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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

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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. His 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.

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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@paloaltou.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."

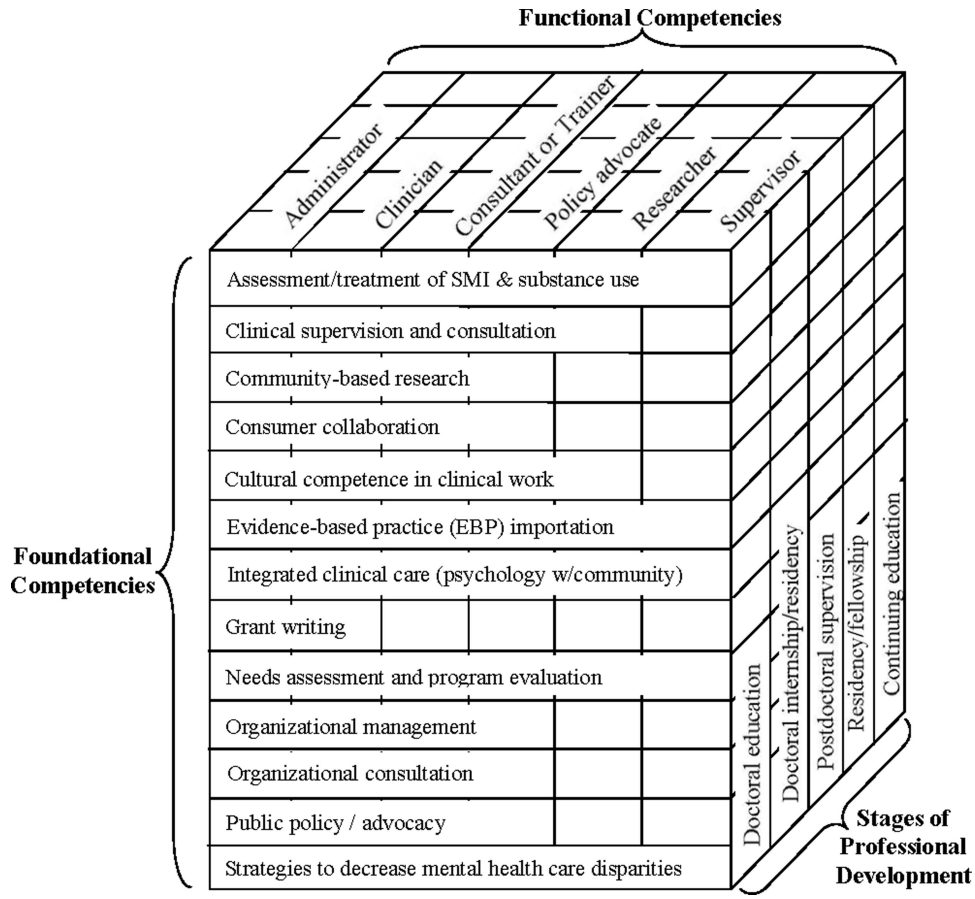

Figure 1. Intersecting competencies of public psychology. *Note*: Adapted from Rodolfa et al.'s (2005, p. 350) Cube Model for general professional psychology competencies.

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 shortcoming 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)

	M	*SD*
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), consumer 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 (Perlman & 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, & McIever, 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
	Screen and treat co-occurring mental illness and substance use disorders in collaboration with consumer groups
Supervisor	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
	Recruit clinicians with proficiencies in clients' primary languages
Clinician	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	Evaluate the impact of CMH programs on mental health care disparities
Supervisor	Supervise trainees in engaging/outreaching to underserved communities
	Needs assessment and program evaluation
Administrator	Provide agency support for needs assessments and program evaluation
Clinician	Administer assessments or conduct interviews for program evaluation
Consultant or trainer	Evaluate outcome data to identify agency needs
Policy advocate	Use data to lobby for or acquire funding for services
Researcher	Employ needs assessment methodologies to inform service priorities
	Evaluate and use outcome data to improve services and seek funding
Supervisor	Supervise trainees on the assessment of service needs and/or implementation of clinical changes
	Organizational consultation
Administrator	Seek consultation for organizational management issues when indicated
Consultant or trainer	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)
Policy advocate	Advise organizations on navigation of pertinent policy and fiscal issues
Researcher	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	Seek consultation from policy or advocacy experts in matters pertinent to managing and sustaining a CMH organization
Clinician	Advocate for client issues through local and national organizations
Consultant or trainer	Advise on advocacy/policy pathways as solutions to agency needs
Policy advocate	Use advocacy/social justice principles to assure program sustainability
	Advocate for funding/policy-related issues through local and national organizations
Researcher	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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