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Public Psychiatry The subject area of public psychiatry embodies a fundamental core of experience and tradition. In the context of the reexamination of American health care initiated by the effect of managed care and the health care reform, the experience of public psychiatry is poised to serve as the foundation for a transformation of behavioral health care. The term public can refer to psychiatric programs, treatment, or institutions paid for by public funds or as objects of public policy, whether paid for or not. The traditional concept of public psychiatry has been expanded to include medical and psychosocial initiatives directed for the public good, whether funded by public or private funds, and directed in particular to those who are economically disadvantaged. The care and treatment offered under public psychiatry are delivered in a variegated mosaic of inpatient and community-based services that are more or less integrated into a coherent network sponsored by public agencies. Funding for public psychiatric services tends to be provided by federally legislated appropriations that are passed through state, county, and municipal government agencies (such as departments of mental health; substance use treatment services; children, youth, and family services; and public health, social services, education, adult corrections, and juvenile justice agencies). Ultimately, most public psychiatry and community services are provided by not-for-profit community mental health, substance use treatment, child guidance, or health care organizations that either are funded by or subcontracted to government agencies. Thus, the very existence of public and community psychiatric services and the policies and resources determining how they are delivered are extremely dependent on legislative mandates and fiscal appropriations from all levels of public government. CONTEMPORARY PUBLIC AND COMMUNITY PSYCHIATRY There are five themes around which the discussion of contemporary public and community psychiatry is structured: public health, public agencies, evidence-based psychiatry, roles for psychiatrists, and delivery systems. Public Health Public health is not simply publicly funded health care but is rather a specific discipline and tradition. It is a complicated field that historically has been defined negatively by the dominance of personal health, that is, the health care delivery systems that take care of individual patients. Until the advent of managed care in the 1990s, U.S. health care was an industry organized largely in terms of individual doctor-entrepreneurs. Each jurisdiction uniquely defined and organized its public health programs, and the

particular pattern of personal health practices had substantial influence—hence the wide variation in public health programs. Nonetheless, as a discipline and tradition, public health’s mission is to assure the conditions in which people can be healthy. Public health consists of organized community efforts aimed at the prevention of disease and the promotion of health. It involves

many disciplines but rests on the scientific core of epidemiology. It provides an essential template for contemporary public and community psychiatry. The Surgeon General's report on mental health underscored the necessity of a public health approach to care and rehabilitation for people experiencing mental illness that is "broader in focus than medical models that concentrate on diagnosis and treatment." Although diagnosis and treatment are core areas of expertise for all psychiatrists, the Surgeon General recommended that even when psychiatric diagnosis or treatment is the primary focus for practitioners, researchers, or educators, they should ground their professional activities in a vision and knowledge base that is "population-based...encompass[ing] a focus on epidemiologic surveillance, health promotion, disease prevention, and access to services." These fundamental public health functions define the public health perspective in public and community psychiatry. In the discussion that follows, these four public health components are framed in current terms of health care reform to define a coherent "public health" strategy for public and community psychiatry. Health Promotion Psychiatric professionals can contribute substantially to the promotion of public health by working with primary health care professionals and educators to identify and provide front-line treatment and referrals to adults and children who have undetected psychiatric symptoms, subthreshold syndromes, and psychiatric disorders. Collaborative care models bring psychiatric professionals into primary care and school settings as consultants for medical, nursing, and education professionals who work in those settings, as well as for educators and direct treatment providers to at-risk or psychiatrically impaired individuals. Furthermore, people with identified mental illness or addictive disorders can benefit from enhanced physical and mental health care, as well as from the alleviation or management of psychiatric symptoms. Achieving or regaining physical or mental health (i.e., recovery) depends not only on genetic and biological factors but also on a person's or family's access to social and psychological resources and integration into supportive social networks. Illness management (also known as disease management or chronic illness care management) is a framework that has been adapted from medicine to guide mental health professionals in delivering services that go beyond traditional diagnostic treatment to promote the health and recovery of people with mental illness or addiction. Illness management has been defined as "professional-based interventions designed to help people collaborate with professionals in the treatment of their mental illness, reduce their susceptibility to relapses, and cope more effectively with their symptoms...[to] improve self-efficacy and self-esteem and to foster skills that help people pursue their personal goals." A number of approaches to illness management have been scientifically and clinically evaluated and have been found to enhance

standard psychiatric treatment. Prevention. Psychiatric disorders most often follow a course over time that begins with an often lengthy period in which prodromal or subthreshold symptoms or functional problems precede the full onset of a disorder with marked impairment. Intervention with adults, adolescents, or children who are not clinically impaired but who are at high risk (e.g., owing to a family history of psychiatric or addictive disorders or exposure to extreme stressors, such as violence, neglect, or the modeling of antisocial behavior) or who are manifesting preclinical symptoms or functional problems (e.g., periodic or pervasive dysphoria, problems with separation from caregivers, or involvement with deviant peers) is an approach to prevention that has been found to be cost effective because it targets a relatively small group of individuals in a timely manner. Application of the traditional public health concepts of primary, secondary, and tertiary psychiatry has been confusing in psychiatry. Primary prevention involves addressing the root causes of illness with healthy individuals, with a goal of preventing illness before it occurs.

Secondary prevention involves the early identification and early treatment of individuals with acute or subclinical disorders or high-risk persons to reduce morbidity. Tertiary prevention attempts to reduce the effects of a disorder on an individual through rehabilitation and chronic illness care management. The Institute of Medicine, in an effort to clarify different aspects of prevention, developed a classification system with three different categories. Universal interventions are those intended for the general public, such as immunizations or media campaigns providing information about illnesses, early warning signs, and resources for health promotion and timely treatment. Selective interventions focus on individuals at higher-than-average risk (e.g., persons with prodromal symptoms or a family history of psychiatric disorders) to reduce morbidity by enhancing resilience and preventing the onset of illness. Indicated interventions target individuals who are experiencing impairment as a result of illness as early as possible in the course of the illness, to reduce the burden of the illness on the individual, family, community, and treatment system. Psychiatric services most often take the form of indicated interventions, but the smaller number of psychiatric practitioners and researchers who conduct and evaluate selective or universal interventions in public and community settings is making a substantial contribution to the larger health of society. Prevention interventions have been found to be effective with adults with a variety of risk factors or preclinical problems. For example, women who have been raped are less likely to develop posttraumatic stress disorder (PTSD) if they receive a five-session cognitive-behavioral treatment than if their recovery is left to chance. Men and women identified with subthreshold symptoms of depression by primary care medical providers are more likely to remain free from the full syndrome of depression or to be able to recover rapidly with treatment if they do become clinically depressed if their standard medical treatment is enhanced by education about depression and learning skills for coping actively with depressive symptoms or stressors. Prevention with adults must be judiciously designed to address the specific factors that place a person at risk for illness or that enhance the person’s ability to cope effectively. For example, brief supportive meetings with people who have experienced a traumatic stressor (e.g., a mass disaster or life-threatening accident) tend to have little benefit and may inadvertently intensify

posttraumatic stress, whereas a focused cognitive-behavioral approach to teaching skills for coping with traumatic memories and stress symptoms has been shown to be effective in preventing posttraumatic stress and depressive disorders with adult and child disaster or accident survivors. A number of prevention programs have been developed and evaluated to address physical and mental health risks in childhood and adolescence, incorporating several elements that influence intervention effectiveness. Their broad and systematic implementation, however, has been halting. A number of states have made an effort to implement school-based interventions involving teachers and the peer group. These tend to be more effective than programs exclusively relying on intervening with parents or children alone. Such interventions in middle childhood have been successful in influencing peer group norms regarding alcohol and substance use, violence and bullying, and depression, thus achieving the dual outcome of reducing immediate initiation of alcohol and substance use and increasing the long-term support within the peer group for sustained abstinence into adolescence. Thus, systems-based multimodal interventions simultaneously targeting and developing enhanced relationships among the child, peer group, school personnel, parents, and the wider community tend to be most effective as universal or selected approaches to early prevention of what otherwise may become lifelong behavioral, legal, academic, and addictive problems. Access to Effective Mental Health Care. Access is a serious problem for most people with severe mental illness or addictions. In the United States, the National

Comorbidity Study (NCS) and the National Comorbidity Study-Replication (NCS-R) found that fewer than 40 percent of people with severe psychiatric disorders had received any mental health treatment in the previous year, and fewer than one in six (15 percent) had received minimally adequate mental health services. Young adults, African Americans, people residing in certain geographical areas, people with psychotic disorders, and patients treated by medical but not mental health providers were at highest risk for inadequate psychiatric treatment. Although income was not a predictor of inadequate treatment, it is likely that many of the people who did not receive adequate mental health services were uninsured or had insufficient insurance coverage for mental health conditions and had no viable source of mental health care other than through a medical provider or clinic or in the public mental health system. Even when mental illness is identified, people with socioeconomic adversities often do not, or cannot, get adequate mental health services in their communities. For example, although it is estimated that more than 200,000 incarcerated adults in the United States have psychiatric disorders, few were detected or received treatment until they reached jail or prison. Federal and state correctional systems have instituted mental health screening and treatment programs to address psychiatric disorders as a health problem for incarcerated adults and to manage the problematic behavior that can occur in controlled settings as a result of mental illness. On returning to the community, the vast majority of prisoners with psychiatric disorders cease to receive more than minimal mental health services: A recent study found that fewer than one in six (16 percent—strikingly similar to the NCS finding) received steady mental health services, and only one in 20 with addictions received steady substance abuse recovery services. Thus, access to mental health and addiction treatment

services is far better in prison than in the community! This has caused great concern because of the possibility that correctional facilities may be a de facto system of care for low-income people (often of minority backgrounds) with serious mental illness. Evidence of serious and pervasive barriers to accessing mental health care can be found in several social crises. Poor children and adults increasingly are deferring physical and mental health care until illnesses become chronic and severe and then often do not know or cannot gain entry into any setting for services except public hospital emergency departments. Children with severe psychiatric or behavioral disorders are being held in emergency department facilities for days and even weeks because the staff cannot locate any treatment facilities with an appropriate level of care that have an opening or are willing to take the child as a patient (or accept the child or family’s insurance coverage or lack thereof). People who cannot afford private services thus face daunting obstacles when seeking appropriate mental health care as a result of a serious underfunding of practitioners and programs. The economic forces and public policy dilemmas driven by the everincreasing cost of health care bear directly on the field of public psychiatry, as well as the lives of tens or hundreds of thousands of people who do not receive adequate care. Psychiatry and Public Agencies Psychiatry’s relationship to public sector agencies has, with some specific exceptions, been one of detachment because of the dominance of the private practice models before the advent of managed care and also largely because of the nature and structure of U.S. social welfare programs. This is a divide that often begins during academic preparation, in that many psychiatry training programs eschew meaningful rotations in public sector settings. In contrast to most industrial nations in which comprehensive social welfare reforms have been initiated, U.S. social welfare programs grew incrementally and categorically, that is, one category of service at a time. Large-scale initiatives, such as President Johnson’s War on Poverty, have been implemented in piecemeal fashion by fragmented federal, state, and local government bureaucracies and have been vastly reduced

through subsequent initiatives, such as the recent changes in federal regulations to “end welfare as we know it.” Various social service agencies have been created through a process and set of alliances that has been called the iron triangle. Advocates form an organization to champion a particular cause, such as blindness, developmental disabilities, primary care, or mental health, among others. They find key legislative sponsors who advance the cause through legislation and appropriation. This creates a bureaucracy and bureaucrats that join the alliance. Through successive legislative sessions, the alliance of advocates, lawmakers, and bureaucrats builds a stronger and stronger categorical agency, for example, adults and families with dependent children or people with biologically based, severe mental illness. From the 1930s through the end of the twentieth century, U.S. social welfare agencies were created on this pattern: The system has resulted in generous funding and hopeless fragmentation of services at local service delivery levels in which each agency depends on separate funding silos that also deliver conflicting rules and regulations. It has been said that “mental health is not a place.” Psychiatrists have a role at the receiving end of every categorical silo because the clients of each categorical agency experience mental illness or various addictions. Services for children with severe emotional, mental, or behavioral disturbances are a dramatic case. Five categorical agencies—child welfare,

education, primary health, substance abuse, and juvenile justice—all have a responsibility to care for these children (and, indirectly, for their caregivers, including parents and families). Especially for the children with the most severe disabilities, the protective service worker taking a child into court, the special education teacher working day to day with the child, the juvenile probation officer, the substance abuse counselor, and the child’s pediatrician all need the consultation and support of a skilled psychiatrist. The situation is similar for adults with severe mental illness, for whom case managers, vocational rehabilitation counselors, basic needs benefits specialists, social workers, psychotherapists, substance abuse counselors, parole or probation officers, legal conservators, visiting nurses, peer specialists, and physicians all may be mandated to deliver services. Workforce Influences on Contemporary Practice Shortages in the ranks of psychiatry have been well documented historically, and some project this to continue. However, as the field of psychiatry connects with its science and evidence base (e.g., neuroscience, genetics, pharmacology, outcomes science) while retaining its strength in the meaningful connection with patients and their families, some would argue that the reversal of the shortage trend has begun. The Decade of the Brain in the 1990s and the Decade of the Mind begun in the 2000s sponsored by the National Institutes of Health (NIH) contributed to this change. Medical students are increasingly stimulated to enter the field by recognizing the importance of psychiatry to health care in general, realizing that this is still a field in which the practitioner (and by extension the interdisciplinary team) is an instrument of change through integration of contemporary knowledge, skillful learned interactions with patients, and a willingness to commit to providing value. The national aggregate numbers, however, cannot adequately capture the extreme variations that exist geographically: Rural and frontier sites are dramatically more likely to experience shortages than more urban environments. Because subsets of the public sector populations have special needs, responses to their needs have to be correspondingly tailored: Children and family needs are expressed differently than those for adults and require different responses. Mental illnesses have culturally driven ways of presenting, and interventions must be culturally competent. Issues of language (including American Sign Language with hearing-impaired individuals) can complicate diagnosis and treatment. The rapidly expanding elderly population will pose significant new challenges for effective treatment. Just these few examples suggest the sophistication with which education and

training must be engineered to meet the existing and changing demands of people in need of services. Contemporary Evidence Base for Effective Public and Community Psychiatry

Since the 1980s, several structured interventions have been developed to address the gap between what historically has been taught in most psychiatry training programs— typically, an office-, clinic-, or hospital-based approach focusing on diagnoses and pharmacotherapy supplemented by psychotherapy—and the competencies required to deliver or to support the delivery of the full array of psychiatric rehabilitation services. Public and community approaches to psychiatric rehabilitation involve not only pharmacotherapy but also an array of complementary services that must be coordinated to assist people with severe mental illness or behavioral disorders and their families and support systems to manage symptoms, to access and use resources effectively, and to gain the greatest degree of autonomy in the least restrictive setting possible. The competences required to effect these interventions go beyond the scope of psychiatry, thus requiring that psychiatrists effectively collaborate with other rehabilitation and mental health specialists. Although psychiatrists rarely implement the educational, resource linkage, and psychotherapy interventions involved in these protocols, it is essential that the psychiatrist become aware of and be able to reinforce these interventions. Hence, familiarity with the manuals that describe how to implement these interventions with fidelity is strongly advised—and increasingly incorporated into psychiatry training. Evidence-Based Manualized Interventions for Child Psychiatric Rehabilitation. Children with severe emotional disturbance and adolescents with severe behavioral disorders traditionally have been removed from their families and placed in restrictive psychiatric or juvenile justice settings (e.g., psychiatric inpatient wards, residential group homes, and juvenile detention centers). These placements separate the child from the natural family, school, peer group, and community environments, which may provide some benefit by reducing the child’s exposure to addiction, conflict, violence, or deviant behavior. However, the placements also deprive the child and family of the opportunity to build better relationships with one another and with other children, families, teachers, and community groups. The second key ingredient to effective public and community child psychiatry comprises interventions that complement pharmacotherapy. Since the 1970s, several rehabilitative approaches for children with severe disorders (and their families) have been developed, tested, and disseminated in replicable manuals and training programs. Implementation of evidence-based practices is not always easy and rarely occurs even in clinics and practice groups that are well trained and motivated to use evidence-based treatment models, given that most current systems of payment and service delivery were not designed to accommodate or support the use of science-based interventions such as those highlighted here. In addition, evidence-based dissemination and implementation strategies must be deliberately designed to support the initial adoption and sustained use of evidence-based mental health treatment models. For example, a recent study of the implementation of one of the most widely disseminated evidencebased mental health interventions for children and families, multisystemic therapy (MST), demonstrated that initial training yielded a very positive early rate of adoption

of the program with good fidelity to the model, but only teams that were provided with regular ongoing supervision and support (for supervisors as well as therapists) from expert consultants were able to sustain the initial successes. Roles of Psychiatrists in Public and Community Psychiatry Multidisciplinary Teams Psychiatrists in the public sector rarely work in isolation. Most often, psychiatrists work within a team that includes professionals from several disciplines (e.g.,

psychology, social work, nursing, occupational therapy, rehabilitation or addiction counseling, social services, housing, and employment specialists) and nondegreed direct care workers (e.g., bachelor's degree–level counselors or case managers, high school graduate indigenous outreach workers, peer-support specialists, and family advocates), each of whom brings unique skills and experience to address the varied needs of people with severe and persistent mental illnesses. The team, rather than any single provider, assumes responsibility for the ongoing care of each patient across the many levels of services and often for many years. Its success is based on effective communication. Every communication should be explicitly focused on the client's (i.e., patient and family) stated goals, as well as on the team's technical and logistical issues, to maximize the client's motivation to participate actively and productively in all services by ensuring that the services truly are patient centered and collaborative. Psychiatrists play three primary roles on multidisciplinary psychiatric rehabilitation teams: Conducting psychiatric evaluations, providing pharmacotherapy, and serving as the team's medical director (and, at times, as the administrative supervisor or team leader). Psychiatric Evaluation and Diagnosis. In public and community settings and populations no less than in any other practice setting or patient population, the sine qua non is a thorough evaluation of all relevant history and systems and an accurate diagnosis. The goal of evaluation and diagnosis is to develop the most clinically effective individualized approach to treatment and rehabilitation for each patient. Psychiatric evaluations in public and community settings must include a careful review of the individual's psychosocial strengths and resources. The focus on strengths and resources often is lost or obscured when systemic factors (e.g., eligibility regulations for governmentally funded services or benefits) emphasize disability or limit the individual's or family's access to services or benefits (e.g., welfare-to-work regulations that place time or other eligibility restrictions on types of temporary aid, such as food stamps or vouchers for household supplies or housing). Pharmacotherapy. The psychiatrist's most visible role usually is providing pharmacotherapy. The most difficult challenge in public sector mental health settings often is not the technical formulation of an effective medication regimen but instead the arranging of a plan of care so that the patient reliably follows the prescribed regimen

(i.e., adherence or compliance). A recent review of interventions designed to enhance adherence to psychotropic medication regimens by patients with schizophrenia found that education alone often was the only strategy used even though it was less effective than approaches that focus on "concrete problem solving," "motivational techniques," and "reminders, self-monitoring tools, cues, and reinforcements" or that provide "an array of supportive and rehabilitative community-based services." Thus, although the psychiatrist must address technical medical issues accurately to formulate diagnoses and to establish an effective psychotropic regimen, effective pharmacotherapy depends heavily on providing—directly, in encounters with patients, or indirectly, by working closely with nonpsychiatric mental health professionals and nondegreed care workers—practical assistance to patients to enable them to anticipate and to manage the psychosocial stressors or problems that can render even the most technically sound medication regimen completely ineffective as a result of nonadherence by the patient. Team Leadership. The psychiatrist also often plays a leadership role as the project or program medical director—with the attendant responsibilities of monitoring the medical safety and well-being of all patients and establishing or supporting management and clinical procedures that support quality of care and a cohesive treatment team. As the team leader or simply as a team member, the psychiatrist serves as a role model for compassionate and professional behavior in relation not only to patients but also to all other team members. Formal or informal leadership is especially important when

psychiatry residents and medical students work on a team as a training experience. The team psychiatrist serves not only as a mentor and a role model for the core aspects of psychiatric practice but also to demonstrate the values and skills necessary to integrate psychiatry within the framework of multimodal community-based longitudinal psychosocial interventions. Psychiatrists who work with persons with severe mental illness and who wish to contribute as key members or leaders of their teams must go beyond their prescription pads to acquire knowledge, attitudes, and skills congruent with contemporary practice guidelines for psychiatric rehabilitation; give respect and support to multidisciplinary team members and gain their respect and support in return; cope with large caseloads; collaborate with agencies and programs to ensure continuity, consistency, and coordination of care; and value the roles and expertise of staff who provide case management, supported employment, skills training, and family and housing supports. If psychiatrists can incorporate these attitudes and skills, they can expect reciprocity and cohesion from other team members, and clients will benefit. Surveys of psychiatrists in the public sector indicate that those who embrace the rehabilitation perspective by expanding their roles to be consultants and teachers for patients, families, trainees, and colleagues from other mental health disciplines are more satisfied professionally than those who focus on diagnosis and treatment alone. New Paradigms. Virtually all health care should be integrated and coordinated to deliver effective, rational, and cost-efficient care. The broader, contemporary definition of care must include public health. In fact, linking public health models with acute care management, which, in turn, is coupled with chronic illness care management, rehabilitation, or recovery models, represents the continuum for an integrated system.

However, this continuum is insufficient without four other components: (1) the application of new research to improve care and the application of bench-to-bedside models to translational research, (2) meaningful involvement of patients and families in a shared decision-making paradigm, (3) integration with primary and specialty care systems, and (4) the development of the clinical system as a system of advocacy. Training preprofessionals in such a model is one approach to introduce meaningful and sustained change to health care and its delivery and is already operational in some systems. New Models for Service Delivery and Treatment Organized Systems of Care. The focus of reform has moved increasingly to coherent, efficient, and accountable delivery systems. The basic idea of the system of care for children with serious emotional disturbances can be described in two ways—in terms of interagency structures and in terms of clinical processes. Five categorical agencies in a given community form a strong consortium that targets a specific population of children (and their families) to whose needs none of the agencies can adequately respond on their own. The consortium agencies commit themselves to treat the child and family with a common plan of care and to find ways to pool their resources to do so appropriately. This often requires that in the central bureaucracies at the state level, a parallel interagency commitment be in place that supports the local system of care initiative, resolves any regulatory conflicts that may arise, and gives permission to innovative aspects of the delivery system. The collaborative interagency structure provides the resources and the flexibility for effective clinical work. From the viewpoint of clinical processes, the system of care provides a full enactment of the traditional clinical practice that meets the requirements of medical quality assurance. What is different is that it is carried out in home and community settings, and it involves participants from different disciplines—child welfare, special education, and juvenile justice—in one standardized treatment methodology. The center of the system of care is the child and family team that is made up the child and family, clinicians and agency representatives involved in the case, and significant supportive individuals

identified by the child and family. Current issues are reviewed—strengths, problems, and needs—diagnostic issues are considered, clinical goals are articulated, and appropriate treatment strategies are identified. The expected outcome of each intervention is specified, and progress toward it is systematically charted. The system of care requires a full array of flexible services. The essential starters include clinical diagnostic services, care coordination or case management, crisis intervention services, and a flexible essential supportive service—child care specialists who can be assigned to support the child and family in any situation. Systems of care that have been particularly effective have relied on substantial community organization and collaboration or innovative funding models, or both, that blend or braid funding streams to focus on clear assignment of responsibility for a particular child and family, as well as adequate resources. The basic model for community support for adults was called assertive community treatment (ACT). ACT was implemented with multidisciplinary teams with psychiatrists, nurses, psychologists, social workers, psychiatric aides, and paraprofessionals. The ACT

team would assume the care of a designated number of adult patients with serious and persistent mental illness and would be available around the clock, 7 days a week. The team would help find housing, manage money, organize household routines, find social contacts, find work, and support the individual’s adjustment to workplace settings. Concurrently, medications would be managed and help provided to facilitate an individual adjusting to community living. At the heart of the program was the basic clinical process that developed and maintained an individualized treatment plan, which was constantly adjusted to the changing needs of each client. The ACT model has been modified in various ways as it has been implemented in different states. Innovative funding models have been developed in several states by using bundled rates and case rates, which make it easier to implement and to sustain than traditional fee-for-service payment systems. In contemporary managed care terms, ACT teams are disease and disability management models that assign accountability to provider systems that may not assume risk in managing community support of persons with disabling conditions. The National Alliance on Mental Illness (NAMI) has developed program models and protocols for the Program for Assertive Community Treatment (PACT) to encourage public agencies to contract for ACT services. Effective Treatment Models. The previous discussions have outlined the various treatment models that have been introduced since the 1980s in the effort to establish an evidence base for the effectiveness of specific interventions and approaches to care. The attention to evidence-based treatment models has been a response to the call for quality and accountability for service outcomes demanded from health care services in general by purchasers and policy makers and part of an effort to cope with the difficulties of evaluating service delivery models or systems of care. The movement to evidence-based services is necessary to break down components of the service delivery system to determine the relative effectiveness of specific service interventions using the evaluative tools and methods that are available. Eventually, the case will be made to address the larger policy questions concerning the value of coherent and rationally organized service delivery in mitigating the effects of mental disability on the development of the child and enabling the recovery process for adults with serious and persistent mental illness. Chronic Illness Care Model: Psychiatry in the Context of Primary Care. Finally, the care of persons with long-term mental health problems is included in innovative developments in the provision of primary health care for persons with chronic illnesses (http://www.improvingchroniccare.org). The Health Resources Services Administration (HRSA), the federal agency responsible for the community health centers or Federally Qualified Health Centers (FQHCs), has adopted the chronic illness care model in its training and technical assistance efforts

for community health centers. The model grows out of the current concern for quality of care and accountability for health care delivery systems for effective outcomes. Depression management is one of the four

chronic health conditions that the HRSA has selected for its training collaboratives. The model begins with the assumption that the health care delivery system is part of a community context and must be responsive in its interactions with the community. Four areas of focus are essential in implementing the model in the health care delivery system: self-management support, delivery system design, decision support, and clinical tracking system. Self-management support gives patients a central role in determining their care, fostering a sense of responsibility for their health. Patients collaborate with the primary care team to establish goals, create treatment plans, and solve problems along the way. Delivery system design requires a reorganization of the way in which the health system operates, so that up-to-date information about a given patient is centralized, follow-up responsibility is assigned as a standard procedure, and so on. Decision support requires that treatment decisions are based on explicit, proven practice guidelines supported by at least one defining study. Guidelines are discussed with patients and providers, and treatment team members are constantly trained in the latest proven methods. Finally, clinical tracking systems track individual patients and populations of patients with similar problems. These systems must be practical and operational—able to check an individual's treatment at any point to confirm that the treatment conforms to recommended guidelines. The real integration of psychiatric care into primary care is an important innovation to consider that would improve physical health care for individuals with psychiatric disorders and eliminate the separation imposed by placing individuals with psychiatric problems into community mental health centers. THE ROLE OF PUBLIC AND COMMUNITY PSYCHIATRY IN TWENTYFIRST CENTURY HEALTH CARE Public psychiatry emerged historically as an attempt to provide humane care for people with severe mental disabilities who did not have the resources to be protected from the stigma and approbation that shielded so-called "eccentrics" and "black sheep" fortunate enough to have been born into the wealthier social strata. Community psychiatry evolved as an answer to concerns that public psychiatric treatment was a de facto form of marginalization and oppression, if not inhumane exile and imprisonment, of economically disadvantaged persons with mental illness. The great ideas of public psychiatry (e.g., providing compassionate respite and meaningful social and vocational rehabilitation) and community psychiatry (e.g., preserving social ties while providing evidence-based treatment) often are lost in the competition for scarce economic and political resources that faces every mental health, medical, and human service profession and organization in the early twenty-first century. The spirit and skills of advocacy that sparked the development and continue to characterize the best practices of public and community psychiatry, as well as the dedication to bring demonstrably effective services to the people who are most in need but are least served, have never been more needed by the entire mental health field. REFERENCES Abualenain J, Frohna WJ, Shesser R, Ding R, Smith M, Pines JM. Emergency department physician-level and hospital-level variation in admission rates. Ann Emerg Med. 2013;61(6):638–643. Andrade LH, Alonso J, Mneimneh Z, Wells JE, Al-Hamzawi A, Borges G, Bromet E, Bruffaerts R, de Girolamo G, de Graaf R, Florescu S, Gureje O, Hinkov HR, Hu C, Huang Y, Hwang I, Jin R, Karam EG, Kovess-Masfety V, Levinson D,

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