs to train psychologists interested in public psychology work. To achieve this aim, we present the following: (a) a sample of ongoing challenges in the community mental health sector along with clinical psychology's potential to provide leadership in public mental health; (b) a review of the current state of doctoral training in public psychology; (c) key components of a Public Psychology Doctoral Training Model designed to prepare psychologists for leadership in community mental health; and (d) presentation of the Diversity and Community Mental Health emphasis area which demonstrates how the Public Psychology Doctoral Training Model can be implemented.

A Changing Public Psychology Context

The community mental health movement of the 1950s through 80s was driven by two Presidential Commissions on Mental Health that transitioned the U.S. public mental health system from primarily institutionalized to community-based care (Pollack & Feldman, 2003; Stockdill, 2005). A subsequent Presidential Commission on Mental Health in 2003 analyzed the transformed community mental health system and found several major problems and shortcomings.

First, the 2003 commission found that a majority of the nation's mentally ill do not have access to psychosocial interventions that have been empirically tested to be effective. As such, the dissemination of evidence-based practices (EBPs) has been viewed as a national priority to ensure that all individuals have equal opportunity to receive treatments that work (Power, 2005; President's New Freedom Commission on Mental Health, 2003; Stirman et al., 2010). Second, the public mental health system is often disjointed and lacking in uninterrupted interdisciplinary care (President's New Freedom Commission on Mental Health, 2003). For example, a client with dual diagnosis may be referred to treatment services for substance abuse but not mental illness, or a client who is discharged from crisis inpatient care may not be connected with step-down levels of service or eventually transitioned back into recovery. Another shortfall in the public sector is that of disproportionate disparities in mental health and mental health care for diverse cultural minority populations (Agency for Health care Research & Quality, 2010; U.S. Department of Health and Human Services, 2001). Many Asian Americans and Latinos, for example, experience limited service access as a result of a paucity of language-matched providers and systematic efforts to train around or incorporate culturally congruent modifications into plans of care (U.S. Department of Health and Human Services, 2001).

In addition to these issues identified by nationwide reports, community mental health is faced with continuously evolving forces that affect the way services are administered and practiced. Some examples of developing issues in community mental health include the recently passed Patient Protection and Affordable Care Act (PPACA) that will change reimbursement and billing practices, or an impetus toward integrated systems of care that is changing service delivery paradigms (e.g., merging of mental health with substance abuse services or integrated bidirectional care which puts mental health into primary care and vice versa). Miller, DeLeon, Morgan, Penk, and Magaletta (2006) argued that political, social, and economic forces affect the organizational, fiscal, and service structures of public more than private sector organizations. For this reason, community mental health psychologists are required to assess and respond quickly in order to navigate changing regulations and zeitgeists of practice with innovation and vision.

Clinical psychology's unique combination of research, teaching, and clinical skills creates a foundation prime for tackling the challenges of the community mental health system (Roe et al., 2006). Dissemination of evidence-based practice, for example, requires the therapeutic skills of a trained clinician combined with teaching skills to train other service providers and analytical skills to evaluate the progress of EBP translation into community settings. In addition, clinical psychology's emerging science of translational and implementation research can inform the integration of EBPs into the public sector (Aarons et al., 2009; Stirman et al., 2010). Making improvements to a disjointed system calls for the ability to evaluate and analyze program needs, implement change, and design outcome-driven assessments to inform ongoing improvement (Cohen, Adams, Dougherty, Clark, & Taylor, 2007; Whealin & Ruzek, 2008). These analytical skills are honed over years of clinical psychology doctoral-level research training. Clearly, clinical psychology is well-positioned to lead transformations in public mental health.

An Opportunity to Enhance Public Psychology Training

Though the impetus for leadership from clinical psychologists in community mental health is apparent, few current doctoral training efforts prioritize key competencies required to guide these transformation efforts. Elimination of mental health care disparities, for example, requires provision of culturally competent psychosocial services (Delphin & Rowe, 2008; Park-Taylor et al., 2009; Whealin & Ruzek, 2008), linguistically matched services, and system-level change (U.S. Department of Health and Human Services, 2001). Furthermore, there is a need for policy and social justice to be infused into current clinical psychology doctoral programs by training students to integrate principles of social justice in community mental health work and to interpret and impact policy related to mental health services (Burnes & Manese, 2008; Burnes

¹ This article uses the phrases "public psychology," "public sector psychology," "community mental health," and "public mental health" interchangeably to refer to mental health services of the publicly-funded sector in several organizations including community and state hospitals and clinics and other social service organizations.

& Singh, 2010). Conceptualizing public policy work as part of a psychologist's career will be important to effect wide-scale change on issues such as health care coverage for underinsured communities or adequate funding for the community mental health system (Lating, Barnett, & Horowitz, 2010; Levant et al., 2001). Indeed, social justice is pursuant to the general principle of Justice in the APA ethics code which states that "Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists" (American Psychological Association, 2002).

Although psychologists are equipped with the scientific knowledge of EBPs, their translation into community settings requires an understanding of practice orientations and the unique organizational and consumer-based needs that have become essential to community mental health (Agnetti, 2008). Many community-based practices, such as Assertive Community Treatment, consumer-involved care, or system-based interventions, have initial evidence showing these approaches work in public mental health (Bronfenbrenner, 2005; DeLuca et al., 2008; Frese & Davis, 1997). Knowledge of community-based practices can help clinical psychologists effectively bridge the divide between divergent theoretical orientations and train around effective EBP translation and implementation into community settings.

Finally, common to challenges arising from the public mental health context is a need for skills in consultation and system-level analysis that would prepare psychologists to implement organization-level changes in outreach to underserved communities or fostering culture change for EBP adoption. Training clinical psychologists in skills related to leadership, supervisory, consultant, or policy advocacy roles may better prepare individuals for work in these public sector roles.

Current Training and Recruitment Is Insufficient

Current doctoral-level training within clinical psychology in community mental health appears sparse (Chu et al., 2012; Roe et al., 2006). Reddy et al. (2010) provided an optimistic estimate that approximately 100 psychologists from U.S. clinical psychology doctoral programs registered to the Council of University Directors of Clinical Psychology are trained for and are expected to pursue careers related to serious mental illness per year. This estimate is inclusive of careers in academia, teaching, independent practice, and private outpatient clinics and hospitals; thus, the expected number of psychologists prepared to serve people with serious mental illness in public settings would be considerably less, and likely much lower than nationwide demand.

In addition, a comprehensive search of the American Psychological Association's accredited programs yielded only 15 clinical psychology doctoral programs that include organized coursework and training opportunities in community mental health, with only four of the 15 addressing the combination of community mental health and diverse underserved communities (American Psychological Association, 2012). These programs constitute less than 7% of APA's 235 accredited clinical psychology doctoral programs—a representation ill-matched with society's changing mental health needs.

This dearth of organized community mental health coursework is paired with evidence that training around the specific skills

required for leadership in the public sector is lacking. Literature has shown that psychologists in the public sector learn "on-the-job" to fulfill their roles rather than receiving formal training to assume community mental health leadership positions (Perlman & Hartman, 1987). Reddy et al. (2010) identified a particular scarcity of doctoral programs offering training opportunities in integrated interdisciplinary treatment approaches or policy, systems, and administration for serious mental illness-related services.

Though academic training programs in community mental health competencies are in the minority, many doctoral students complete their clinical practicum and internships in public sector settings, illuminating a disconnect between academic coursework and CMH clinical placements. As many as 24.9% of doctoral-level practicum take place in community mental health centers, clinics, or other social service agencies (Lewis, Hatcher, & Pate, 2005). An even greater number (35%, or 241 of 682 total) of North American psychology internship placements accredited by the Association of Psychology Postdoctoral and Internship Centers (APPIC) in 2011 are situated in CMH centers or public hospitals. In addition, 70% of clinical psychology doctoral programs provide the opportunity for practicum exposure to clients with serious mental illness, though only 19% of these programs provide ongoing seminars or research labs related to serious mental illness (Reddy et al., 2010). The insufficient availability of systematic public psychology training illuminates a need for training models that can be widely applied within clinical psychology doctoral programs.

Key Components of the Public Psychology Doctoral Training Model

This article presents a competency-based doctoral training model designed to train clinical psychologists in the competencies involved in public psychology work. The Public Psychology Doctoral Training Model specifies program elements encompassing coursework, research, and clinical training designed to augment general clinical psychology education with an emphasis in diversity and community mental health. The model is predicated on three key components described in the following sections. The Diversity and Community Mental Health (DCMH) area of emphasis is presented as an example of the training model for others who wish to offer similar programs.

Key Component #1: Public Psychology Competencies

Public psychology work requires a set of proficiencies beyond that of general doctoral psychology training, with some scholars arguing that public psychology constitutes a circumscribed specialty within the general clinical psychology field (Chu et al., 2012). To advance the field of public psychology, Chu et al. (2012) delineated the foundational and functional public psychology competencies needed for psychologists to lead and transform community mental health and called for the establishment of concomitant education and training efforts. As such, within the Public Psychology Doctoral Training Model, curricula should cover the full range of these functional and foundational competencies.

The public psychology foundational competencies constitute the basic knowledge, skills, and attitudes of community mental health work. They include the following: (a) assessment/treatment of

serious mental illness, (b) assessment/treatment of substance use disorders/dual diagnosis, (c) clinical supervision and consultation, (d) community-based research, (e) consumer collaboration, (f) cultural competence in clinical work, (g) evidence-based practice (EBP) importation, (h) grant writing, (i) integration of traditional psychology with community clinical care, (j) needs assessment and program evaluation, (k) organizational consultation, (l) organizational management, (m) public policy/advocacy, and (n) strategies to decrease mental health care disparities (see Chu et al., 2012, for a full description of each competency and empirical methods utilized to derive such competencies). Psychologists exercise the foundational competencies of public psychology in a variety of roles, or functional competencies, within the community mental health context. Key functional competencies described by Chu et al. (2012) include the following: (a) administrator (program manager, director, or other), (b) clinician (direct service), (c) consultant or trainer, (d) policy advocate, (e) researcher (including program evaluator and grant writer), and (f) supervisor.

Key Component #2: Academic, Community, and County/State/Federal Partnerships

A second key component of the Public Psychology Doctoral Training Model lies in the formation of a collaborative learning environment beyond that of a traditional academic context. Community/academic partnerships lay the foundation for reciprocal hands-on and experiential learning, as exposure to community perspectives is needed for many core public psychology competencies such as community-based research, consumer collaboration, or understanding community barriers to EBP implementation. Community partnerships may take several forms including collaborative didactic instruction, or partnerships where students receive clinical training in designated community placements. Through such collaborations, community partners benefit from more knowledgeable trainees whereas academic partners benefit from hands-on training from community providers. Students benefit from a streamlined education program.

Collaboration with county, state, or federal partners can provide the interaction with local advocacy efforts needed for trainees to understand the larger policy forces that influence community mental health services. Such partnerships may also be pursued to generate the recruitment pathways, positions, or funding needed to facilitate the pursuit of public sector careers. Many publicly funded programs already exist to provide financial assistance for psychologists in public mental health careers, particularly in underserved or mental health professional shortage areas. The National Health Service Corps (NHSC),² for example, is a federally funded program that provides loan forgiveness for qualified psychologists to work in particular mental health organizations where underserved communities receive services. The Mental Health Loan Assumption Program (MHLAP)³ is a similar program funded by the State of California. Partnerships with qualifying community mental health organizations to train and eventually employ students that will be eligible for such scholarship or loan repayment programs can foster community mental health career paths during key post-doctoral employment years.

The Public Psychology Doctoral Training Model's emphasis on collaborative partnerships as a foundation for the training context has roots within Bronfenbrenner's (1979) ecological model, which

posits that an individual is influenced by the interaction between multiple levels of a system. For a trainee, the microlevels of one's immediate academic institution and clinical practicum interact at a meso-level, which are influenced at the macrolevel by society's mental health policies and organizational structures. By incorporating close partnerships between academic programs, community constituents, and county-, state-, or federal-level partners, the current training model accounts for the fact that a student's overall training experience is influenced by systems-level interactions.

Key Component #3: Group Case-Method Learning Beyond the Classroom

The third component of the Public Psychology Doctoral Training Model lies in its approach to group case-method learning beyond the classroom, an applied teaching process whereby students acquire skills and apply knowledge in the context of real-world community mental health problems. The case-method approach to learning has roots in business, medicine, and law and involves the use of real-life situations to stimulate learning and analysis by students (Boehrer & Linsky, 1990; Christensen & Hansen, 1987; Raju & Sanker, 1999). Case studies are thought to be superior to other methods of instruction because they require students to engage with multiple phases of the experiential learning process whereby experiences are transformed, manipulated, and internalized into knowledge via direct involvement by the student (Kolb, 1984; Kreber, 2001). Research has shown that case-method learning is a useful teaching tool that enhances problem-solving, critical thinking, organizational skills, and peer learning and is more effective than traditional lecture techniques that emphasize abstract conceptualization and didactics (e.g., Grant, 1997; Halpin, Halpin, Good, Raju, & Sankar, 2000; Watson, 1975).

Two additional components augment the benefits of case-method learning for public psychology training. First, moving case method learning to contexts outside the classroom (e.g., by involving interaction with community constituents) can help to prepare future clinical psychologists for the complex psychosocial issues, crisis situations, organizational demands, and political and fiscal forces required of public mental health positions. Second, the Public Psychology Doctoral Training Model advocates for implementing case-method learning in groups. Public psychology positions involve working in interdisciplinary teams or with consumers or consumer advocates to attend to the multiple systemic factors contributing to clients' mental health problems. Integrating group work within the doctoral training experience prepares students to negotiate the different working styles and personalities of colleagues and ultimately thrive in public mental health organizational cultures. Indeed, scholars have recommended using case studies in combination with group work (Gross Davis, 1993; Knoop, 1984).

Case method learning beyond the classroom is particularly important for public psychology doctoral training for several rea-

² The NHSC loan repayment website can be found at <http://nhsc.hrsa.gov/loanrepayment/>

³ The MHLAP website can be found at: <http://www.oshpd.ca.gov/hpef/MHLAP.html>

sons. Because of the community-collaborative nature of public psychology training, it is important that competencies are acquired both with traditional didactics or research and experientially in engagement with community organizations, providers, and consumers. In addition, case-method learning beyond the classroom can provide the training needed to adequately prepare students for leadership in public sector organizations. Kreber (2001) argues that using experiential case methods ultimately fosters greater self-direction in learning. Students practice self-direction when they are required to make decisions about what, why, and how to learn in the midst of grappling with a case study; this self-direction can be a particularly important building block for the skills and initiative required for public psychology leadership (Boud, 1988; Candy, 1991).

Case Study: The Diversity and Community Mental Health Area of Emphasis

The Diversity and Community Mental Health (DCMH) emphasis area⁴ at Palo Alto University (PAU) is presented as an example of an effort modeled after the Public Psychology Doctoral Training Model. The DCMH emphasis area, started in 2009, is designed to supplement and enhance PAU's clinical psychology Ph.D. program. Main objectives of the DCMH emphasis are to recruit students to serve the diverse and underserved communities of community mental health, to train these students in specific competencies needed as public psychology leaders, and to train and mentor psychologists motivated to pursue community mental health careers. In the following sections, we describe the structure of the DCMH emphasis related to the three key components of the Public Psychology Doctoral Training Model as a tool for other doctoral programs endeavoring to launch similar efforts.

DCMH Example of Key Component #1: Public Psychology Competencies

The aforementioned public psychology foundational and functional competencies are acquired in the DCMH emphasis primarily through a series of five academic courses combined with a public mental health clinical community placement and doctoral research serving public mental health communities. The clinical, academic, and research components of the DCMH emphasis span three years with the bulk of the coursework occurring in its first year. Following is a detailed description of DCMH coursework to demonstrate how the public psychology competencies are operationalized within the DCMH's curriculum.

Students first learn about the history, theory, research, and practice of community mental health in an "Introduction to Community Mental Health" course. Theoretical, research, and clinical foundations central to working in community mental health are covered (e.g., systems and ecological models, wellness and recovery approaches, consumer collaboration, strength-based work, etc.), and students are exposed to the unique role of public psychologists as consultant, administrator, researcher, director, policy advocate, or supervisor.

A second course on "Organizational Management and Consultation" focuses on the new roles and skills required of CMH psychologists in the areas of administration, fiscal planning and procurement, policy development, advocacy, consultation and su-

perision, research, organizational analysis, and strategic thinking. Essentially, this course emphasizes the competencies needed for leadership in public mental health.

These two foundational DCMH courses are followed by three courses covering specific topic areas germane to public psychology. A "Mental Health Disparities" course familiarizes students with the state of mental health and mental health care disparities in underserved communities served by community mental health and covers common practices and models of working with and engaging underserved communities to ameliorate such disparities. The second course, "Serious Mental Illness," covers the serious psychotic and affective disorders treated in public mental health with a particular focus on the implementation and dissemination of evidence based treatments for chronic and serious mental illness in real world community settings. Finally, the DCMH course "Substance Abuse" teaches the foundations of prevention, assessment, and treatment of substance abuse, dependence, and co-occurring disorders. Special community mental health considerations such as collaboration with consumer support groups, harm reduction programs, or motivational interviewing are emphasized. Together, the five courses along with clinical and research training focused on community mental health issues and clientele, ensure that DCMH students are proficient in the range of foundational and functional competencies of public psychology.

DCMH Example of Key Component #2: Academic, Community, and County/State/Federal Partnerships

The DCMH emphasis has collaborative partnerships with neighboring Santa Clara and Marin California county mental health departments and a county-contracted community-based organization, Asian Americans for Community Involvement (AACI). These community partnerships are central rather than peripheral to the program's curricular efforts. For example, one of the DCMH core courses is co-taught by a public psychologist who is the director of behavioral health services at AACI. Consumers and public psychologists are regularly integrated as guest speakers into all of the DCMH courses, and students are mentored in the community by shadowing local community mental health psychologists in their work settings or within policy development work at county and state executive and advisory meetings. Students also observe consumer-led support groups to learn about community mental health issues from consumers themselves.

Community partnerships offer numerous benefits for both DCMH students and community partners. Students benefit from an educational experience infused with influence from the community mental health organizations. Students also complete clinical practicum at partnership sites, gaining hands-on experience serving public mental health clientele. In turn, partnership sites benefit from trainees already versed in the clinical, organizational, and political issues at play within community mental health clinics.

Our partnerships have also yielded unique pathways for recruitment of DCMH trainees into public sector work. The DCMH emphasis has developed a consortium partnership with Marin

⁴ A full description of PAU's DCMH emphasis area and course descriptions are available at PAU's website <http://www.paloalto.edu>, or upon request from the primary author.

county mental health to create dedicated internship positions for DCMH students who have an interest in pursuing public psychology career paths. DCMH also offers a state-funded educational stipend by partnering with California's Department of Mental Health through the Mental Health Services Act Proposition 63, an earmarked fund providing resources (generated by a 1% tax on personal income in excess of \$1 million) to California county mental health systems (California Department of Mental Health, 2011). Proposition 63 was a ballot initiative and policy campaign made possible by the collaboration of multiple stakeholders from the community mental health system and state legislation, and was successfully passed by California voters in November 2004. DCMH scholarship recipients are given up to \$20,772 in tuition support in exchange for one year of postdoctoral payback employment within the California county mental health system. The postdoctoral payback requirement provides an incentive and natural career pathway for scholarship students to continue careers in public mental health. The scholarship is particularly aimed at recruiting psychologists capable of serving the ethnic and linguistic diversity needs of public mental health clients.

The DCMH emphasis area's approach to collaborative partnerships represent only a fraction of the different ways that mutually beneficial relationships can be organized. Most importantly, the DCMH emphasis has sought to integrate such partnerships throughout every aspect of its operations; other doctoral programs looking to develop similar partnerships may pursue like arrangements such as community partners as core instructors or dedicated clinical training sites, the establishment of training grants, or the integration of partners into fundamental coursework. Ultimately, doctoral programs looking to develop public psychology training efforts should enter discussions with their surrounding community mental health organizations to identify opportunities of mutual interest.

DCMH Example of Key Component #3: Group Case-Method Learning Beyond the Classroom

DCMH courses use group case-method learning beyond the classroom to engage students with real community problems while emphasizing public psychology competencies. Each course is built around group-oriented projects that encourage experiential acquisition of skills needed to address public mental health challenges. Teams are randomly assigned so that students learn to work with other group members with diverse work styles and personalities that mirror the type of interdisciplinary team work encountered in public mental health.

Three examples illustrate the DCMH emphasis area's case-method learning. First, DCMH students demonstrate knowledge and skills in administration, grant-procurement and writing, and organizational management by responding to an actual California county mental health Request For Proposals (RFP). The RFP requires groups of DCMH students to develop an outpatient dual diagnosis service delivery program, balanced budget and staffing pattern, and evaluation plan that is reviewed by a mock review panel. Because this project is typically completed in collaboration with a community partner, the students' work has informed this partner's actual RFP proposals submitted in the past—an exercise of learning beyond the classroom.

In DCMH's Serious Mental Illness course, students demonstrate the foundational competency of evidence-based practice (EBP)

importation in the research and development of a treatment manual, followed by a proposal for EBP dissemination and culture change in a community setting. In a separate program evaluation project, DCMH students evaluate gaps and make recommendations for quality improvement in an actual California county mental health system via Internet research, informant interviews, community shadowing, and mock chart review.

In each of these group case-method projects, students are encouraged to practice creativity in developing their own unique solutions and approaches. An overarching structure for the project is provided but detailed instructions are intentionally excluded to foster self-directed learning and leadership. We have found that students initially struggle with the lack of structure but steadily grow in initiative, independence, and leadership with each successive group project in the DCMH emphasis.

Conclusions

Given the need for increased psychology leadership in the community mental health system, it is critical for doctoral programs to develop systematic approaches to clinical psychology training in public psychology competencies. The Public Psychology Doctoral Training Model was developed as a template for such a training program, predicated on three main components: a curricula based on public psychology competencies, collaborative academic, community, and county/state/federal partnerships, and group case-method learning beyond the classroom.

The Diversity and Community Mental Health (DCMH) area of emphasis is structured after the Public Psychology Doctoral Training Model and was provided as a sample illustration. To date, we have not collected outcome data evaluating students' actual demonstration of competencies at the beginning and end of the three-year training emphasis. Evaluation tools to measure students' acquisition of the knowledge, skills, and attitudes related to public psychology competencies are needed to evaluate the effectiveness of the DCMH emphasis. Additionally, because the DCMH emphasis is only in its third year of operation with few of its doctoral trainees already graduated, we do not have longitudinal data on public psychology employment trends or practice of public psychology competencies over time. Next steps for our program development efforts are to develop and collect these outcome data.

Recommendations for other doctoral programs looking to offer similar public psychology training efforts include the following:

1. Programs should offer a subset of courses that complement general doctoral curricula and cover the content areas and skills (i.e., public psychology foundational and functional competencies) needed for public sector psychology leadership. Readers are referred to the DCMH emphasis area presented in this article for an example of how courses can be structured to cover the public psychology competencies.
2. Trainees should be engaged with clinical practicum offered in partnership with community mental health agencies, and doctoral-level research that is community-based and that uses research methods useful for community mental health issues (e.g., mixed methods, translational research, community based participatory research, etc.).

3. Course design should include learning strategies that depart from traditional didactic approaches. In particular, community mental health constituents (e.g., community providers, consumers, and family members) should be extensively integrated into course structure via coinstruction, guest speakers, community advocacy events, or experiential projects. Courses should include group case-method learning beyond the classroom to foster self-directed leadership skills, the ability to work collaboratively in teams, and application of public psychology competencies with real-world community mental health problems.
4. Partnerships with county, state, or federal organizations should be pursued with the goal of creating pathways for training, recruitment, or financial remuneration that will facilitate public psychology careers. The specific nature of partnerships will vary based on opportunities available for different doctoral programs. Examples may include partnering with qualifying National Health Service Corps organizations who will eventually employ trainees making them eligible for NHSC loan repayment, advocating in collaboration local public agencies to create designated practicum, internship, and employment slots for psychologists, or applying for training grant opportunities.

Given the importance of recruiting bilingual and bicultural psychologists representative of the diverse and underserved communities of community mental health (e.g., U.S. Department of Health and Human Services, 2001; Vasquez & Jones, 2006), it may be advisable for public psychology doctoral training programs to publicize program emphases on underserved communities and mental health disparities to attract a diverse set of trainees representative of such communities. Specific outreach to potential students of diverse backgrounds and the development of financial assistance programs (e.g., loan repayment programs, scholarship programs, or training grants) can also assist in such recruitment efforts. Alternatively, programs may integrate language proficiency training to increase the number of psychologists able to provide mental health services in non-English languages.

The description of the Public Psychology Doctoral Training Model and guidelines for program development in this article were provided as an innovation with aspirations to spur further interest and development of public psychology training efforts in the clinical psychology field. Because longitudinal data on the competencies and career paths of DCMH students are not yet available, the impact of the DCMH emphasis area is currently unknown. However, it is our hope that programs based on the Public Psychology Doctoral Training Model may eventually increase the voice and leadership of future clinical psychologists amid the challenges of a changing public mental health services context.

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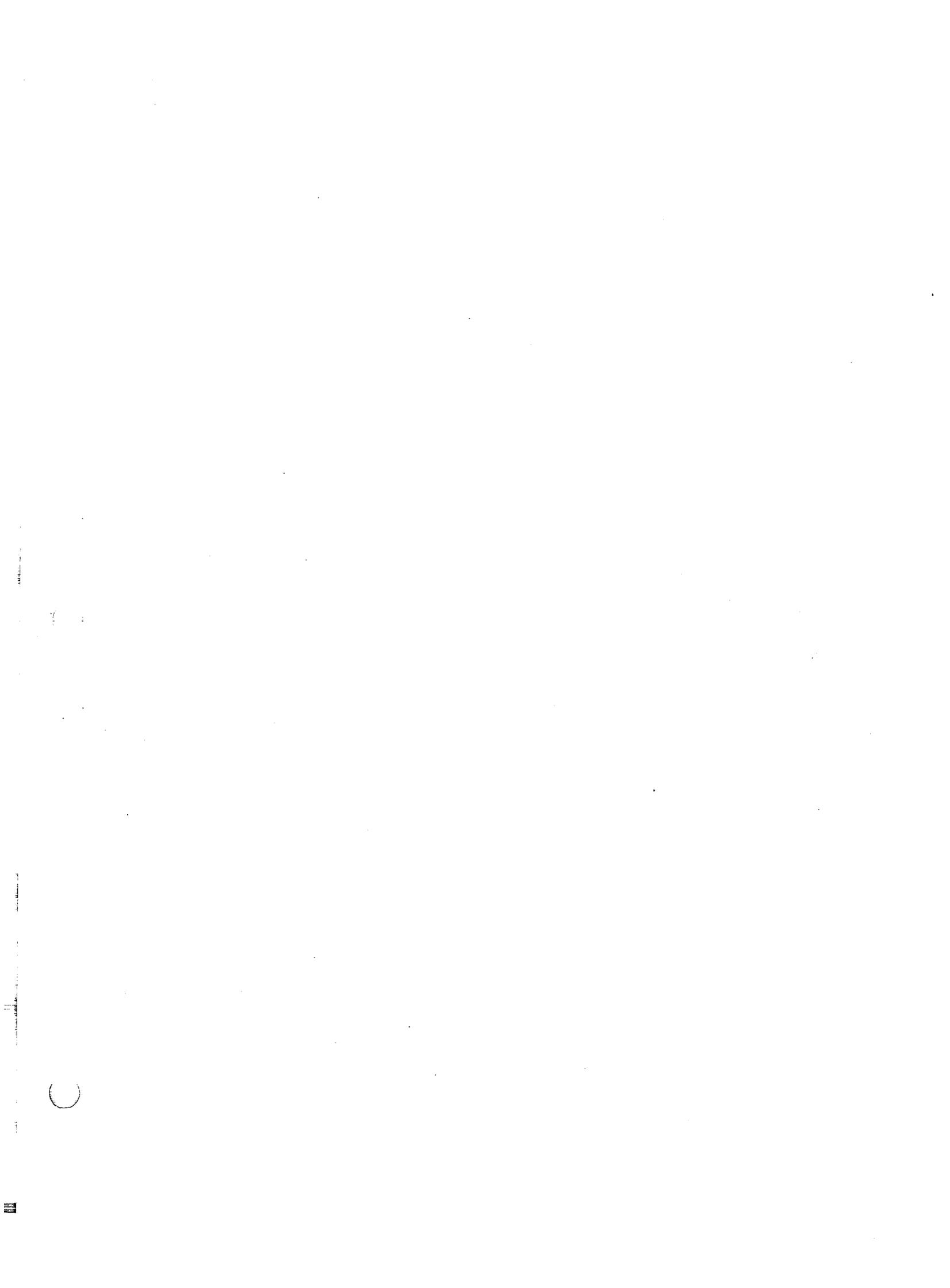
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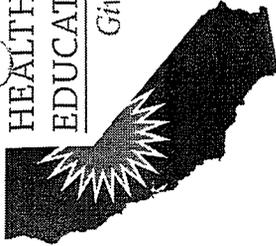
Revision received April 9, 2012

Accepted April 23, 2012 ■



**UCSF Psychiatric-Mental Health Nurse Practitioner Public Mental Health Clinical Placements
for MHSA Stipend Recipients 2009-12**

| Name of Community Based Organization (CBO) | County where CBO is located | Contract Started | # Students Placed Total Since Start of Contract |
|---|---------------------------------------|-------------------------|--|
| 1. San Francisco County Community Behavioral Health Services (multiple sites) | San Francisco | NK | 5 |
| 2. San Mateo County Behavioral Health & Recovery Services | San Mateo | NK | 7 |
| 3. Marin County Mental Health Services | Marin | NK | 1 |
| 4. Contra Costa County Health Services, Mental Health Division | Contra Costa | 2005 | 2 |
| 5. Richmond Area Multi-Services | San Francisco | NK | 1 |
| 6. Turning Point Community Programs | Sacramento, Stanislaus, Merced & Yolo | NK | 1 |
| 7. Glide Health Services (UCSF SON Faculty Practice) | San Francisco | NK | 4 |
| 8. Progress Foundation (UCSF SON Faculty Practice) | San Francisco | NK | 5 |
| 9. Hyde Street Community Services | San Francisco | 2009 | 1 |
| 10. The Effort | Sacramento | 2010 | 1 |
| 11. Sutter/Yuba County Mental Health Services | Sutter & Yuba | 2010 | 1 |
| 12. Family Service Agency | San Francisco | 2011 | 1 |
| 13. Through the Looking Glass | Alameda | 2011 | 1 |
| 14. Prevention & Recovery in Early Psychosis | San Francisco, Alameda | 2011 | 1 |
| 15. Ventura County Behavioral Health Department | Ventura | 2012 | 1 |



Mental Health Services Act Workforce Education and Training (WET) Five-Year Plan Work Plan

| Date | Action | Notes |
|------------------|--|--|
| December 3, 2012 | WET Advisory Committee Meeting <ul style="list-style-type: none"> Present proposed timeline for WET Five-Year Plan development to WET Advisory Committee and gather input | |
| January 2, 2013 | OSHPD WET staff begins evaluation of current WET programs | <ul style="list-style-type: none"> Includes review of Request for Bid, contract and progress reports to identify outcomes May require amendments to progress reports |
| January 29, 2013 | WET Advisory Committee Meeting <ul style="list-style-type: none"> Present draft of the proposed WET Five-Year Plan Vision, Values and Mission statement to the WET Advisory Committee and gather input Present draft list of proposed members of the WET Five-Year Plan Advisory Sub-Committee to the WET Advisory Committee and gather input Gather input on WET Five-Year Plan stakeholder engagement process including selection of stakeholders and methods to engage stakeholders | |
| January 30, 2013 | OSHPD WET staff begins planning stakeholder engagement process | <ul style="list-style-type: none"> Staff will use initial input gathered from the WET Advisory Committee |

Mental Health Services Act Workforce Education and Training (WET) Five-Year Plan Work Plan

| Date | Action | Notes |
|-------------------|--|---|
| February 8, 2013 | WET Five-Year Plan Advisory Sub-Committee roster finalized | <ul style="list-style-type: none"> The Foundation will finalize roster taking into consideration WET Advisory Committee input |
| February 27, 2013 | <p>WET Five-Year Plan Advisory Sub-Committee Meeting</p> <ul style="list-style-type: none"> Present revised draft of the Proposed WET Five-Year Plan Vision, Values and Mission statement to the WET Five-Year Plan Advisory Sub-Committee Meeting Gather additional input on WET Five-Year Plan stakeholder engagement process including selection of stakeholders and methods to engage stakeholders Gather input on scope of work to include for the Consultants mental health workforce needs assessment and identify key informants for consultant | <ul style="list-style-type: none"> OSHDP/HPEF considering funding opportunities for consultant (i.e. foundations, private grants, etc) and exploring options for gathering information on needs assessment |
| March 1, 2013 | OSHDP WET staff concludes evaluation of current WET programs | <ul style="list-style-type: none"> Outcomes will be shared with Advisory Committee, OSHPD website, etc |
| March 4, 2013 | Phase 1 of stakeholder engagement process begins | <ul style="list-style-type: none"> Phase 1 of stakeholder engagement process consists of strategies that include but are not limited to County site visits, community forums, focus groups, surveys, and interviews to gather information on values, mental health workforce needs, objectives, actions, and performance indicators that should be included in the next WET Five-Year Plan |

Mental Health Services Act Workforce Education and Training (WET) Five-Year Plan Work Plan

| Date | Action | Notes |
|-------------------|--|--|
| April 18, 2013 | WET Five-Year Plan Advisory Sub-Committee Meeting | |
| June 20, 2013 | WET Advisory Committee Meeting | |
| June 21, 2013 | Phase 1 of stakeholder engagement process ends | <ul style="list-style-type: none"> Develop forums to share this information |
| June 24, 2013 | OSHDP WET staff starts writing WET Five-Year plan based on input received during phase 1 of stakeholder engagement | |
| July 1, 2013 | Consultant begins contracted work | |
| July 24, 2013 | OSHDP WET staff finalizes the proposed draft of the WET Five-Year Plan | <ul style="list-style-type: none"> First draft will include input gathered through stakeholder engagement process |
| August 8, 2013 | WET Five-Year Plan Advisory Sub-Committee Meeting <ul style="list-style-type: none"> OSHDP WET staff presents proposed draft of WET Five-Year Plan and requests feedback | |
| August 15, 2013 | Consultant provides OSHDP WET staff with preliminary needs assessment data | |
| August 23, 2013 | OSHDP WET staff incorporates WET Five-Year Plan Advisory Sub-Committee recommendations | |
| September 5, 2013 | WET Advisory Committee Meeting <ul style="list-style-type: none"> Consultant present preliminary needs assessment data OSHDP WET staff presents proposed draft of WET Five-Year Plan which includes Vision, Values, Mission, Goals, Objectives and Actions and Needs Assessment section based on the input gathered from initial needs assessment, robust stakeholder engagement process, and WET Five-Year Plan Advisory Sub-Committee input WET Advisory Committee provides feedback to OSHPD | |

Mental Health Services Act Workforce Education and Training (WET) Five-Year Plan Work Plan

| Date | Action | Notes |
|---------------------------------|--|---|
| September 20, 2013 | <ul style="list-style-type: none"> Gather feedback on phase 2 of stakeholder engagement process OSHDP WET Staff finalizes first draft of WET Five-Year Plan and first draft of proposed 10-year budget | <ul style="list-style-type: none"> Staff will take into consideration input gathered from all stakeholders and advisory committee members |
| September 25, 2013 | Consultant provides OSHPD statewide needs assessment data | <ul style="list-style-type: none"> There will be priority on the data that is needed for the development of the WET Five-Year Plan which includes what changed from the 2008 needs assessment and what relation those changes have to the efforts of MHSA WET programs |
| September 30 - November 2, 2013 | Phase 2 of stakeholder engagement process to gather feedback on the draft WET Five-Year Plan | <ul style="list-style-type: none"> OSHDP will solicit feedback from a wide variety of stakeholders on proposed draft of WET Five-Year Plan |
| November 13, 2013 | WET Five-Year Plan Advisory Sub-Committee Meeting <ul style="list-style-type: none"> Review stakeholder feedback on first draft of WET Five-Year Plan Provide final recommendations to OSHPD WET staff | |
| November 22, 2013 | OSHDP WET staff incorporates the WET Five-Year Plan Advisory Subcommittee feedback | |
| December 1 - December 6, 2013 | Government Partners Meeting <ul style="list-style-type: none"> Review and approve 10-year budget and funding and governance | |
| December 18, 2013 | WET Advisory Committee Meeting <ul style="list-style-type: none"> Review and approved WET Five-Year Plan | |
| January 2014 | Mental Health Services Planning Council Meeting <ul style="list-style-type: none"> Reviews and approves the WET Five-Year Plan at its regularly- | |

Mental Health Services Act Workforce Education and Training (WET) Five-Year Plan Work Plan

| Date | Action | Notes |
|-----------------------|---|-------|
| | scheduled meeting | |
| February - March 2014 | The WET Five-Year Plan is sent to the OSHPD Director's Office | |
| March 2014 | The WET Five-Year Plan is sent the California Health and Human Services Agency for final approval | |
| April 1, 2014 | The WET Five-Year Plan is finalized and submitted | |

VOID

Supplemental Documents

**Mental Health Services Act
Workforce, Education and Training (WET)
Summary of 10-Year Spending Plan and Expenditures
Dollars in Thousands**

| | 10-Year Funding Amounts² | Expenditures to date³ | Amounts Remaining to be Allocated |
|---|--|---|--|
| Calculated WET Amounts¹ | | | |
| FY 2004-05 (45% of actual MHSA revenue) | \$114,200 | | |
| FY 2005-06 (10% of actual MHSA revenue) | \$86,100 | | |
| FY 2006-07 (10% of actual MHSA revenue) | \$93,500 | | |
| FY 2007-08 (10% of actual MHSA revenue) | \$150,700 | | |
| Total Statutory WET Funding | \$444,500 | | |
| WET Expenditures: | | | |
| 1) Local Programs | | | |
| County Allocations | \$210,000 | 210,000 | \$0 |
| Regional Partnerships ⁴ | \$27,000 | \$18,000 | \$9,000 |
| 2) State-Administered Programs | | | |
| Stipend Programs | \$100,000 | \$38,730 | \$61,270 |
| Psychiatric Residency Programs | \$13,500 | \$3,381 | \$10,119 |
| Statewide Technical Assistance | \$8,000 | \$2,960 | \$5,040 |
| MH Loan Assumption Program | \$75,000 | \$15,000 | \$60,000 |
| Physician Asst (Song-Brown) Program | \$5,000 | \$2,000 | \$3,000 |
| 3) Uncommitted Funds | | | |
| | \$6,000 | \$0 | \$6,000 |
| Total Expenditures | \$444,500 | \$290,071 | \$154,429 |

¹ 10 Per WIC 5892, calculated WET amounts based upon percentage of actual MHSA revenues collected between FY 2004-05 through FY 2007-08. WET funding must be spent within 10-year period or funds will revert.

² 10 year spending plan initiated for FY 2008-09 through FY 2017-18. Note that the CA Social Work Education Center (CalSWEC) contract (Stipend Program) was funded in 2006-07 and 2007-08 utilizing one time Community Services and Supports (CSS) funds which is not reflected in the totals above.

³ Expenditures reflect county allocations and contract encumbrances through FY 2011-12.

⁴ Balance of \$9 million for Regional Partnerships will require appropriation in FY 2014-15.

Summary of WET Programs

At the State level, these programs are included in the current Five-Year Workforce Education and Training Development Plan and can be categorized as:

➤ *Partnership Strategies*

- Support of five regional partnerships designed to promote and enhance local workforce capacity
- Continued support of a statewide technical assistance center (Working Well Together) focusing on the promotion of persons with lived experience in the community public mental health workforce

➤ *Program Development Strategies*

- Psychiatric residency programs that add psychiatric resident positions and provide core faculty time and psychiatric resident time in community public mental health settings
- Added a mental health track to the Song-Brown Residency Program for Physician Assistants
- Strategically increasing the number of California communities federally designated as mental health professional shortage areas

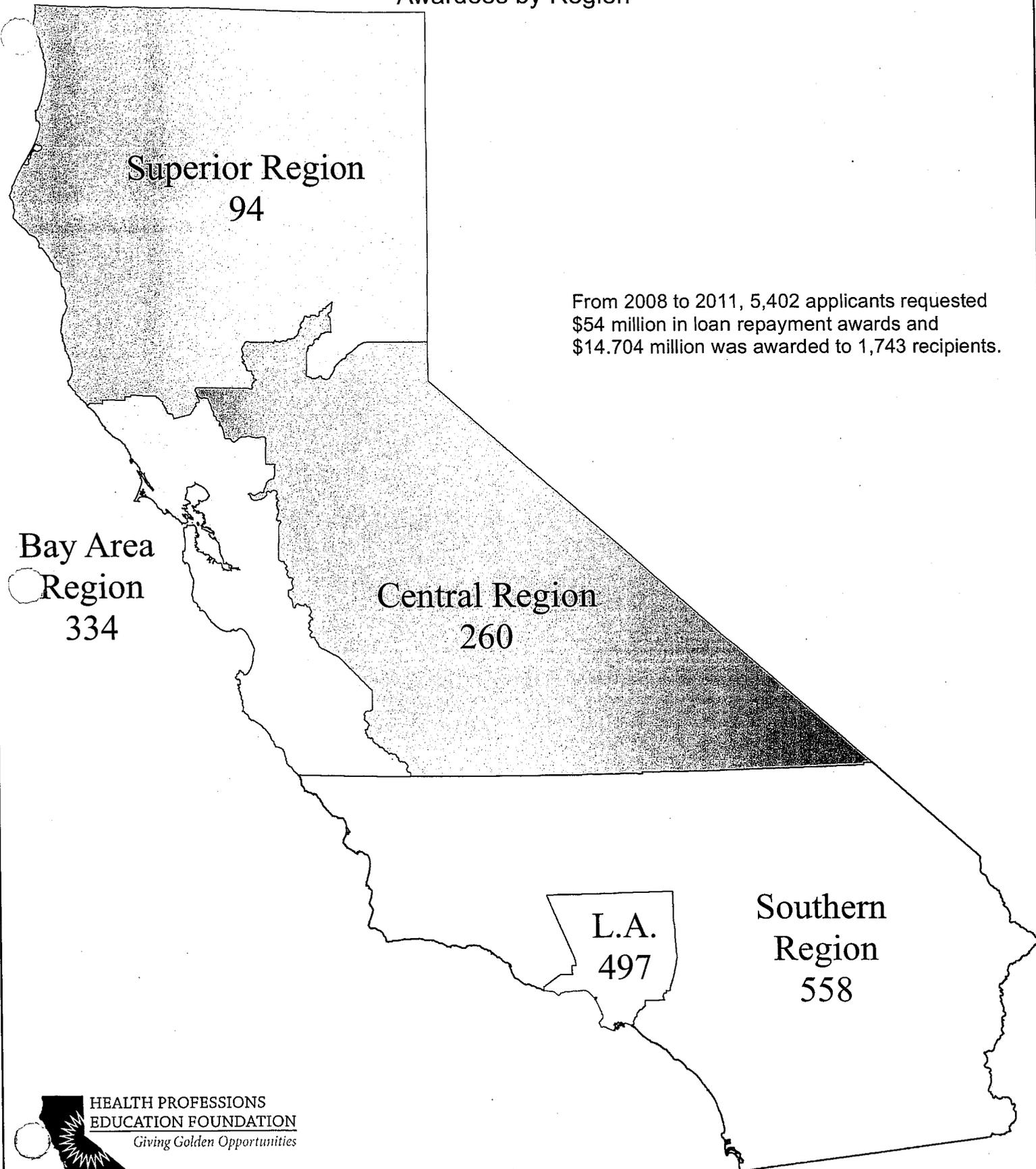
➤ *Financial Incentives Strategies*

- The Mental Health Loan Assumption provides qualified applicants with up to \$10,000 in educational loan repayments in exchange for service in the community public mental health system in a position the County Mental Health Director identifies as being hard-to-fill and/or hard-to-retain
- Stipend programs, modeled after the federal Title IV-E, for graduate students in social work, marriage and family therapy, clinical psychology and psychiatric mental health nurse practice who commit to receiving their training and working in the community public mental health system

The funds remaining to be allocated are being expended in accordance with the ten-year spending plan that can be found at Attachment B at

http://www.cmhda.org/go/portals/0/cmhda%20files/committees/mhsa%20comm/1105_may%202/finalgovtpartnersminutes04-07-08.pdf

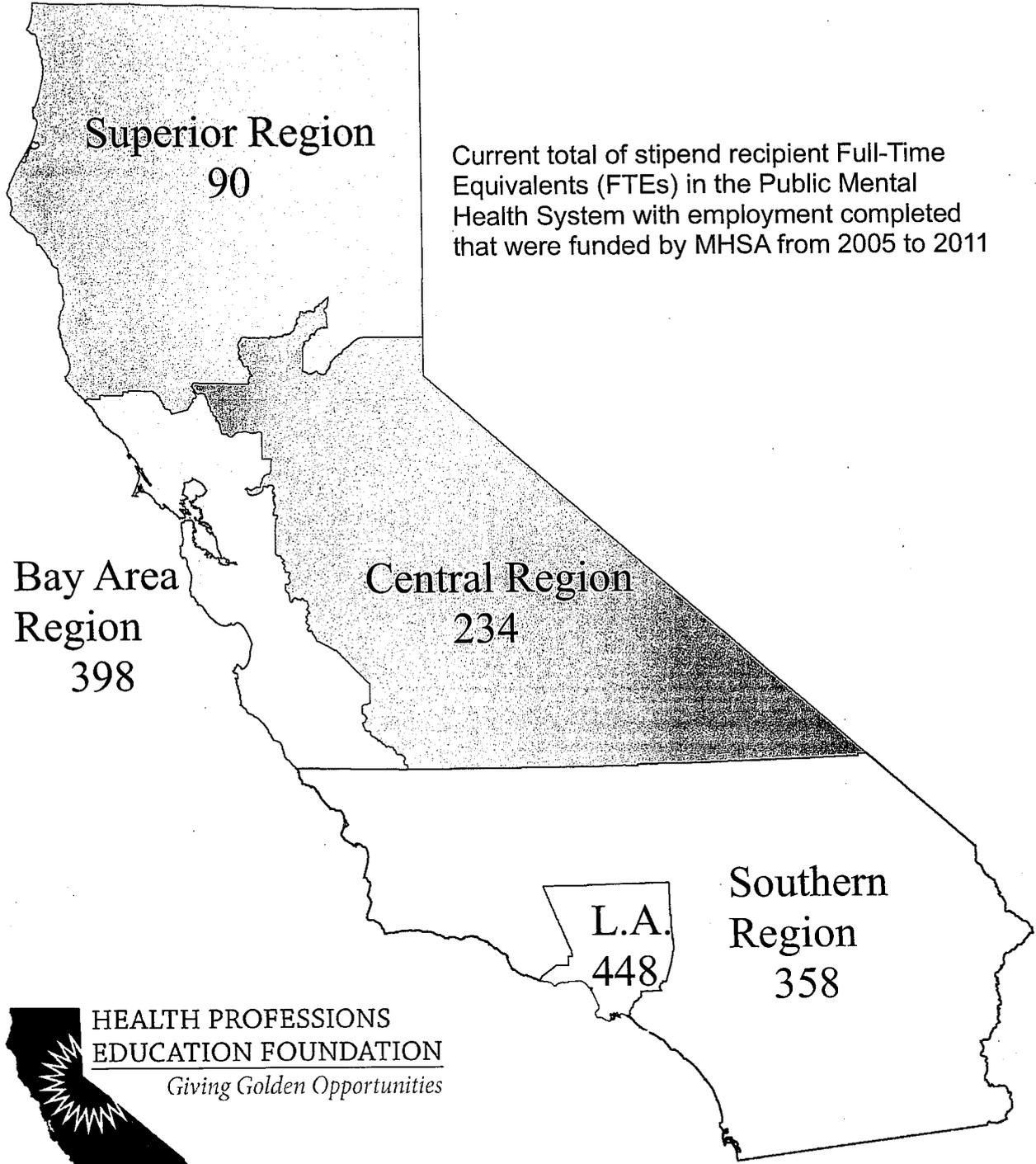
Mental Health Services Act (MHSA)
Workforce Education and Training (WET)
Mental Health Loan Assumption Program (MHLAP)
Awardees by Region



From 2008 to 2011, 5,402 applicants requested \$54 million in loan repayment awards and \$14.704 million was awarded to 1,743 recipients.



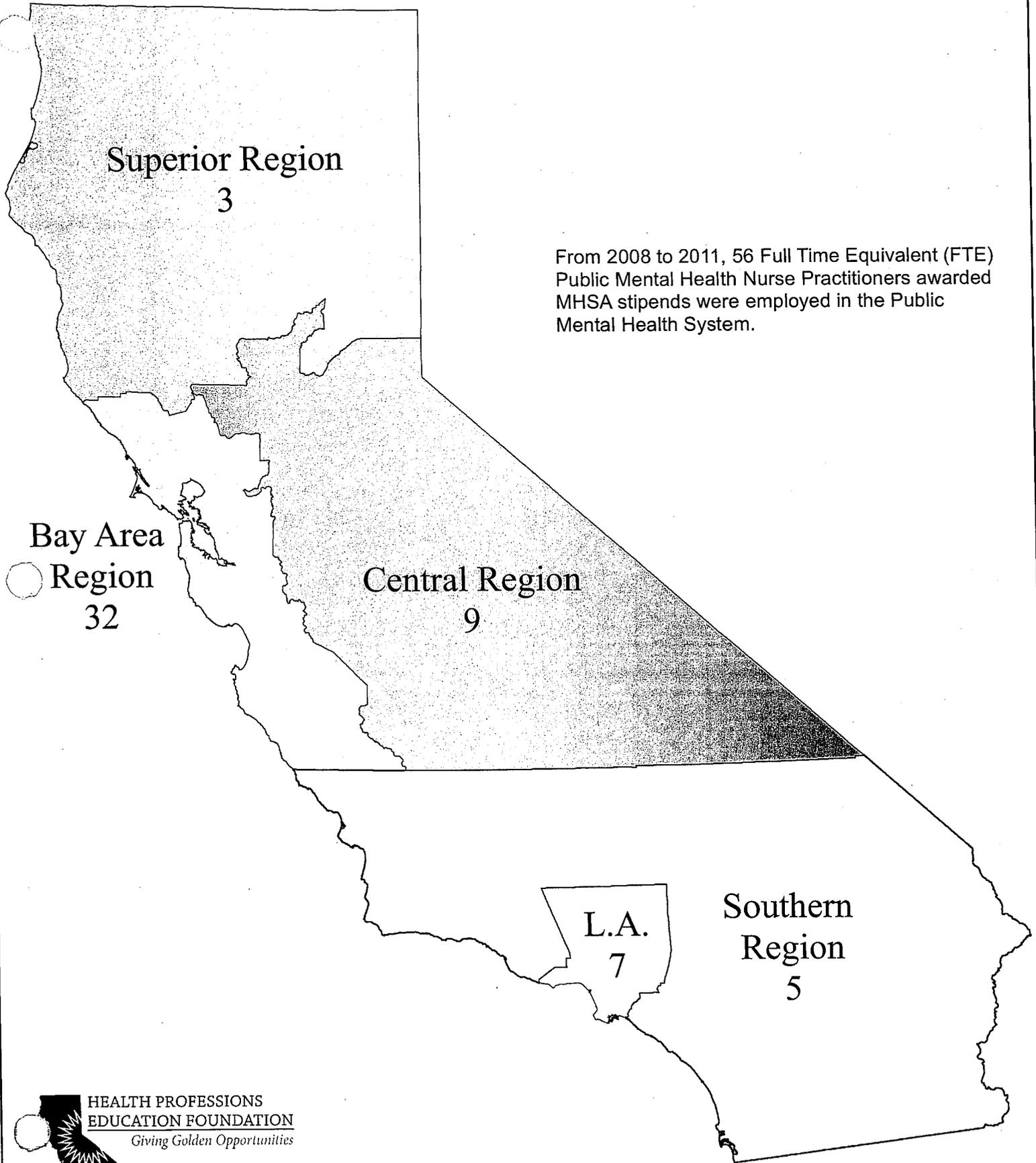
Mental Health Services Act (MHSA) Stipend Recipients by Region



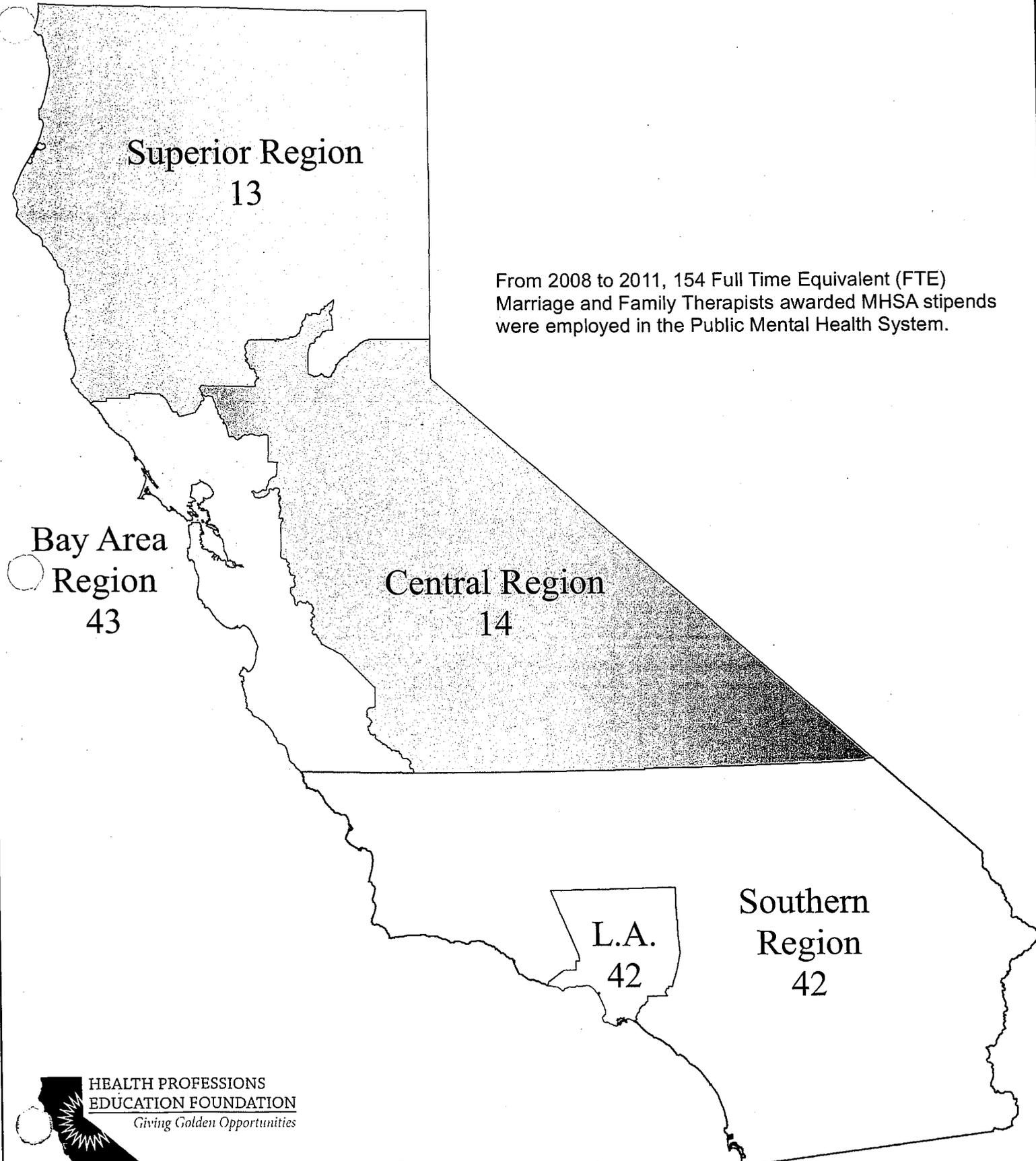
Current total of stipend recipient Full-Time Equivalents (FTEs) in the Public Mental Health System with employment completed that were funded by MHSA from 2005 to 2011



Mental Health Services Act (MHSA)
Workforce Education and Training (WET)
Public Mental Health Nurse Practitioners by Region



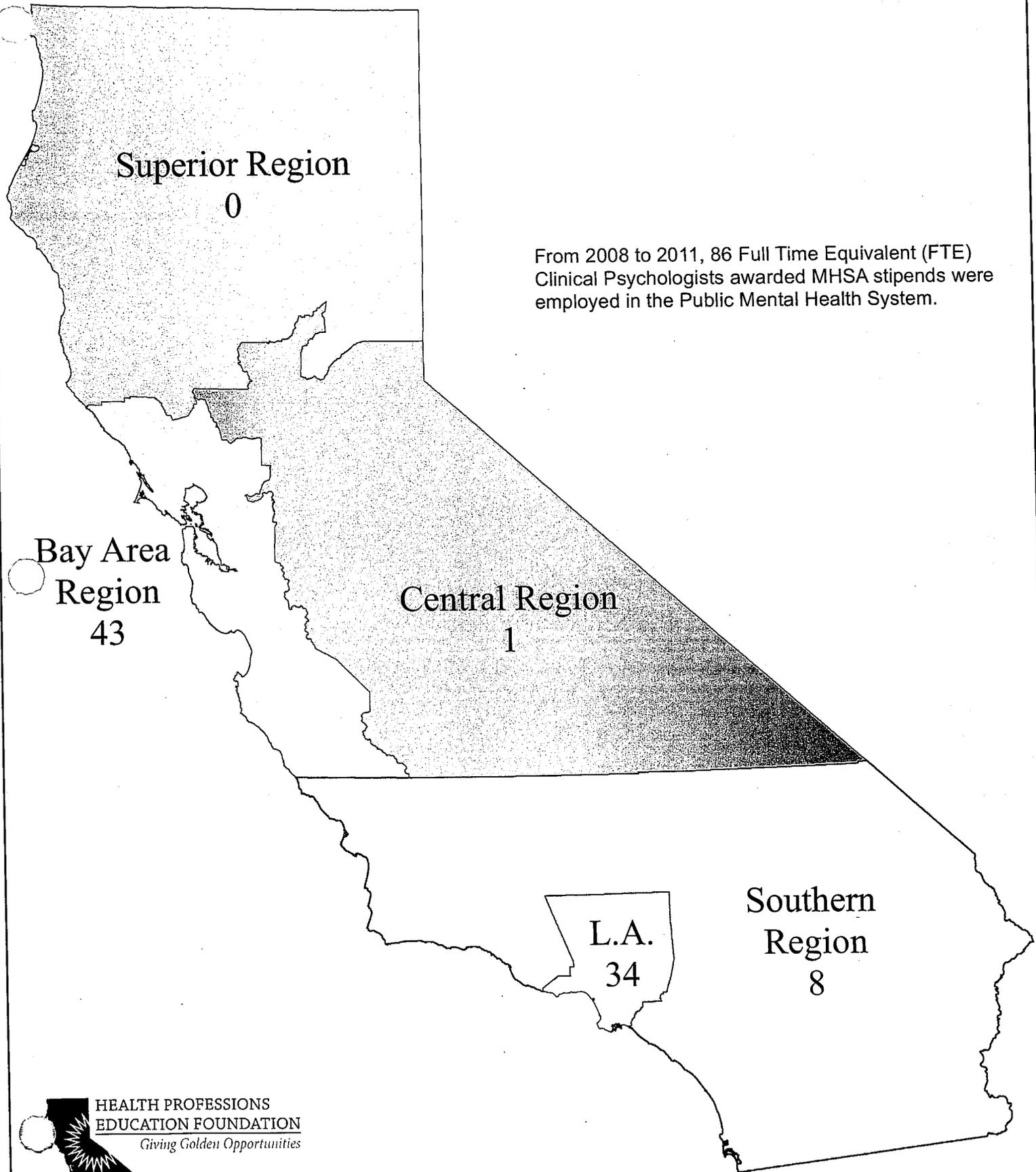
Mental Health Services Act (MHSa)
Workforce Education and Training (WET)
Marriage and Family Therapists by Region



From 2008 to 2011, 154 Full Time Equivalent (FTE) Marriage and Family Therapists awarded MHSa stipends were employed in the Public Mental Health System.



Mental Health Services Act (MHSA)
Workforce Education and Training (WET)
Clinical Psychologists by Region



From 2008 to 2011, 86 Full Time Equivalent (FTE) Clinical Psychologists awarded MHSA stipends were employed in the Public Mental Health System.

