PETITION FOR THE RECOGNITION OF A
SPECIALTY IN PROFESSIONAL PSYCHOLOGY

THIS PETITION gives guidance to the types and amounts of information necessary for a formal
decision to be reached. Petitioning organizations may use additional pages where necessary.
The petitioning organization is free to provide any additional material deemed relevant.

NOTE: Complete responses to all questions posed in each of the criteria are required. Appendix
materials should not be considered as substitutes for the completion of responses to questions in
the criteria.

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PETITION PACKAGE
Preamble

Knowledge and practice skills in psychology have expanded and become increasingly differentiated over the past 50 years. Historically, the American Psychological Association (APA) acknowledged four professional specialties in psychology: clinical, counseling, school, and industrial/organizational psychology. It is important to note that these specialties first gained de facto recognition through a process of historical evolution. The APA accreditation guidelines also reference clinical, counseling, and school psychology as specialties.

A shared core of scientific and professional knowledge, skills, and attitudes is common to professional specialties. This shared core has been recognized in several conference reports on the future of professional psychology including the reports of groups and conferences of the National Council of Schools and Programs of Professional Psychology, the Joint Council on Professional Education in Psychology, and the National Conference on Scientist-Practitioner Education and Training for the Professional Practice of Psychology. Nothing in this document precludes a provider of psychological services from using the methods or dealing with the populations of any specialty, except insofar as they do so “within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience” (APA Ethical Principles of Psychologists and Code of Conduct, 2002).

The public will continue to need the services of general practice specialists, such as those offered by clinical, counseling, school and industrial/organizational psychologists. However, the emergence of new specialties to provide needed psychological services must also be recognized and validated. There must be a mechanism within the field to provide for the recognition of specialties.

Recent decades have produced what amounts to an explosion in professional knowledge and areas of application. As a result, new areas of application of psychology's scientific and applied knowledge have been organized around particular emphases in professional practice. The training to acquire this knowledge and skill may occur at the doctoral and/or postdoctoral levels. Such a proliferation of knowledge and an expansion of practice domains has resulted in a need to establish a process for recognizing specialties in professional practice that are differentiated from core scientific and applied professional foundations in psychology. At various times in past years, groups within and outside APA have worked to articulate such an identification and recognition process. Acknowledgement is given to the work of APA's Task Force on Specialty Criteria, the Board of Professional Affairs Subcommittee on Specialization, and the Board of Educational Affairs Task Force on Scope and Criteria of Accreditation, as well as the American Board of Professional Psychology for important contributions to this process. Their efforts have been a part of the continuing evolution of a process to identify specialties in psychology. It is now time for APA to exercise leadership in the design and implementation of a de jure process for the recognition of specialties in psychology.

For purposes of this endeavor the following definition of a specialty is adopted:

A specialty is a defined area of professional psychology practice characterized by a distinctive configuration of competent services for specified problems and populations. Practice in a specialty requires advanced knowledge and skills acquired through an organized sequence of education and training in addition to the broad and general education and core scientific and professional foundations acquired through an APA or CPA accredited doctoral program.* Specialty training may be acquired either at the doctoral or postdoctoral level as defined by the specialty.

*Except where APA or CPA program accreditation does not exist for that area of professional psychology

Although the specific dimensions of specialty programs may vary in their emphases and in available resources, every defined specialty in professional psychology will contain: (a) core scientific foundations
in psychology; (b) a basic professional foundation; (c) advanced scientific and theoretical knowledge germane to the specialty; and (d) advanced professional applications of this knowledge to selected problems and populations in particular settings, through use of procedures and techniques validated on the same.

The relationship between a body of knowledge and a set of skills in reference to each of the parameters of practice specified in Criterion VI below represents the most critical aspect of the basic definition of a specialty.

A specialty is distinguished from a proficiency, which is a circumscribed activity in the general practice of professional psychology or one or more of its specialties that is represented by a distinct procedure, technique, or applied skill set used in psychological assessment, treatment and/or intervention within which one develops competence.

The American Psychological Association and its Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) will consider petitions for formal recognition of specialties. Petitions that are received by CRSPPP will be reviewed and acted upon by the APA Council of Representatives. CRSPPP will review the status of each specialty at least every seven years and recommend whether the specialty should continue to be recognized.
Name of Proposed Specialty: Psychological Assessment and Treatment of Persons with Serious Mental Illness/Severe Emotional Disturbance

Please check one:

☐ X Petition for Initial Recognition
☐ Petition for Renewal of Recognition
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Criterion I. Administrative Organizations

The proposed specialty is represented by a specialty council or one or more organizations that provide systems and structures sufficient to assure the organized development of the specialty. 

Commentary: The evolution of a specialty generally proceeds from networks of psychologists interested in the area to the eventual establishment of organized administrative bodies which carry out specific responsibilities for the specialty and its practitioners. These responsibilities include governance structures which meet regularly to review and further describe the specialty and appropriate policies for education and training in the specialty.

1. Please provide the following information for the organization or specialty council submitting the petition:

Name of organization or specialty council:
Council for Psychological Training in Assessment and Treatment of Persons with Serious Mental Illness and Severe Emotional Disturbance.

Address: 8A – 1500 Alberni St.
City/State/Zip: Vancouver, BC V6G 3C9
Phone: 604 488-8854   FAX: NA
E-mail address: jansenm@shaw.ca
Website of organization: PsychTrainingSMI.com

2. Please provide the following information for the President, Chair, or representative of the organization or specialty council submitting the petition:

Name: Mary A. Jansen, Ph.D.  APA membership status: Fellow
Address: 8A – 1500 Alberni St.
City/State/Zip: Vancouver, BC V6G 3C9
Phone: 604 488-8854   FAX: NA
E-mail address: jansenm@shaw.ca

Please Note: In the event that the primary representative (Dr. Jansen) is not available, the current APA Task Force on Serious Mental Illness/Severe Emotional Disturbance (SMI/SED) Chair, the current President of Division 18 - the Division of Psychologists in Public Service, and the current Chair of the Division 18 Section on SMI/SED should be contacted.

3. Please provide the following information for the organization or specialty council submitting the petition:

Council for Psychological Training in Assessment and Treatment of Persons with Serious Mental Illness and Severe Emotional Disturbance

Year founded? 2013  Incorporated? Yes___ No _X__ State incorporated ______
Describe the purpose and objectives of the administrative organization or specialty council submitting the petition.

This specialty petition is submitted by the Council for Psychological Training in Assessment and Treatment of Persons with Serious Mental Illness and Severe Emotional Disturbance, hereafter referred to as the Council. The Council is comprised of three primary organizations, all of which have an interest in promoting specialized training and competency development for psychologists to work with individuals who have, or are at risk of developing, serious mental health disorders. The Council consists of the following organizational members: the APA Task Force on Serious Mental Illness/Severe Emotional Disturbance, APA’s Division of Psychologists in Public Service (Division 18), and the Section on Serious Mental Illness and Severe Emotional Disturbance of Division 18. Each of the organizational members has two representatives who sit on the national Council.

The Council provides guidance and the structures necessary for coordination of the specialty. The Council identifies issues important for the organized development and implementation of the specialty and provides a mechanism for information exchange and coordination. The Council also ensures that training guidelines for the specialty remain current and the Council disseminates updates on training. The Council also conducts regular training for site visitors who will make recommendations to the CoA regarding accreditation of post-doctoral programs applying for accreditation in this specialty.

The Council is the organizational home for specialized psychological training for psychologists and other mental health professionals who are interested in working with people with serious mental health disorders (SMI) and those with emerging severe emotional disturbances (SED). The Council oversees the development of curriculum materials, establishment of competencies to work with these populations, evaluation mechanisms to ensure competency of professional psychologists for this work, conducts training, and encourages research and publications in this area.

The Council also works to promote understanding of the etiology, nature, impact, and amelioration of SMI/SED among psychologists and the general public by posting information, research, links to relevant organizations, and other pertinent information on its website.

Please append the bylaws for the petitioning organization or specialty council if bylaws are not provided on the website.

Please see Specialty Council website (PsychTrainingSMI.com) for the Council bylaws.

Outline the structure and functions of the administrative organization or specialty council (frequency of meetings, number of meetings per year, membership size, functions performed, how decisions are made, types of committees, dues structure, publications, etc.) using the table below. Provide samples of newsletters, journals, and other publications, etc.

An annual meeting is held at the APA Convention and a conference call is held once each quarter. Council business is conducted primarily via e-mail and conference calls.
Present a rationale that describes how your organization or specialty council provides systems and structures which make a significant contribution to the organized development of the specialty.

The Council was begun as a result of recognition by the three primary members, the APA Task Force on Serious Mental Illness and Severe Emotional Disturbance (hereafter referred to as the APA Task Force), APA’s Division 18, Psychologists in Public Service (hereafter referred to as Division 18), and the Division 18 Section on Serious Mental Illness/Severe Emotional Disturbance (hereafter referred to as the Division 18 Section) of the following: a) there is considerable public need for psychologists who are specially trained to work with people with serious mental illness and those with severe emotional disturbances; and b) there is interest among psychologists in learning more about how to work with these populations to help individuals recover from the effects of their illness and realize their goals and full potential. After considerable discussion and planning, the APA Task Force, Division 18, and the Division 18 Section determined that a formal petition to APA should be developed to request recognition of a post-doctoral specialty in the Psychological Assessment and Treatment of Persons with Serious Mental Illness/Severe Emotional Disturbance.

At the same time, the APA secured funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a curriculum to train psychologists in the concepts of recovery from serious mental illness and the interventions to assist people to achieve their full potential; these interventions are known are psychosocial or psychiatric rehabilitation (PSR) interventions. A draft of the curriculum was pilot tested and it was also reviewed by members of the APA Task Force, the Division 18 Section, psychologists at several universities, members of the public with SMI/SED disorders, and the members of the two committees established by APA to guide the project. The completed curriculum (American Psychological Association & Jansen, 2014) was released by APA in 2014.
accompanying slides are available from APA (http://www.apa.org/pi/mfp/psychology/recovery-to-practice/training.aspx) and a link is provided on the Council website (www.PsychTrainingSMI.org).

In 2013, during the time that the curriculum was being developed, the Council was officially formed. Once fully formed, the Council began regular meetings and began work on developing the remaining structures needed to govern the specialty once it is recognized. Some examples of the work of the Council include continued identification of doctoral and post-doctoral programs that offer training in this area, securing of funding for a meeting to identify necessary competencies, presentation of CE symposia and workshops at the APA convention, development of initial evaluation mechanisms and a clinical practice guideline tool.

4. Signatures of official representing the organization or specialty council submitting the petition:

Name: Mary A. Jansen, Ph.D. Title: Executive Officer Date: December 31, 2017

Mary A. Jansen, Ph.D.

Reference

Criterion II. Public Need for Specialty Practice

The services of the specialty are responsive to identifiable public needs

Commentary: Specialties may evolve from the professions’ recognition that there is a particular public need for applications of psychology. Specialties may also develop from advances in scientific psychology from which applications to serve the public may be derived.

1. Describe the public needs that this specialty fulfills with relevant references. Under each need specify the populations served and relevant references.

Definitions

The literature base is well developed for those with psychotic disorders, especially schizophrenia and schizoaffective disorders, but less well developed for bipolar disorder, clinical depression, personality disorders, and concurrent addictive disorders. While some studies exist, most researchers have assumed that the findings from major studies of individuals with schizophrenia would generalize to others with serious mental illnesses. Due to the paucity of research specific to these disorders, we likewise assume to generalize the findings to these populations as well, although some information about bipolar disorder and treatment interventions for this condition are also presented.

Prior to responding to the questions in this Criterion, we present the definitions for Serious Mental Illness (SMI) and for Severe Emotional Disturbance (SED). We follow in this petition the definitions set forth by the U.S. federal government for SMI.

For SMI:

Precursors to the term serious mental illness have included terms such as “chronic mental illness” or “severe and persistent mental illness.” The change in terminology to SMI/SED represents a shift in emphasis, focusing less on diagnosis and duration of illness and more on functional impairment. SAMHSA defines SMI as follows:

SMI among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment, which substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment. Downloaded from: http://nrepp.samhsa.gov/05f_glossary.aspx#S.

For SED:

Children with SED are defined as persons:

From birth up to age 18, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities….these disorders include any mental disorder (including those of biological etiology) listed in DSM-III-R or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-III-R "V" codes, substance use, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance….Functional impairment is defined as
difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in their environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition (Federal Register, Volume 58, Number 96. Pages 29422-29425).

The term serious emotional disturbance (SED) is used to describe conditions experienced by children and adolescents whose symptoms meet criteria as specified in the DSM-V, ICD9-CM or subsequent versions.

For adults and for youth, use of the SMI/SED terms requires a person to have experienced or currently be experiencing a functional impairment that significantly interferes with one or more major life activities. While this term is broadly inclusive, including disorders such as schizophrenia and other disorders on the psychotic spectrum, mood disorders, and co-occurring personality disorders, it excludes developmental and substance use disorders as primary diagnoses.

Those with SMI/SED are distinct from others with mental health disorders primarily because of the differences in symptomatology, the severity of their illnesses, the resultant functional limitations, and the debilitating societal stigma and self-stigma that they confront. The incidence and prevalence of SMI/SED are similar across virtually every demographic that one can think of – SMI/SED strikes people in all ethnic and racial groups, socioeconomic groups, genders, non-binary and transgender individuals, religions, countries of origin or in which people live, those with other conditions/disorders/disabilities, and virtually any other variable of interest. Individuals with SMI are typically adults who have the following diagnoses: schizophrenia, schizoaffective disorder, bipolar illness, delusional disorders, other psychotic disorders, or depression with a significant impact on functioning. These individuals may have co-morbid, but not primary, substance use, exposure to trauma, or personality disorders.

**SMI Prevalence**

Prevalence data for the US are obtained via SAMHSA’s annual survey of households.

Results from the latest survey (2015) indicate that “An estimated 9.8 million adults in the nation had a serious mental illness (SMI) in the past year, representing 4.0 percent of all U.S. adults in 2015”, a percentage which has remained stable from 2008 through 2015 (Center for Behavioral Health Statistics and Quality, 2016).

Results further indicate that only about 6.4 million of those with SMI or 65.3 percent received mental health services for their illness in the past year. The reasons that approximately 35% do not receive mental health services are complicated and include one or more of the following: stigma, poverty, lack of insurance, provider lack of knowledge of appropriate treatments, fear of treatment including hospitalization or medication, distrust of providers or the mental health system, and perceived lack of treatment (Corrigan, Druss, & Perlick, 2014; Kessler et al., 2001; Kreyenbuhl, Nossel, & Dixon, 2009; Torrey et al., 2001). Globally, the proportion of people with mental health disorders is highly similar throughout the world and most do not receive treatment (World Health Organization, 2001).
With respect to co-morbid substance use disorders (SUD), “Among the 19.6 million adults aged 18 or older in 2015 who had a past year SUD, 2.3 million (11.9 percent) also had SMI in the past year. The 2.3 million adults with SMI who met the criteria for an SUD in the past year represent 23.8 percent of the 9.8 million adults with SMI” (Center for Behavioral Health Statistics and Quality, 2016).

**SED Prevalence**

Prevalence rates vary, and are influenced by such factors as the type of disorders and the criteria used to define them, age and sex of the children/youth, characteristics of the population (SES, ethnicity, social and cultural context), data collection methods (interview, survey, record review), and study design (type of informant, sampling strategy) (Hayden & Mash, 2014). In their classic report, *A system of care for severely emotionally disturbed children & youth*, Stroul and Friedman (1986) cited epidemiologic research estimating that 11.8% of youth experience clinical maladjustment, and noted Knitzer’s (1982) review of prevalence research which concluded that 5% would be a conservative estimate of children with SED. The National Institute of Mental Health (NIMH) used this same figure to estimate the percent of youth with SED (with severe and persistent problems) in their announcement of the Child and Adolescent Service System Program in 1983 (Stroul & Friedman, 1986). Kessler et al (2012) offer a figure of 8.0% for prevalence of SED among adolescents.

More recent studies indicate similar prevalence estimates. Three large scale studies in the US, based on diagnostic interviews, offer prevalence data on SED/psychiatric disorders: a supplemental study to the National Health and Nutrition Examination Survey (NHANES; Merikangas, et al. 2010), the National Comorbidity Survey Adolescent Cohort (NCS-A; Kessler, et al., 2012), and the Great Smoky Mountain Study (GSMS; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). The diagnostic instruments and age groups differ across these studies, which yielded prevalence estimates ranging from 6.8% to 11.5%.

When substance use disorders are included, and looking across time, the prevalence rates are even higher. In the NCS-A nearly half of adolescents aged 13–18 years had ever had a mental disorder (including substance use disorders), with 28% meeting the criteria for severe impairment (Perou, et al., 2013).

In the Great Smoky Mountain Study participants (ages 9-21 years of age) were followed and interviewed up to nine times (Copeland, Shanahan, Costello, & Angold, 2011). Cumulative prevalence of
psychiatric disorders was striking, as by age 21, 61.1% of participants met diagnostic criteria for a well specified disorder, and an additional 21.4% for a “not otherwise specified” disorder. The researchers concluded that although at any given time a small percentage of children/youth meet criteria for a DSM disorder, by young adulthood, the majority do, making the experience nearly universal. (This study included substance disorders, which were the most common disorder.) An additional longitudinal study showed similar results (Jafee, Harrington, Cohen, & Moffit, 2005).

Impact of SED on Development

Children and adolescents are uniquely affected by SEDs as these typically interrupt or challenge their emotional, social, and neurocognitive development, academic achievement, and functioning in the family and the community. A Summit on Young Children’s Mental Health noted that mental health is a critical part of childhood development; mental health problems may result in avoiding or missing age-appropriate experiences, and may cause great difficulty to the children and youth, and distress to peers, teachers, and parents (Society for Research in Child Development, 2009).

While it is clear that many children and youth experience mental health problems, in this specialty petition we focus only on the subset who have the most serious emotional disorders, and whose functioning is the most compromised if appropriate treatment and supports are not provided. The diagnostic categories that are our focus include schizophrenia, bipolar disorder, and major depression.

Schizophrenia is a disorder that commonly occurs in early adulthood, however, early manifestation is seen in children as young as 12 (Clemmensen, Vernal, & Steinhausen, 2012). Early onset schizophrenia (EOS) involves onset during ages 13 to 17, with a prevalence of 1 to 2 per 1000. Very early onset (VEOS) occurs before the age of 13, with an estimated prevalence of 1 per 10,000 children/youth (Armando, Pontillo, & Vicari, 2015). In reviewing psychosocial interventions for EOS and VEOS, Armando, et al. noted that until very recently, most treatments have been based on interventions designed and used with adults, and not specifically tailored to younger participants. They called for high quality research on treatments for children and adolescents with schizophrenia. While the prevalence data of EOS and VEOS have been low, a more recent community-based screening study identified about 9% of 9-11 year olds with psychotic-like experiences, and deemed them at-risk of psychosis (Laurens & Cullen, 2016). They suggest that identifying children with multiple antecedents of schizophrenia offers a potential window for early intervention.

Another concerning disorder that is a subset of serious emotional disorders is bipolar disorder. Pediatric bipolar disorders are moderately common; with a prevalence of 1.8% (including bipolar I, bipolar II, and cyclothymic disorders, which are comparable to adult rates (Fristad & MacPherson, 2013). The significant impairment these cause in psychosocial functioning, quality of life, and suicidality make them a serious public health concern (Fristad & MacPherson, 2013). The World Health Organization (WHO) recognized bipolar disorder as sixth among medical disorders that caused loss of life, whether due to death or disability (Dusetzina, et al., 2012). Bipolar disorder has been noted as the most expensive behavioral health condition (Peele, Xu, & Kupfer, 2003).

The prevalence of major depressive disorder (MDD) is estimated to be about 2% in children, and between 4% to 8% of adolescents, with a cumulative incidence of approximately 20% by age 18 in community samples (Birmaher, Brent, and the AACAP Work Group on Quality Issues, 2007). Among depressive disorders, Major Depressive Disorder with psychotic features has been noted to be more severe, have greater long-term morbidity and increased risk of bipolar disorder. Comorbidities are common, with 40-90% of youth with depression also having additional diagnoses (dysthymic disorder, anxiety, conduct, and substance use disorders), (Birmaher, et al., 2007).

There are an abundance of risk factors that put children and adolescents at a greater risk for SED and declining quality of care. Youth in foster homes, abuse victims, those living in poverty, and/or
experiencing high life stress are all at greater risk for developing SED or SMI (Fontanella, Gupta, Hiance-Steelsmith, & Valentine, 2014; Subica, 2013; Willard, Long, & Phipps, 2016).

**Public Health Needs**

The needs of the population of people with SMI and SED are considerable. We will discuss them further and in more detail in Criterion IV (in terms of their requiring distinct knowledge and skills) and Criterion VI (in terms of the essential advanced didactic and experiential preparation required for practice to meet the needs of this population). Although individuals with SMI and SED are themselves members of the public, some of their needs also impact the broader public. We focus in this Criterion on public needs, i.e., those problems and needs of people with SMI and SED that can be considered to impact directly on members of the public other than those with SMI/SED. In Criterion VI, we discuss assessment and intervention procedures that are designed specifically to ameliorate the needs of this population of people with SMI and SED (thereby decreasing the public health need).

Mueser, Silverstein, and Farkas, (2013) succinctly summarized the public health costs of SMI: “In sum, serious mental illnesses are a major public health concern that take a high toll on individuals with these conditions, their families, and society” (p. 55). With respect to the economic costs of these public health concerns, the data in a recent economic analysis are telling:

Direct non-health care costs were estimated for law enforcement, homeless shelters, and research and training. Indirect costs were estimated for productivity loss from unemployment, reduced work productivity among the employed, premature mortality (i.e., suicide), and caregiving….The economic burden of schizophrenia was estimated at $155.7 billion ($134.4 billion-$174.3 billion based on sensitivity analyses) for 2013 and included excess direct health care costs of $37.7 billion (24%), direct non-health care costs of $9.3 billion (6%), and indirect costs of $117.3 billion (76%) compared to individuals without schizophrenia. The largest components were excess costs associated with unemployment (38%), productivity loss due to caregiving (34%), and direct health care costs (24%)….Schizophrenia is associated with a significant economic burden where, in addition to direct health care costs, indirect and non-health care costs are strong contributors, suggesting that therapies should aim at improving not only symptom control but also cognition and functional performance, which are associated with substantial non-health care and indirect costs (Cloutier, et al., 2016, p. 764).

We discuss the following public needs below:

- Greater morbidity, mortality of individuals with SMI/SED and years of life lost through premature death from serious health problems along with the attendant increased health care costs incurred by these factors
  - Stigma
  - Lack of appropriate mental health treatment
  - Lack of insurance
  - Racial and cultural Issues, e.g., stigma, poor adherence to guideline based treatment, use of inappropriate treatment settings, practitioner bias
- Additional implications of inadequate access to treatment for those with SMI/SED including psychological and social problems of those with SMI/SED, and impact on public health needs.
• Greater incarceration and forensic hospital utilization with attendant increased costs in the justice and forensic sectors noting the additional factors associated with SMI/SED and the justice and forensic systems. These include:

  a) Racial/cultural issues

  b) Immigrant and refugee issues.

• Greater burden on families and caregivers with increased health care costs for these individual caregivers.

• Economic burden due to greater health-care costs, lost productivity, tax revenue, and decreased economic growth, and on family caregivers, and social systems such as housing, criminal justice and forensic systems.

Increased Morbidity, Mortality and Premature Death, and Increased Health Care Costs

In 1999, the U.S. Surgeon General released the first report addressing mental illnesses (U.S. Department of Health and Human Services, 1999). The Report noted that one in four Americans had a mental disorder and that two thirds of those did not receive treatment for their illness. In the US, individuals with SMI are now known to die an average of 25 years earlier than those without these illnesses; this is the most widely recognized health-care issue for people with SMI.

While the average is typically cited as 25 years of life lost (Schroeder & Morris, 2010), some report it as 15 - 20 years (Thornicroft, 2011), some offer 10 - 15 years as the earlier mortality mark (Lawrence, Hancock, & Kisely, 2013; National Institute of Mental Health, 2012), and others provide a large range between 13 – 30 years (de Hert, et al., 2011; Olfson, Gerhard, Huang, Crystal, & Stroup, 2015). The World Health Organization presents the range as between 10 and 26 years, and indicates that for people with schizophrenia, the mortality rate is 2 to 2.5 times higher than the general population, while for people with bipolar disorder, the mortality rate is 35 – 50% higher than for those in the general population (World Health Organization, undated). Several reports indicate that the mortality gap between those with SMI and the general population is widening (Cuijpers & Smit, 2002; Hiroeh, et al., 2007; Joukamaa, et al., 2001; Kisely, et al., 2007; Lawrence, Holman, & Jablensky, 2001; Lawrence, Mitrou, & Zubrick, 2009).

We found three principal reasons for these premature deaths in the literature: clinical risk factors, socioeconomic factors, and health system factors (Aron, Honberg, Duckworth, et al.,2009; Mitchell, Delaffon, & Lord, 2012). These premature deaths occur as a result of both natural causes such as cancer, cardiovascular diseases, respiratory diseases, HIV/AIDS, diabetes, etc., and from unnatural causes such as suicide, injuries from violence or other traumatic events, and accidents (De Hert, et al., 2011; Horvitz-Lennon, Kilbourne, & Pincus, 2006; Mazi-Kotwal & Upadhyay, 2011). According to one report, “Only 80% of people with schizophrenia die from natural causes, for example, compared with 97% of the general population. The higher rates of these deaths are largely attributable to accidents and suicide, which tend to occur more often in early than late adulthood” (Thornicroft, 2011, p. 441).

We discuss these factors below as they relate to increased health-care costs and affordability, especially due to the fact that the illnesses and causes of death are some of the most expensive to treat when early diagnosis and treatment are not available or utilized. Additionally, SAMHSA recently called attention to the need to reduce the disparity in life expectancy for those with SMI:

Mental illness contributes to premature death in the U.S. household population…Results show a robust association between one measure of mental illness (i.e., SPD) [severe psychological distress] and death, even after adjusting for sociodemographic risk factors, smoking, obesity, and chronic health conditions. The reduced life expectancy of persons with SPD underscores the
importance of efforts to lessen the burden associated with mental illness. (Muhuri, August 7, 2014).

**Natural Causes - Respiratory diseases, cancers, diabetes and cardiovascular diseases: Primarily attributable to smoking and obesity**

*Smoking*

Although the same factors that lead to illness and death in the general population affect people with SMI, the excess rate of death from natural causes is primarily attributable to the effects of smoking and obesity, which lead to the respiratory diseases, cancers of many kinds, diabetes, and cardiovascular diseases, that ultimately cause much of the premature disability and death seen in this population (Parks, Svendsen, Singer & Foti, 2006; Schroeder & Morris, 2010). In addition to the illnesses themselves there are disparities in screening for diseases such as cancer in people with SMI and these disparities also have obvious consequences for mortality (Howard, et al., 2010).

People with SMI/SED frequently have co-morbid substance use disorders and when taken together, these individuals account for almost half of the Americans who die annually from smoking related disorders (Schroeder & Morris, 2010). These individuals smoke more cigarettes per day and consume forty-four percent of all cigarettes sold in the US (Lasser, et al., 2000; National Institute of Mental Health, 2009). Generally speaking, the more severe the mental illness, the higher the smoking prevalence (DeLeon & Diaz, 2005; Grant, Hasin, Chou, Stinson, & Dawson, 2004; Lasser, et al., 2000).

The reasons why people with SMI/SED smoke cigarettes at such a high rate are many and varied. Research into the physiologic reasons for the high rates of smoking in this population is relatively recent and the answers are not yet fully known. Genetic research has found an association with certain chromosomes and the nicotine receptor gene in people with schizophrenia and bipolar disorder (Leonard, & Adams, 2006; Leonard, et al., 2001). This receptor gene has been implicated in impaired sensory processing in individuals with schizophrenia and schizoaffective disorder (Martin & Freedman, 2007). It has been hypothesized that there is a therapeutic effect of smoking for people with SMI/SED because nicotine is thought to normalize the deficits in sensory processing, attention, cognition and mood (George, et al., 2006; Sacco, Bannon & George, 2004). Nicotine may also offer some relief from the side effects of psychotropic medications because smoking decreases blood levels of these drugs (Ziedonis, Williams & Smelson, 2003); moreover, when people using psychotropic medications stop smoking, their blood levels of the medications typically rise substantially (Desai, Seabolt, & Jann, 2001) and it has recently been found that people with psychotic disorders experience more severe nicotine withdrawal symptoms than do those without mental health disorders (Smith, Homish, Giovino, & Kozlowski, 2014).

In addition, smoking offers the same rewards that it does for the general population, i.e., reduction in stress, anxiety, and boredom, and opportunities for social interaction with other smokers. However, the postulated genetic and neurobiologic mechanisms, coupled with the highly addictive properties of nicotine, may be the reason why smoking is so prevalent and why, for this population in particular, it is so difficult to stop.

*Obesity*

Like smoking and the neurobiologic effects of nicotine, weight gain in people with SMI/SED is not a simple matter. The physiologic interplay between the causes of obesity, diabetes, and metabolic syndrome in people with SMI/SED is highly complex. While the ultimate effects of these factors (increased morbidity and mortality) are known, the relationships between the underlying factors are only beginning to be understood.

Obesity is far more prevalent in people with SMI/SED than in the general population (Dickerson, et al., 2006; Parks, et al., 2006). This can be due to a variety of reasons including poor nutrition, limited
income to purchase healthy foods, being homeless or inadequately housed without access to kitchen space to prepare nutritious meals, cognitive deficits that make it difficult to understand and process the importance of healthy eating, and arguably most importantly, induced weight gain due to the iatrogenic effects of psychotropic medications, especially the second generation anti-psychotics, most particularly clozapine and olanzapine, which induce weight gain. Medications for bipolar disorder such as valproic acid and lithium can also cause weight gain especially when used in combination with the second generation anti-psychotics (Ellingrod, et al., 2012).

Becoming overweight and obese leads to musculoskeletal disorders, pain and difficulties in getting adequate exercise, which in turn can lead to diabetes, insulin resistance, and cardiovascular disorders, and these can ultimately lead to metabolic syndrome with its increased risk of type 2 diabetes, heart attack, and stroke (Allison, et al., 2009; Parks, et al., 2006). In the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) people using antipsychotic medications had much higher rates of metabolic syndrome than people in the general population (McEvoy, et al., 2005), putting them at significantly greater risk of the cardiovascular events that can result from the syndrome. Other researchers also suggested that second generation anti-psychotic medications may put people at risk of sudden cardiac arrest and death (Manu, 2011).

A meta-analysis of the research on this topic found that the prevalence of metabolic syndrome in people with schizophrenia and related disorders is consistent across treatment setting (inpatient vs outpatient), country of origin, and gender. Older individuals were at greater risk, but those who had been ill the longest had the highest risk of developing the syndrome. When individual studies were evaluated, waist size was most useful in predicting metabolic syndrome; use of antipsychotic medication, especially clozapine, conveyed the highest risk. Those who did not use anti-psychotic medications were at lowest risk of this life-threatening syndrome (Chiu, Chen, Chen, Yu, & Lu, 2010; Mitchell, et al., 2013).

Like smoking, losing weight for people taking anti-psychotic medications is very difficult. When the impact that psychotropic medications have on weight gain is considered, it is easy to understand why losing weight for this population is so extremely difficult.

Unnatural Causes

Although most deaths are from natural causes (Brown, Kim, Mitchell & Inskip, 2010), people with SMI/SED are also at increased risk of dying from unnatural causes including suicide, violence, and accidents, with the majority attributable to suicide and other perpetrated violence (Harris & Barraclough, 1997; Hiroeh, Appleby, Mortensen & Dunn, 2001; Ösby, Correia, Brandt, Ekborn, & Sparen, 2000). Use of alcohol and other drugs is often a complicating factor, especially in accidental deaths (Bossarte, Simon & Barker, 2006; Khalsa, et al., 2008). Moreover, rates of premature death from suicide and violent crime have been increasingly compared to the general population since the 1970s (Fazel, Wolf, Palm & Lichtenstein, 2014). Fazel and colleagues also found that compared to the general population, both men and women with schizophrenia were eight times more likely to die prematurely (before age 56), highlighting the need for much closer follow-up and better treatment for this population who are at substantially elevated risk of adverse outcomes.

Suicide

For people with SMI/SED, the risk of suicide is greatly increased (Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Pompili, et al., 2007). In seminal works, Harris and Barraclough (1997; 1998) reported this risk to be 9 – 10 times greater than the risk for people in the general population; their work continues to be the most often cited on this topic to date. Several risk factors have been consistently identified. These include previous suicide attempt or previous attempts to harm oneself, presence of depressive symptoms, involvement with the police, and being a young male at time of inpatient admission (Appleby, Dennehy, Thomas, Faragher, & Lewis, 1999; Bakst, Rabinowitz & Bromet, 2010; Kan, Ho, Dong, &
People are most at risk immediately following discharge from the hospital, and within ninety days of discharge (Olsson, et al., 2016), especially for those discharged from a first admission (Appleby, et al., 1999; Bakst, et al., 2010; Lee & Lin, 2009; Pompili, et al., 2011). The risk is greater for those without a previous admission during the year, compared to those hospitalized more than three times in the previous year (Geddes & Juszczak, 1995; Goldacre, Seagroatt, & Hawton, 1993; Heila, et al., 1997; Lee & Lin, 2009). Pompili et al., (2007) report that the suicide risk is three times higher for adolescents or young adults with schizophrenia than for adults with this disorder. Risks for both suicide and violence are greater during the first episode of psychosis and for those who have not received treatment. Given that this appears to be a critical period for these events and that onset of SMI typically occurs during adolescence or young adulthood, it is particularly important to monitor young people closely especially following discharge from hospital.

**Violence**

People with SMI/SED are at increased risk of being victims of violence in the community (Brekke, Prindle, Bae & Long, 2001) and are exposed to high rates of interpersonal violence (Carmen, Rieker, & Mills, 1984; Goodman, et al., 2001; Greenfield, Strakowski, Tohen, Batson, & Kolbrener, 1994; Lipschitz, et al., 1996; Mueser, et al., 1998; Mueser, et al., 2004) and are at much greater risk of homicide. Reasons for this include the fact that people with mental disorders are frequently very poor and often live in deprived areas with high crime rates, their symptoms may cause them to be less aware of risks to their own safety, and people with SMI/SED are often thought of as dangerous (Crump, Sundquist, Winkleby & Sundquist, 2013), potentially sparking attacks from others who are fearful.

People with SMI/SED can sometimes be perpetrators of aggression and violence, especially when they are not receiving treatment and are under the influence of alcohol and other drugs. The risk of retribution and increased fear and stress can lead to the possibility of further escalating violence both to themselves and to others (Wehring & Carpenter, 2011). The risk of an individual committing a homicide is greater during the first episode of psychosis and for those who have not received treatment (Nielssen & Large, 2010).

However, people with SMI/SED are much more often the victims of violence rather than the perpetrators of it, with victimization of individuals with these illnesses found to be more than four times the incidence in the general US population (Choe, Teplin & Abram, 2008; Teplin, McClelland, Abram & Weiner, 2005). Skeem, Manchak and Peterson (2011) summarized the research as follows:

As a whole, a large body of research indicates that “risk of violence is modestly elevated for people with mental disorder, particularly those who misuse substances” (Silver, 2006, p. 685). Still, most people with mental illness are not violent, most violent offenders are not mentally ill, and the strongest risk factors for violence (e.g., past violence) are shared by those with- and without- mental illness (see Link & Stueve, 1995; Monahan et al., 2001; Mulvey, 1994; Walsh, Buchanan, & Fahy, 2002). … Based on a meta-analysis of 204 diverse studies and samples, Douglas, Guy, and Hart (2009) found a small correlation between psychosis and violence (r = .16 or OR = 1.53). However, there was no meaningful correlation for offenders with mental illness (r = .00 or OR = 0.91) and general offenders (r = .01 or OR = 1.27). … In a meta-analysis of 58 prospective studies of offenders with mental illness (70% with schizophrenia), Bonta et al. (1998) found that clinical variables (e.g., diagnoses, treatment history) did not meaningfully predict a new general offense (r = -.02) or a new violent offense (r = -.03). Instead, the strongest predictors of a new violent offense (r [.20 were antisocial personality, juvenile delinquency, criminal history, and employment problems. (p. 117).
In summary, people with SMI/SED have high levels of medical co-morbidities which impact their level of general functioning (Briskman, Bar, Boaz, & Shargorodsky, 2012). Reasons for the poorer health status of people with SMI/SED range from the cognitive deficits seen in this population to medication side effects, but also include such social factors as social disadvantage, racial bias among providers, language or other cultural barriers, physician bias leading to somatic complaints not taken seriously, and self-stigma, leading to individuals’ embarrassment and reluctance to make and keep general medical appointments (de Hert, et al., 2011; Dickerson, et al, 2003; Howard, et al., 2010; Mechanic & Bilder, 2004; U.S. Department of Health and Human Services, 2001). We look at each of these and other factors, separately below.

Factors that account for the increased morbidity, mortality and premature death

**Stigma and health care issues**

Stigma toward people with SMI/SED is experienced at all levels of society and in many settings including medical services (community clinic and hospital), housing, educational and vocational settings, social and leisure pursuits including attempts to develop intimate relationships, and more mundane daily activities such as shopping for groceries and household items, and exercising legal rights such as attempting to vote or register to vote (Walker, Klein, Hemmens, Stohr, & Burton, 2016). There are very real consequences for people with SMI/SED and for other members of the public as a result of the stigma experienced from most members of society, including professionals (Corrigan, et al., 2014).

Societal stigma and its internalized counterpart, self-stigma, lead to a multitude of problems that impact on physical health access and outcomes (Anderson & Kurdyak, 2016), treatment seeking and adherence, premature death, and pursuit and attainment of educational, vocational and social goals and objectives (Clement, et al., 2014; Corrigan, et al., 2014; Corrigan & Shapiro, 2010). Being told that one has a serious mental illness can have devastating effects on a person’s identity including increased symptom severity, decreased adherence to treatment, and decreased self-esteem, quality of life, and social support (Livingston, & Boyd, 2010). Yanos, Roe and Lysaker (2010) have proposed that a person’s identity becomes one of an ill person (illness identity) and that identity affects the person’s self-esteem, sense of hope leading to increasing depression, social isolation, suicidal ideation and in some cases suicidal attempts, and ultimately his or her illness course and potential for recovery.

Within the mental health care system, people with SMI/SED experience stigma at many levels: by providers in treatment settings (Corrigan, 2004; Druss, Bradford, Rosenheck, Radford, & Krumholz, 2000; Joy, Clement, & Sisti, 2016; Koroukian, Bakaki, Golchin, Tyler, & Loue, 2012; Sullivan, Han, Moore, & Kotrla, 2006; Thornicroft, 2013), and from systems level problems that can be traced back to stigma such as lack of service availability, lack of insurance coverage and inability to pay for services, and lack of transportation to services to name a few (Barry, Huskamp, & Goldman, 2010; Mojtabai, et al., 2011). Some mental health providers perceive people with SMI/SED as more dangerous (Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2004) and a recent study has even found that some professionals use electronic medical information systems to code the records of individuals with psychiatric disorders who are seen frequently with various icons or other notations, including using icons designating these individuals are “frequent flyers” (Joy, et al., 2016). Such disparaging labelling can affect professionals at all levels in the health and mental health care sectors and can affect decisions made by health care professionals.

Unfortunately, people with SMI/SED are some of the poorest, most stigmatized, and most isolated and excluded in our society. People who are stigmatized have reduced opportunities for community inclusion, housing, employment, and social opportunities (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Mueller, et al., 2006). The experience of social inequality and the stress associated with dealing with exclusion can have pronounced psychological effects and impact negatively on physical health status as well. The effects of poverty on health status are well-established (U.S. Government Accountability Office, 2007); poverty is consistently mentioned as a key cause and also a product of
social exclusion and poor health (Bergland, 2016; Pickett & Wilkinson, 2015; Rözer, Kraaykamp, & Huijs, 2016). People who are isolated from community and friends and lack social supports, tend to have more physical health problems (Cacioppo & Hawkley, 2003; Cattell, 2001; Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Holt-Lunstad, Smith, & Layton, 2010; Szreter & Woolcock, 2004; Toussaint, Shields, Dorn, & Slavich, 2016).

**Lack of appropriate mental health treatment**

The inability to accomplish the everyday milestones that most of us take for granted such as attainment of educational and vocational goals, adolescent and early adult separation from parents and re-location into independent living, achievement of social goals, etc., has been called the most costly of all the impacts experienced by people with SMI:

Despite the striking nature of psychotic symptoms in schizophrenia and other severe mental illnesses, the most costly problem in these conditions is impairments in everyday functioning. These impairments lead to a total cost that is substantially greater than that associated with the treatment of psychosis by both medications and psychiatric admissions. Impaired everyday functioning in people with schizophrenia spans the major functional domains of independence in residence, productive activities, and social functioning. Achievement of typical milestones is less common than in the healthy population, and many functional skills (i.e., social, vocational, and independent living) themselves are performed at lower levels. (Harvey and Strassnig, 2012, p. 73).

From an economic perspective, spending for all mental health conditions exceeds spending for any other health condition. In 2013, U.S. costs for mental health were $201 billion, far ahead of the second most costly condition, heart disease whose costs were a mere $147 billion (Roehrig, 2016). While these data are not specific to SMI/SED, it has been estimated that the indirect costs (loss of annual earnings) due to SMI were $193.2 billion (Kessler et al., 2008). Extrapolating from those data, Insel (2008) estimated the economic burden of SMI to be $317 billion and this excludes costs associated with comorbid conditions, incarceration, homelessness, and early mortality, further estimated to be equivalent to more than $1,000/year for every man, woman, and child in the US.

Interest in reducing this economic burden and cost to society has led to recent research aimed at reducing the economic costs of SMI/SED. While research on the economic benefits of providing specialized evidence-based interventions for those with SMI/SED is quite recent, several of the EBPs and promising practices designed for this population have shown reduced societal costs (Dixon & Schwarz, 2014; Gilmer, Stefancic, Tsemberis, & Etter, 2014; Jolley, et al., 2015; Knapp, et al., 2013).

According to the NIMH “Research on psychiatric epidemiology shows that mental disorders are common throughout the US, affecting tens of millions of people each year, and that only a fraction of those affected receive treatment” (NIMH webpage, 2014), exemplifying the underlying public need for services for this population. Additionally, NIMH indicates that “While mental disorders are common in the United States, their burden of illness is particularly concentrated among those who experience disability due to serious mental illness (SMI).” (NIMH website, retrieved from http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-adults.shtml on February 22, 2016) Despite recognition of this need, psychologists and other mental health providers remain ill prepared to provide the kinds of services needed to help individuals recover from the effects of their illness.

Globally, the latest report from the Centers for Disease Control and Prevention (CDC) incorporates data from the World Health Organization which indicates that “Mental illnesses account for a larger proportion of disability in developed countries than any other group of illnesses, including cancer and heart disease (World Health Organization, 2001). The CDC estimates that in 2004, 25% of adults in the United States reported having a mental illness in the previous year. The economic cost of mental
illness in the United States is substantial, approximately $300 billion in 2002.” Additionally, the report concludes that “Many mental illnesses can be managed successfully, and increasing access to and use of mental health treatment services could substantially reduce the associated morbidity” (Centers for Disease Control and Prevention, 2011, p.1).

Lack of insurance

People with SMI/SED have a higher burden of general medical disorder but poorer access to and lower quality of general medical care than people without SMI/SED (Horvitz-Lennon, et al., 2006; Lawrence & Kisely, 2010). People with SMI/SED are much less likely to have a primary care physician than those without SMI/SED. According to a report by the Agency for Healthcare Research and Quality, those with psychotic disorders and bipolar disorder are 45 percent and 26 percent less likely, respectively, to have a primary care doctor than those without mental disorders (Agency for Healthcare Research and Quality, 2009). As we mentioned previously, these issues contribute to the poorer care and premature death seen in this population (Thornicroft, 2013).

If they are working, people with SMI/SED may be earning so little that they fall just above the eligibility line for Medicaid, but without access to health insurance, making access to other than emergency health care extremely difficult. Without access to health-care, they may end up in emergency rooms or in jail when treatment is needed, and this can ultimately lead to a worsening of their mental health condition (Atdjian & Vega, 2005; Graham, 2007; Wilkinson & Pickett, 2009). A recent analysis of emergency department wait times for individuals requiring a mental health evaluation revealed that those who were uninsured or on Medicaid waited significantly longer than those with private insurance and were more than twice as likely to remain in the emergency department for 24 hours or more (Pearlmutter, et al., 2017). Delays in receiving treatment due to lack of health insurance have also been reported for young people with emerging psychoses (Anderson & Kurdyak, 2016; Compton, et al., 2009). As we mentioned, delays in first episode treatment have been related to violence and homicide for this population and are linked to poorer outcomes, making early intervention an issue of considerable importance. All of this has financial implications due to the increased costs of emergency treatment and hospital admittance or re-admittance.

As with the other issues discussed here, these factors contribute to increased use of costly emergency room use, higher costs to treat more serious and often life threatening conditions, and for many greater morbidity and higher mortality.

Stigma, health care, and racial/cultural issues

The problems of discrimination and differential treatment of individuals from minority cultures and races exacerbate the disparities in treatment (both access and appropriateness) faced by those with SMI/SED. These issues are not only public health issues but impact on the public good in many ways. Due to their importance, we briefly discuss these here. We present some of this information Criteria III, IV, and VI as well.

Following publication of the Surgeon General’s 1999 Report (U.S. Department of Health and Human Services, 1999), it was recognized that disparities in mental health and physical health care are influenced by a variety of factors, including the race/ethnicity of the individual. As a result of this recognition, a Supplement to the Surgeon General’s report was published that looked specifically at culture, race and ethnicity (U.S. Department of Health and Human Services, 2001). This Supplement spawned an increase in research on, and publications about the impact of these mediating variables on mental health care in the US.
The Supplement summed the situation up concisely:

Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality. A major finding of this Supplement is that racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their over-all health and productivity (U.S. Department of Health and Human Services, 2001, p. 3).

Virtually every publication on this topic since the Supplement has concluded that substantial differences remain in the way that people from racial and ethnic minorities are treated compared to the way that people from non-minority groups are treated (Alexandre, Martins & Richard, 2009; Atdjian & Vega, 2005; Compton, et al., 2009; Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006; Mallinger, Fisher, Brown & Lamberti, 2006; Rost, Hsieh, Xu, Menachemi, & Young, 2011; Snowden, 2003; Whitley & Lawson, 2010; Williams & Mohammed, 2009).

The issues and research reports are complex. Some have found differences for one group but not for another and at times the findings of one study conflict with the findings of another study. The findings are also complicated by the fact that there are differences in some physicians’ attitudes toward people from non-majority racial and ethnic backgrounds. Additionally, there are consumer differences related to factors such as a person’s willingness to seek treatment, interest in remaining in treatment, willingness and or ability to fill prescriptions, socioeconomic status and the multitude of factors that SES affects and that in turn affect SES, including availability of health insurance (Atdjian & Vega, 2005; Canadian Mental Health Association & Wellesley Institute, 2009; Graham, 2007; Veling, et al., 2007; Wilkenson & Pickett, 2009). All of these make presentation of a consistent pattern challenging.

Although there are many different racial and ethnic groups in North America, most of the literature is centered on African Americans and Hispanics. The most consistent findings relate to provision of treatment based on published guidelines, including appropriate prescribing practices, and provision of care in appropriate settings.

**Racial/cultural issues in health care: guideline based treatment**

A number of researchers have found that both African Americans and Hispanics are less likely to receive treatment that is based on established guidelines (Wang, Berglund, Kessler, 2001; Wang, Demler, Kessler, 2002; Whitley & Lawson, 2010; Young, Klap, Sherbourne & Wells, 2001). With respect to prescription of antipsychotic medication, ethnic minorities are less likely than non-ethnic minorities to be treated with newer antipsychotic medications (Puyat, et al., 2013). African Americans often do not receive appropriate medications or the appropriate dose of a medication. Some studies indicate that African Americans are less likely to receive antipsychotic medication (Mallinger, et al., 2006) and some studies have indicated that when these medications are prescribed, the dosages are higher than recommended (Blazer, Hybels, Simonsick, & Hanlon, 2000; Chung, Mahler & Kakuma, 1995; Kuno & Rothbard, 1997; Lawson, 1999; Melfi, Croghan, Segal, Bola & Watson, 2000; Sclar, Robinson, Skaer & Galin, 1999; Snowden & Pingatore, 2002; Walkup, et al., 2000). Relatedly, some investigators found that African Americans are diagnosed more frequently with schizophrenia (although it has also been suggested that this could be due to the way symptoms are presented) and Hispanics are diagnosed more frequently with depression. Atdjian and Vega (2005) reported that African Americans often receive higher doses of antipsychotic medication while Hispanics often receive lower doses of these medications.

**Racial/cultural issues in health care: treatment settings**

Another consistent finding is that African Americans are over-represented in non-forensic inpatient settings and in emergency room departments (Snowden, Hu, & Jerrell, 1999). Both African Americans and Hispanics are over-represented in forensic psychiatric hospitals and in jails and prisons. As is widely recognized, these settings have become some of the largest treatment venues in the US for
people with SMI/SED (Lindsey & Paul, 1989; Rosenhan, 1984; Whitley & Lawson, 2010), further increasing the cost of these public systems.

Several reasons have been proposed in the literature. These include lack of insurance, miscommunication or mis-perceptions of providers due to language or other cultural factors, bias of providers toward people with SMI/SED and those from minority racial and ethnic backgrounds, and challenges presented by the characteristics of the population itself.

There can be many reasons for miscommunication. Many people in North America come from countries where English is not the first language and may not even be spoken. In addition to difficulties with language, there are many other ways that culture can have an impact on what is communicated. Some cultures do not acknowledge the existence of mental illnesses or acknowledge their existence only in certain circumstances. Within some cultures, there is great stigma associated with mental illness; for others, there are gender differences in acceptability of different illnesses (Alegria, et al., 2002; Kung, 2004; Leong and Lau, 2001). Misunderstanding due to translation problems is another potential difficulty (Baker, Hayes & Fortier, 1998; David & Rhee, 1998). Establishing trust can require overcoming reluctance and fear due to years of prior mis-treatment or prejudice (Akutsu, Snowden & Organista, 1996; Snowden, Hu & Jerrell, 1999; Takeuchi, Sue & Yeh, 1995; Yeh, Takeuchi & Sue, 1994).

Racial/cultural issues in health care: practitioner bias

Practitioner bias such as holding beliefs and expectations about members of a certain group or population has been suggested as one of the major reasons why people with SMI/SED and people from racial and ethnic minorities receive sub-standard care (Ahn, Proctor & Flanagan, 2009; Atdjian & Vega, 2005; Osborne, 2001; Snowden, 2003). Most bias is subtle and often providers do not even recognize that they are prejudiced (Burgess, van Ryn, Dovidio & Saha, 2007), but there is abundant evidence that physicians and other providers hold biases that impact their interpretation of presenting behaviors and symptoms, and that subsequently impact on the clinical judgments they make (Moy, Dayton & Clancy, 2005). Provider bias can be especially important when consumer characteristics such as poverty, reluctance to accept treatment, take medications, or “adhere” to recommendations are expressed (Mazi-Kotwal & Upadhyay, 2011; Snowden, 2003). One difficulty with overcoming bias is that practitioners are reluctant to admit that they are prejudiced, even if they do realize it. Sensitivity and cultural competence training have been recommended but these have not always achieved the desired results (Burgess, et al., 2007).


In addition to the public health issues we discussed above, there are many other problems confronted by those with SMI/SED. Here we discuss only some of these and concentrate on those that psychologists with specialized training can be expected to ameliorate. We provide greater detail about these psychological and social problems and their implications for the people directly affected, i.e., those with SMI/SED and for needed training to address these needs in Criteria IV and VI.

There are several challenges presented by people with SMI/SED. Individuals may have had negative past experiences with providers, which can contribute to suspicions of mental health professionals, and they may not want to be involved with the mental health system. The pervasive effects of stigma and the vulnerability of individuals who are ill can make it difficult for them to seek help (Mazi-Kotwal & Upadhyay, 2011; Thormicroft, 2011), or they may miss appointments or drop out of treatment (Atdjian & Vega, 2005). Individuals can sometimes be perceived as hostile, fearful and uncooperative. These behaviors can reinforce a provider’s biases and can negatively influence interactions. These factors can make it challenging for mental health providers to know how to be of assistance (Phelan, Stradins & Morrison, 2001). When racial and ethnic differences or language barriers are added, the result can be less than optimal and potentially damaging for the person who needs assistance, ultimately
leading to the observed disparities in treatment and dire consequences that we discussed in this and the previous section.

**Neuropsychological functioning**

People with SMI/SED typically experience problems in neuropsychological functioning resulting in impaired cognition and memory; equally importantly, an inability to function well in social, educational, and work settings is the norm (Couture, Penn & Roberts, 2006; Hurford, Kalkstein, & Hurford, 2011; Nasrallah, Keefe, & Javitt, 2014).

**Trauma**

Trauma sequelae are highly prevalent in people with SMI/SED; it has been estimated that as many as 90 percent of those with SMI/SED have experienced trauma and many have had multiple exposures to trauma (Rosenberg, et al., 2001). Trauma and its consequences may have additive impacts on clients and their interactions with healthcare providers.

**Severe depression and despair**

Depression can also result from abuse and trauma but may be experienced as a result of losses that often follow the onset of SMI/SED including loss of friends, family ties, educational and work possibilities, poverty, homelessness, loneliness, poor physical health, hopelessness and loss of self-esteem – all common for people with SMI/SED and all factors that complicate their treatment (Yanos, et al., 2010).

**Stigma**

In addition to the problems that stigma causes for individuals and the impact of stigma on the health care system that we presented earlier, it is well known that people with SMI/SED are some of the poorest, most stigmatized, and most vulnerable in our society. As a result of their stigmatization, they have reduced opportunities for community inclusion, participation, employment, housing, and social opportunities (Corrigan, et al., 2012; Mueller, et al., 2006), all of which can have pronounced psychological effects and impact even more negatively on physical health status as well. Lack of opportunity for community participation and employment reduces their earning potential and ability to purchase goods and pay taxes and also means that they must remain on social programs such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).

**Greater Incarceration and Forensic Hospital Utilization and Increased Costs in the Justice and Forensic Sectors**

As we illustrated in the previous section, the physical health problems that cause premature disability and death are exacerbated by social issues such as stigma, physician prejudice, poverty, and inability to access health care, to name just a few. The psychological, social, and health problems of people with SMI/SED who become entangled with the criminal justice and forensic systems are even more complicated and are intertwined with homelessness, substance abuse, physical health problems, and the double stigmas of mental illness and criminality.

The prevalence of people with SMI/SED in justice-related settings is higher than their overall prevalence in the population with incarceration rates estimated to be about 20% (American Psychiatric Association, 2000). As with the public health system, the failure to provide timely and appropriate treatment results in overuse of the criminal justice and forensic systems and increases the burden on these already under-resourced systems.
Recent estimates suggest that over one million people with serious mental illness (SMI) are booked into U.S. jails each year resulting in an overall prevalence rate of 15% for men and 31% for women (Steadman, Osher, Robbins, Case, & Samuels, 2009). In fact, the odds of a person with SMI being jalled are significantly greater than the odds of being hospitalized (Morrissey, Meyer, & Cuddeback, 2007). Individuals displaying symptoms characteristic of mental illness were found to have a 67% higher probability of being arrested than individuals not displaying such symptoms (Teplin, 1984, 2000). Moreover, after this initial arrest, individuals with SMI are more likely to be detained in jail (as opposed to released on own recognizance or have cases dismissed), and once jailed, stay incarcerated 2.5–8 times longer in comparison to their non-mentally ill counterparts (Council of State Governments, 2005, p. 356–357).

People with SMI/SED who are in the criminal justice and forensic systems are frequently homeless, have recently been homeless, are at high risk of homelessness, have high rates of co-occurring substance use disorders, almost always have been exposed to or been the victims of trauma, and most are poor, socially isolated and vulnerable (Draine, Salzer, Culhane, & Hadley, 2002; Greenberg & Rosenheck, 2008). Homelessness and incarceration appear to increase the risk of each other, and these factors seem to be mediated by mental illness and substance abuse, as well as by disadvantageous sociodemographic characteristics.

Fellner (2006) highlighted the deplorable conditions endured by persons with SMI/SED:

All too often, seriously ill prisoners receive little or no meaningful treatment. They are neglected, accused of malingering, or are treated as disciplinary problems. Without the necessary care mentally ill prisoners suffer painful symptoms and their conditions can deteriorate. They are afflicted with delusions and hallucinations, debilitating fears, and extreme and uncontrollable mood swings. They huddle silently in their cells and mumble incoherently or yell incessantly. They refuse to obey orders or lash out without provocation. They assault other prisoners or staff. They beat their heads against cell walls, smear themselves with feces, self-mutilate, and commit suicide (p.137). … Security staff typically view mentally ill prisoners who break rules and act out as difficult and disruptive. Whether as punishment or simply an administrative housing decision, officials often place them in barren high-security solitary confinement units. The lack of human interaction and the limited mental stimulus of twenty-four-hour-a-day life in small, sometimes windowless segregation cells, coupled with the absence of adequate mental health services, dramatically aggravate the suffering of the mentally ill. Some deteriorate so severely that they must be removed to hospitals for acute psychiatric care. But after being stabilized they are returned to the same segregation conditions, and the cycle of decompensation begins again. The penal network is thus not only serving as a warehouse for the mentally ill, but, by relying on extremely restrictive housing for mentally ill prisoners, it is acting as an incubator for psychiatric breakdowns (p.140).

Factors associated with SMI/SED and the justice and forensic systems

Racial/cultural issues

Similarly to the non-forensic health-care system, there are clear differences in the way that people of color are perceived and treated by criminal justice authorities and the forensic system in the US. These differences are confounded with social determinants of health, education, employment, housing, socio-economic status, and other aspects of life in the US. (Primm, et al., 2010; Thompson, 2011). African Americans are frequently labeled as criminals when they are actually suffering from SMI/SED, which may account for their overrepresentation in the system (Foulks, 2004).
Immigrants and Refugees

An increasingly visible issue concerns the detention of immigrants by U.S. Immigration and Customs Enforcement (ICE). People with SMI/SED who are immigrants or refugees have considerable problems. According to recent reports, over 350,000 immigrants are detained each year. An unknown percentage of these have an SMI/SED and are taken into custody despite a criminal court finding that they should not be detained but require inpatient mental health treatment. These individuals frequently are not provided assessment or medication, receive little care and are often segregated in isolation, further exacerbating their mental illness (Venters & Keller, 2012). In addition to the obvious moral, ethical, and humane issues, these detentions and failure to provide treatment add to the costs incurred by the U.S. ICE.

Due to language and cultural factors, immigrants and refugees may be at particular risk of ending up in the forensic/criminal justice system. When an immigrant or refugee does not speak the dominant language and is influenced by cultural factors that deviate from the country’s norm, and also has SMI/SED, the consequences can be challenging for all involved. The vast majority of immigrants and refugees who need mental health services never receive them. It is estimated that 92% of immigrants and refugees who need mental health services will not receive them (Birman, et al., 2005; Ellis, et al., 2010; Kataoka, Zhang & Wells, 2002). The likelihood of these individuals ending up in the forensic/criminal justice system can be quite high.

Family and caregiver burden

SMI and SED are complex and, in addition to the very serious impact on the affected individuals, these disorders impact the individuals’ surrounding environment (Millier, et al., 2014). Yet, it is only recently that the health, social and economic impacts on family and other caregivers have been documented.

People with SMI/SED are often dependent on caregivers, most of whom are family members, and who report substantial burden in the form of detriments to physical health and psychological well-being (Gater, et al, 2014). Effects on caregivers have been identified worldwide, with higher psychological burden found especially for female caregivers (Fernando, Deane, McLeod, & Davis, 2017), high social and economic burdens on families of those with SMI/SED, particularly female family members compared to male family members (Singh & Goyal, 2017), and significantly greater social isolation and significantly less quality of life than non-caregivers (Hayes, Hawthorne, Farhall, O’Hanlon & Harvey, 2015). Reducing stigma related to SMI/SED has the potential to reduce caregiver burden (Fernando, et al., Davis, 2017).

Economic Burden due to Greater Health Care Costs, Lost Productivity, Tax Revenue, and Decreased Economic Growth, and on Family Caregivers, and Social Systems such as Housing, Criminal Justice and Forensic Systems.

Individuals with SMI/SED constitute the largest and fastest-growing group of Social Security disability beneficiaries (Danziger, Frank, & Meara, 2009; McAlpine & Warner, 2000). As we indicated, there are substantial impacts on many public health sectors (Millier, 2014). Referring specifically to schizophrenia, Millier et al. (2014) stated: “The costs of the disease’s management remain large for individuals and society” (p. 85). The tremendous economic burden reported by Cloutier et al. (2016) for the US that we cited at the beginning of this section, is not just a U.S. issue. Similar results have been found worldwide. For example, a systematic review conducted of economic burden studies from several countries found that the enormous burden documented by Cloutier et al., mirrors similar findings from countries all over the world (Chong, et al., 2016). Researchers have found similar results in individual country-level studies in Australia (Neil, Carr, Mihalopoulos, Mackinnon, & Morgan, 2014), China (Montgomery, et al., 2013; Xu, Wang, Wimo, & Qiu, 2016), Germany (Frey, 2014), India (Singh & Goyal, 2017), Japan (Sado, et al., 2013), and Norway (Evensen, et al., 2016), among others.
As we indicate in our responses to subsequent sections of this Criterion, psychological interventions, namely those that, based on rigorous empirical research, have been designated as evidence-based and promising practices for this population, and are known as psychosocial rehabilitation (PSR) interventions, have been shown to improve outcomes and can improve the course of SMI/SED, with the potential to alleviate the public burdens documented above.

With respect to SED, estimates of the cost of mental disorders (including costs of health care, special education services, and juvenile justice, as well as loss of productivity) among youth below age 24 in the US are $247 billion per year (Perou et al., 2013).

The extent of mental health concerns for children has been described as “the 20/20 problem,” meaning that despite the fact that 20% of U.S. children need mental health services, only 20% of those children receive services (notwithstanding the quality or appropriateness of the services) (Society for Research in Child Development, 2009). Furthermore, the Surgeon General’s Report on Mental Health (U.S. Department of Health and Human Services, 1999) noted that at least one in 10 children/youth has SED. A report by the National Advisory Mental Health Council’s workgroup on child and adolescent mental health famously concluded that “No other illnesses damage so many children so seriously” (Glied & Cuellar, 2003, p. 39).

Discussing the need for specialty mental health services for children, Costello (2016, p. 7) noted that “barely one in four received any specialty mental health care, and those who did waited 2 or 3 years for services.” Although the highest prevalence rates are attributable to mild cases, Kessler et al. (2012) noted that mild adolescent disorders powerfully predict serious adult disorders.

All of the personal and social issues we presented above (and will discuss in greater detail in Criteria IV and VI) contribute to poorer access to care, worsening medical and psychological problems, and ultimately the potential for higher healthcare, justice, and other economic costs to society. For example, a recent report indicates that U.S. spending for mental disorders (all disorders, not just SMI/SED) far exceeds spending on any other disorder including heart disease, cancer, and trauma. The report indicates that for 2013, spending for mental health conditions was $201 billion whereas for heart disease, spending was a distant second at $147 billion (Roehrig, 2016). This lends further credence to the reports of economists such as Cloutier et al. (2016), cited earlier, and others who have documented the enormous economic burdens associated with SMI/SED.

An example from the homeless literature exemplifies this point. People with SMI/SED are often either homeless or at risk of becoming homeless (Padgett, 2007). Being homeless or at risk of being homeless has far reaching impacts that go beyond simply not having a place to live. The daily struggles for basic necessities such as food, safety, and shelter from the elements means that little time or energy is left for health care, even when serious illness or disease is present (Koh & O’Connell, 2016). The state of being homeless is traumatic in and of itself and puts individuals at risk of victimization, physical and sexual abuse/assault, and criminal activity. When added to the already difficult circumstances that people with SMI/SED experience, homelessness is a serious complicating and additive factor (Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011; Hopper, Bassuk, & Olivet, 2010), further increasing the economic impact on several public health sectors including health, social services, and potentially the criminal justice and forensic sectors.

With specific reference to the question in this Criterion, we should note that there are far reaching societal implications that go beyond the moral and ethical need to provide appropriate treatment for those with SMI/SED. Inequalities in health care and other essential services undermine the social fabric that holds societies together and can ultimately lead to societal unrest and uprisings as seen recently in several countries around the world. Such inequalities can contribute to higher levels of mental illness, further impacting those involved and draining additional financial resources from health care systems that are increasingly under-funded (Canadian Mental Health Association & Wellesley Institute, 2009;
Nasrallah, et al, 2015). Although not a panacea for all of society’s ills, ensuring equity in physical and mental health treatment has implications for all segments of society, not just those affected by SMI/SED (Canadian Mental Health Association & Wellesley Institute, 2009; U.S. Department of Health and Human Services, 2011).

2. Describe what procedures this petitioning organization and/or other associations associated with this specialty utilize to assess changes in public needs.

The Council utilizes data from several national public and private organizations that conduct routine surveys and collect data to determine needs and service provision to meet the changing needs of the SMI/SED population. For example, SAMHSA collects annual data through its annual survey of households, called The National Survey on Drug Use and Health (NSDUH). In addition to the tables and information presented in the NSDUH, several reports of interest to the Council are produced from the main report on specific topics of interest, including Behavioral Health Trends in the United States, Key Substance Use and Mental Health Indicators in the United States, Receipt of Services for Substance Use and Mental Health Issues Among Adults, Suicidal Thoughts and Behavior Among Adults, and others. While these reports do not have SMI/SED as their main focus, they do contain information that allows for the assessment of trends and changes in SMI/SED. Several state-level reports are also produced from the NSDUH and these allow for prevalence comparisons between and among states as well as a more in-depth look at age based comparisons at the state level.

The National Alliance on Mental Illness (NAMI) also conducts periodic surveys and produces reports on various topics of interest. Examples of these include reports on topics such as First Episode Psychosis (2011), The Family Experience with Primary Care Physicians and Staff (2011), Schizophrenia: Public Attitudes, Personal Needs (2008), Starting the Conversation: College and Your Mental Health (2016), Engagement: A New Standard for Mental Health Care (2016), State Mental Health Legislation 2015: Trends, Themes & Effective Practices (2015), A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care (2015) among many others. These and others can be accessed via the NAMI website at www.nami.org.

The National Association of State Mental Health Program Directors (NASMHPD) also publishes a wide array of reports, analyses, toolkits for service provision, and a weekly update of legislative actions and other timely events, all of which contain highly useful information to inform changing needs. The weekly updates are especially helpful for staying informed and up to date with legislation and other public policy activities that can affect individuals with SMI/SED and their families. These publications allow the Council to assess emerging needs and trends in provision of health and mental health services. The NASMHPD publications are available at www.nasmhpd.org.

There are several federal, state and local surveys designed to monitor developments related to children’s health and these are useful for gathering information about SED. The federal surveys and surveillance systems that collect data on mental disorders among children include the following: National Health and Nutrition Examination Survey (NHANES), National Health Interview Survey (NHIS), National Survey of Children’s Health (NSCH), National Survey on Drug Use and Health (NSDUH), National Violent Death Reporting System (NVDRS), National Vital Statistics System (NVSS), National Youth Risk Behavior Survey (YRBS), and the School-Associated Violent Death Study (SAVD). These are available at the relevant national organization websites. However, childhood-onset schizophrenia is not included in ongoing U.S. national surveillance, in part because of its low frequency, and because of the challenges in identifying it through surveys or nonclinical interviews (Perou et al., 2013). The London Child Health and Development Study is a community based study that is prospective and longitudinal, and began by sampling children from 9-11 years old who presented premorbid risk markers for schizophrenia (Laurens & Cullen, 2016), and will identify targets for preventive intervention.

In addition to national surveys, other longitudinal studies which assess rates of SED have been conducted. Investigators in The Great Smoky Mountain Study used clinical interviews while others have
employed school-based screening, such as the study by Li, Green, Kessler and Zaslavsky (2010), which used the K6 screening scale, along with sociodemographic correlates to predict school-level prevalence of SEDs. Miller, Li and Kabell (2015) used the MMPI-A to identify secondary students with emotional disturbance, and were able to distinguish between social maladjustment and emotional disturbance.

There are several ongoing efforts to assess the well-being of children; some of these monitor children’s well-being globally. These include: the Multi-National Project for Monitoring and Measuring Children’s Well-Being, an ongoing, multi-phase effort to improve our ability to measure and monitor the status of children around the globe (http://multinational-indicators.chapinhall.org/domainlist.lasso), the Federal Interagency Forum on Child and Family Statistics which alternates publishing a detailed report, America’s Children: Key National Indicators of Well-Being, with a summary version that highlights selected indicators (http://www.childstats.gov/americaschildren/index.asp), the Child and Youth Well-Being Index (CWI), managed by Duke University and presents an evidence-based measure of trends over time in the quality of life or well-being of America’s children and young people (http://www.soc.duke.edu/~cwi/sectionc.htm), the International Society for Child Indicators (ISCI), supported by the Annie E Casey Foundation and Child Watch International which brings together international experts in the field to contribute to the well-being of all children, share knowledge and experience, enhance dissemination of information on the status of children (http://www.childindicators.org), and Child Trends, which provides information on national trends and research on over 100 key indicators of child and youth well-being with new indicators added each month (http://www.childtrendsdbank.org).

Studies tracking the incidence of SMI/SED are another way that changes in public needs are assessed. Several journals devoted to scholarly work in the area of SMI/SED. We access them on a regular basis to remain up to date with the latest research findings. Some of these journals (in alphabetical order) include: American Journal of Psychiatric Rehabilitation, Archives of General Psychiatry, BMC Psychiatry, Journal of the American Academy of Child and Adolescent Psychiatry, Psychiatric Rehabilitation, Psychiatric Services, Psychological Services, Schizophrenia Bulletin, Schizophrenia Research, and World Psychiatry.

3. Describe how the specialty attends to public need.

The specialty attends to the needs of the public by training post-doctoral psychologists to help individuals with SMI/SED overcome the functional deficits that lead to the severe impairments they experience in everyday life (Cloutier, et al., 2016; Harvey and Strassnig, 2012). It is those impairments that create the enormous public burdens we have portrayed above. Helping people achieve their full functional capability will help to alleviate the continued strain on public mental health and forensic systems by reducing recidivism and the associated costs of recidivism, reducing criminal activity and resultant safety issues, and contributing to the nation’s economy by fostering greater productivity and tax revenues for local, state and federal governments.

Authors of the Schizophrenia Patient Outcomes Research Study (PORT) stated this concisely:

Consistent with the paradigm shift in schizophrenia treatment from a focus on long term disability to one focused on optimism and recovery, the ultimate goal of the Schizophrenia PORT has been to increase the use of evidence based treatments in order to optimize outcomes by reducing illness symptoms and the disability and burden associated with the illness (Kreyenbuhl, Buchanan, Dickerson & Dixon, 2010, p. 100).

We present the research supporting the effectiveness of these specialized interventions in Criterion VI and to a lesser extent in Criterion IV. However, since the questions in this Criterion are about addressing the needs of the public, below we present information from research aimed specifically at documenting the cost effectiveness of the interventions for this population. Following this, we will discuss issues related to training psychologists in this specialization.
Cost Effectiveness of Psychosocial Rehabilitation (PSR) Interventions

Research on the first of these PSR interventions, assertive community treatment (ACT) (designed for those individuals that are most ill and have the highest use of inpatient services), has been conducted since the intervention was developed in the mid-1980s. ACT has been found to be highly effective all over the world (Adair, et al., 2016; Aubry, Nelson, & Tsemberis., 2015; Bond, Drake, Mueser & Latimer, 2001; Burns, Fioritti, Holloway, Malm, & Rössler, 2001; Burns & Santos, 1995; Phillips, et al., 2001). Due to ACT’s reduction in the use of costly inpatient hospitalizations, several investigators also found a cost benefit (Dixon, 2000; Latimer, 1999; Phillips, et al., 2001; Rosen, Mueser, & Teeson, 2007; Wiley-Exley, Domino, Ricketts, Cuddeback, Burns, & Morrissey, 2013) although the outpatient resources needed to support individuals in the community are considerable. In addition to direct cost-savings, users of ACT and their families report greater satisfaction and quality of life as a result of ACT services (Bond, et al., 2001; McCrone, et al., 2009). Recently, supported housing using a model known as Housing First was shown to enhance the effects of ACT by demonstrating improved functioning, perceived quality of life, and housing stability, leading to the conclusion that combining integrated psychosocial rehabilitation services such as those included in ACT programs with supported housing such as Housing First may be cost effective for those with SMI/SED (Ly & Latimer, 2015).

Although quite recent, several researchers looking at cost effectiveness of newer PSR interventions found that the interventions designed to improve employment possibilities, provide early intervention services for those experiencing early warning signs, and improve cognitive functioning are not only effective but have the potential to reduce the substantial burden of SMI/SED on the affected individuals, their families and care givers, and public health, housing, social services, and justice and forensic systems and that these interventions reduce costs (Dixon & Schwarz, 2014; Gilmer, et al., 2014; Jolley, et al., 2015; VanMeerten, et al., 2013). In a report on the economics of providing evidence-based interventions to people with schizophrenia and published by the London School of Economics and Political Science in 2014, the authors state: “There is a strong business case for investing in the early intervention and community-based interventions proven to generate savings or value-for-money gains through reduced inpatient admission, or through other routes” (Knapp, et al., 2014, p. 3).

Some researchers have focused on one or two specific interventions to look at outcomes related to alleviating the economic burden of SMI/SED. Besides the research on cost effects of ACT, most of the other research focused on provision of the evidence based practice of Supported Employment (SE), particularly the model most widely studied, Individual Placement and Support (IPS). Due to the success of the recently completed RAISE early treatment for first episode psychosis initiative (Kane, et al., 2016), there is considerable interest in determining the effects of these services on cost. Notably, cognitive remediation has been shown to be beneficial both on its own, and when added to other interventions such as SE has been found to enhance their effects. Therefore, the cost effects of providing cognitive remediation have also been studied. Estimates of cost savings for some of the other PSR interventions such as Family Psychoeducation and CBT, have been derived although there are no formal scientific investigations leading to strong conclusions. Below, we first present results of research on SE, early intervention and cognitive remediation; following that, we offer information about the estimates of potential savings for Family Psychoeducation and CBT.

Researchers have documented the cost effectiveness of providing SE (Bond & Drake, 2014; Knapp, et al., 2013; Salkever, 2010) and shown that SE IPS can reduce social security costs (Drake, Skinner, Bond, & Goldman, 2009). Several have also demonstrated that employment leads to decreased mental health costs (Bond et al., 1995; Bush, Drake, Xie, McHugo, & Haslett, 2009; Clark 1998; Drake, Xie, Bond, McHugo, & Caton, 2013; Henry, Lucca, Banks, Simon, & Page, 2004; Latimer 2001; Perkins, Born, Raines, & Galka, 2005; Rogers, Sciarrappa, MacDonald-Wilson, & Danley, 1995; Schneider et al., 2009), and the six-country EQOLISE study (Knapp, et al., 2013), found better employment outcomes and lower costs for the SE IPS model, leading some to conclude that long-term cost reductions may be even greater than those measured by existing studies (Bush et al., 2009).
Due to the heightened interest in determining the effects of intervening early in the course of SMI/SED, several investigators sought to determine if providing a range of evidence-based and promising PSR services to those with first episode psychosis would demonstrate cost savings. The combination of interventions often includes intensive case management, supported housing, CBT, family psychoeducation, and supported employment combined with low-dose medication regimens. Studies of this nature have been conducted in several countries and have found health, social and economic benefits (Hastrup, et al., 2013; McCrone, Craig, Power, & Garety, 2010; Mihalopoulos, Harris, Henry, Harrigan, & McGorry, 2009; Mihalopoulos, McGorry, & Carter, 1999). In the UK, Park, McCrone and Knapp (2016) found that providing early intervention services saved the equivalent in U.S. dollars of more than $2,600 per person over three years. Similarly in the US, Breitborde, et al. (2015) found that provision of early intervention services resulted in significant savings over the six months of the study, leading them to conclude “that for every $1 spent on EPICENTER care, $2.79 dollars were saved during the first 6 months of treatment” (p. 7). Further, Rosenheck, et al. (2016) used results from the NIMH RAISE trial of early intervention services to link early intervention treatment to quality of life adjusted years and found that the estimated benefits exceeded costs compared to usual community care evidencing a cost benefit for the early intervention services.

With respect to the cost benefit of providing cognitive remediation, to date there are few investigations, none showing a direct reduction in costs. However, functional improvements in several domains have been demonstrated (Dixon & Schwarz, 2014; Lee, et al., 2013a; Wykes, Huddy, Cellard, McGurk, & Czobor, 2011). In addition, reductions in higher cost services such as inpatient admissions, ER use, use of day care settings have been demonstrated (Reeder, et al., 2014; Vita, et al., 2016). These studies also showed increased use of less costly community PSR services, thereby making direct inferences about cognitive remediation and cost benefit difficult to discern. However, due to the enhancing effect of cognitive remediation on other PSR interventions (Chan, Hirai, & Tsoi, 2015; McGurk, et al., 2015; Wykes, et al., 2011), several researchers believe the likelihood is high that cost reductions will result (Reeder, et al., 2014; Vita, et al., 2016; Yamaguchi, Sato, Horio, & Yoshida 2017).

Cost effectiveness studies on family psychoeducation are just beginning to be undertaken but there have been several studies estimating the value of the intervention. According to Andrew (2014) who designed an economic model to weigh the cost versus savings:

There is a 97% chance that family therapy will be cost-saving: that is, the costs of providing family therapy will be more than outweighed by savings made in the health care system. It is likely that the model underestimates savings from family therapy since it only considers those arising from a reduction in hospitalisation rates. Other areas for savings may include: decreased service use from family members, increased employment rates among family members, an increase in the ability to live independently, and shorter hospital stays. In addition, this economic analysis does not place any monetary value on improvements in mental health or wellbeing for either the individual with schizophrenia or family members. If such benefits were quantified, the cost effectiveness argument for providing family therapy would be even stronger. (p. 12).

Similarly, the cost effects of providing CBT for those with SMI/SED have also been modelled and like other PSR interventions, CBT was found to be cost effective due to the reductions in hospitalization and increased quality adjusted life years (Knapp, McCrone & McDaid, 2014; National Institute for Health and Care Excellence, 2014).

When it comes to children and youth, it is possible to identify those at risk of developing psychosis during the prodrome period prior to the onset of visible symptoms (National Collaborating Centre for Mental Health, 2014), and with early detection services, reduce the duration of untreated psychosis (DUP) (see Criterion VI for a fuller discussion of the implications of DUP). Importantly, intervention prior to the onset of the first episode of psychosis using CBT has reduced transition to psychosis at 12 months (Stafford, Jackson, Mayo-Wilson, Morrison, & Kendall, 2013). By conducting
economic evaluations for early detection services, and including costs beyond the health care system such as criminal justice systems costs, the economic costs of suicide, and the economic costs of unemployment, McCrone, Park and Knapp (2011) determined that the costs that could be avoided would be greater than the costs of providing early detection services. Relatedly, intervening in the course of SED, (i.e., following onset of symptoms during childhood), has been shown to be more cost effective than delaying until adulthood, reducing vulnerability to such problems as homelessness, substance abuse or addiction, and unemployment, as well as personal and social loss due to unrealized potential (Miles, Espiritu, Horen, Sebian, & Waetzig, 2010).

Psychologists who work with children and youth with SED provide evidence-based care, including interventions that enhance functioning, and promote hope and recovery/reclaiming (Warner, 2010; Miles et al., 2010). A model for intervening for children’s mental health was offered by Miles, et al. (2010), which “describes a process of acting to optimize children’s positive mental health and minimize the symptoms and impacts of mental health problems” (p.64). The Intervening Model includes four components: Promoting Health, Re/Claiming Health (comparable to Recovery in adult care systems), Treating Problems, and Preventing Problems. The term Re/Claim is offered as a separate term that denotes interventions for optimizing positive mental health for populations who have identified mental health problems. This emphasizes the idea that even for those with severe mental health problems, optimizing mental health is a valid goal, and aims toward a holistic state of balanced health (not limited to alleviating negative impact of mental illness). The term Re/Claim was chosen to connote an active process, involving enhancing an environment, “a positive, dynamic, ongoing process that engenders hope and optimism in the face of adversity” (Miles et al., 2010, p. 68).

This model includes the comprehensive array of interventions that specialists in SMI/SED offer, and which can occur at various population levels (individual, family, state, tribal, etc.). Although all four categories are relevant, specialists in the treatment system are especially active in Re/Claiming (e.g., wraparound care, Painter, 2012), Preventing problems (e.g., early identification, Laurens & Cullen, 2016), and most active in Treating (e.g., psychosocial, psychoeducational, individual, and family interventions, McClellan, Stock & the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, 2013; Tiffin & Welsh, 2013), and have also worked in early intervention (Rosenheck, et al., 2016) and systems collaboration (Lee, et al., 2013b).

Public Need for Specially Trained Providers: Post-Doctoral Psychology Training

In the early 1990s, an NIMH sponsored National Forum convened leaders from several disciplines to make recommendations about how to synthesize and transfer new knowledge to those in training (National Institute of Mental Health, 1990). The Forum was led by an eminent psychologist (Harriett Lefley) and included leaders in four key disciplines (psychiatry, psychology, social work, nursing) plus experts in psychosocial rehabilitation and family members. One of the psychology leaders told the group that there were few faculty or clinical supervisors with the needed expertise, there existed a lack of relevant coursework, and few mentors and role models (Hargrove, 1990). These concerns were echoed by Johnson (1990), who added: “work with the seriously mentally ill has not been highly regarded by psychologists, and opportunities for training to work with this population are seriously deficient.” (p. 64). In each decade since the 1990s, and increasingly since the turn of this century, it has been progressively more emphasized that specialized training is needed to provide adequate treatment for those with SMI/SED (Carr, Bhagwat, Miller, & Ponce, 2014; Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Gill & Murphy, 2013; Hargrove, 1990; Klee, et al., 2016; Mueser, et al., 2013). We also know that many psychologists feel inadequately prepared to treat individuals with SMI/SED, are uncomfortable doing so, and prefer to work with individuals they feel prepared to help achieve success (Bernheim, 1990; Buck, Romeo, Olbert, & Penn, 2014).

In 2012, Chu, et al., proposed a training model to help alleviate the problem of psychologists in the public sector who are not prepared to effectively treat people with SMI/SED. Although it is in the public sector where many with SMI/SED are seen, individuals are increasingly seeking services in
integrated health care settings and for those with financial resources, from private sector providers. To meet the emerging and rapidly changing needs within the health care environment, specialized training needs to be broadly available. Some have even called for the mental health field to consider treatment of people with SMI/SED a discipline: “Since the 1980s, it has been asserted in the scholarly literature that education in psychiatric/psychosocial rehabilitation (PSR) theory and techniques is a necessary component of academic preparation for practitioners providing services to people with serious mental illness (SMI) and, in fact, may be considered an academic discipline in itself.” (Gill & Murphy, 2013, p. 260). Mabe and colleagues (2014) also point out that SAMHSA has endorsed the recovery paradigm as part of its primary mission:

In this decade, virtually every mental health professional and advocacy organization in the United States has endorsed the recovery model of mental health care, and the adoption of this new concept of recovery has been a primary mission of the Substance Abuse and Mental Health Services Administration (SAMHSA, 2005 as cited in Mabe, Ahmed, Duncan, Fenley, & Buckley, 2014, p. 348).

But, it is also true that: “Relatively neglected have been initiatives to educate physicians and doctorally trained psychologists in the concepts and practices of recovery-oriented care” (Mabe, et al., 2014, p. 348).

In order to meet this recognized public health need, in 2016 the Council requested and received funding from the APA Board of Educational Affairs and from Division 18 to hold a meeting following the 2016 APA convention; the purpose of the meeting was to identify the specific competencies needed to meet the training needs of psychologists. While we recognize that not every post-doctoral specialty program could include all of these, the competencies that were identified are those that would ideally be included or available to trainees. These competencies and a broad, general descriptive narrative are included as part of Criterion VII and are in the Training Guidelines at Appendix I of this petition, and are available on the Council website (www.psychtrainingsmi.org).

As we have mentioned, helping people achieve their full functional capability will help to alleviate the continued strain on public mental health and forensic systems by reducing recidivism and the associated costs of this recidivism, reducing criminal activity and resultant safety issues, and contributing to the nation’s economy by fostering greater productivity and tax revenues for local, state and federal governments. Recognition of a post-doctoral specialty in SMI/SED is designed to begin the process of moving the profession forward toward the goal of providing more relevant training for psychologists to achieve these goals.

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Criterion III. Diversity

The specialty demonstrates recognition of the importance of cultural and individual differences and diversity.

**Commentary:** The specialty provides trainees with relevant knowledge and experiences about the role of cultural and individual differences and diversity in psychological phenomena as it relates to the science and practice of the specialty in each of the following areas: i) development of specialty-specific scientific and theoretical knowledge; ii) preparation for practice; iii) education and training; iv) continuing education and professional development; and v) evaluation of effectiveness.

Because the population is diverse:

1. **Describe the specialty-specific scientific and theoretical knowledge required for culturally competent practice in the specialty, how it is acquired and what processes are in place for assessment and continued development of such knowledge.**

   Cultural competency for psychologists, commonly thought to be comprised of knowledge, skills, awareness, and dynamic sizing (Sue, Zane, Hall, & Berger, 2009), is essential for accurate assessment of health and pathology, as well as for the ability to tailor treatment to the diversity found in individuals. Culturally competent treatment helps clinicians address the wide ranging symptoms and functional deficits that typically accompany an SMI/SED diagnosis. In addition to the presence of mental health symptoms, factors such as gender, age, ethnicity, race, religion, spiritual beliefs, sexual orientation, migration history, level of acculturation, trauma history, and childhood adversity have all been found to influence patterns of diagnosis and access to treatment among persons diagnosed with SMI/SED, and thus must be considered as psychologists engage in assessment, case conceptualization and formulation, and intervention. The specialty values diversity in all its possibilities, and strives to assure these values are inculcated in those obtaining training and/or working with an individual having an SMI/SED diagnosis.

   **Specialty-Specific Scientific and Theoretical Knowledge**

   The specialty recognizes that diversity issues impact the mental health of both adults and children. As Costello (2016, p. 715) noted, “far too many children have psychiatric disorders.” As revealed in her 20-year prospective study, 10-15 percent of the child community sample experienced significant functional impairment connected with psychiatric symptoms. But while SEDs occur broadly, some subgroups seem to be more susceptible. In light of the impact of the diversity factors, it is important that practitioners working with the SMI/SED population are knowledgeable about cultural contexts and engage in culturally competent practice. Cultural influences, societal beliefs, and religion should all be considered in interpreting symptoms, along with the possible impact of diagnosis and treatment on family functioning (Kuniyoshi & McClellan, 2014). Professionals in the field of SMI/SED examine the connection between research and practice regarding cultural competency in the SMI/SED population. While a full exposition of all that is known about cultural and individual factors impacting on individuals diagnosed with an SMI/SED diagnosis is beyond the scope of this application, exemplars of the key role these variables play is provided next.

   **Sex/Gender.**

   Patterns of SED onset differ by sex and/or gender, with higher rates (by parental report) for boys (6 percent) than for girls (4 percent) (Federal Interagency Forum on Child and Family Statistics, 2015). The London Child Health and Development Study (CHADS; Laurens & Cullen, 2016) found that a trio of
antecedents of schizophrenia were more prevalent for boys (13.4 percent) than for girls (5.8 percent) in the 9-11 year old children screened. Patterns of schizophrenia onset have been found to vary by sex, with earlier onset for males (peak incidence between ages 15 and 24), and more gradual increase over age for females (peaking between 20-29, and then again between ages 45-54) (Tiffin & Welsch, 2013). Perhaps because of their earlier onset and their propensity for a greater preponderance of negative symptoms, males diagnosed with schizophrenia tend to have worse outcomes than females (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012). With regard to bipolar illness in adults, gender differences in prevalence of bipolar I are less apparent, though males may be more likely to present with an initial manic (rather than depressed) episode (Kawa et al., 2005); bipolar II is more prevalent in females (Nivoli et al., 2011). More recently, some attention has been directed to identifying any potential associations between non-binary or transgender status and increased prevalence of SMI/SED, especially schizophrenia (see for example, Rajkumar, 2014). However, much of this work is very preliminary and has been critiqued for lacking rigor.

Race/Ethnicity and Immigration Status.

In the US, parents report more serious emotional or behavioral difficulties for White (6 percent) or Black (5 percent) non-Hispanic children than for Hispanic children (4 percent) (Federal Interagency Forum on Child and Family Statistics, 2015). The CHADS study described above found differences for specific ethnic groups, with schizophrenia antecedents more prevalent among children of African-Caribbean and Black African minority groups compared to White British children, resembling the schizophrenia incidence in the United Kingdom (Laurens & Cullen, 2016). Children of South Asian ethnicity were less likely than the White British youth to manifest the antecedents. Laurens and Cullen suggested further study of these differences might offer an opportunity to identify protective processes, as well as risks, that might operate prior to schizophrenia onset.

With regard to adults diagnosed with SMI/SED, the 2015 U.S. National Survey on Drug Use and Health (Center for Behavioral Health Statistics and Quality, 2016) found a similar pattern of results as those reported for children in the Federal Interagency Forum on Child and Family Statistics, with Hispanic/Latino populations consistently reporting a lower likelihood of an SMI/SED diagnosis than non-Hispanics. There is a robust literature indicating that African Americans are more likely than Caucasians to be diagnosed with schizophrenia (see, for example, Barnes, 2008 and Coleman et al., 2016). There continues to be debate about whether these racial disparities are true differences in prevalence and incidence of the disorders, or result from (potentially biased) diagnostic methods (Arnold et al., 2004). In a worldwide mental health survey, the prevalence of bipolar disorders was consistent across diverse cultures and ethnic groups, with an aggregate lifetime prevalence of 0.6% for bipolar I disorder, 0.4% for bipolar II disorder, 1.4% for subthreshold bipolar disorder, and 2.4% for the bipolar disorder spectrum (Merikangas et al., 2011; however pockets of heightened rates of bipolar illness have been reported throughout the world (Fearon et al., 2006).

Migration is increasingly understood as an important risk factor for the development of psychosis. The exact magnitude of this risk varies, depending on the given migrant group and setting in which the study is conducted. In the UK, for example, psychosis risk ranges from slight increases (of 1.5 or less) for white migrants, to 2-4 times greater risk for people of Pakistani and Bangladeshi origin, and up to 10 times higher rates among black Caribbean and African groups (Kirkbride et al., 2012). An increased risk of schizophrenia among first and second-generation immigrants, especially those from developing countries, has been noted (Kuniyoshi & McClellan, 2014). The cause of this increased risk is much debated. As Kirkbride (2017) notes, it is not found in all cultures (for example, Hispanics in the US do not have a heightened risk for psychosis), and may reflect in part the suffering and stress many emigrants encounter before they leave their original homes as well as the stigma and discrimination they face in their new homes.

The growing population of refugees that come to the US from other countries provides a variety of challenges for physical and mental health treatments. Nazzal and colleagues (2014) investigated best
practices on how to provide preventative care and intervene within this ethnically and economically diverse refugee population. These cultural differences are especially evident for those receiving mental health care and practitioners need to have cultural competence when approaching children in need of services. Attention is also needed when the parent’s immigration status intersects with children’s mental health. In a study of U.S. born Latino children’s mental health, Rojas-Flores, Clements, Koo, and London (2017) found that effects on the children (especially those witnessing parental detainment) could include PTSD and psychological problems following the detention or deportation of a parent.

**Poverty and Adverse Childhood Experiences.**

Adverse childhood experiences increase the likelihood of the development of an SED. In the US, children living below the poverty level were twice as likely (8 percent) to have serious emotional difficulties than those whose family incomes were 200 percent or more of poverty level (4 percent) (Federal Interagency Forum on Child and Family Statistics, 2015). British adolescents who had experienced such traumatic events as physical abuse, unwanted sexual experiences, exposure to domestic violence, or bullying (as victims or perpetrators) had a greater prevalence of psychotic-like experiences (Kelleher & Cannon, 2011). An association between maltreatment and illogical thinking was confirmed in a study of school-age children in the US (Toth, Stronach, Rogosch, Caplan & Cicchetti, 2011). The authors recommended that children and youth who present with disordered thinking should be assessed for trauma history. A promising brief (10-item) trauma screening measure for children has been developed and validated (Lang & Connell, 2017), and could make an important contribution to trauma-informed care. Often, children with severe psychopathology present within the context of significant psychosocial stressors (e.g., family mental illness, parental separation or divorce physical or sexual abuse, police or justice system involvement, and history of learning disorder) (Park, McDermott, Loy, & Dean, 2011). Previous researchers have discovered that children and youth who are homeless experience disproportionally higher rates of emotional problems and psychiatric disorders. The barriers to access for mental health concerns is one reason that Adkins et al., (2017) were interested in exploring the use of technology to provide youth who are homeless with the necessary therapeutic services. This application further explores the need for understanding of social context when working with children with serious mental health concerns.

Within the adult SMI population, there is increasing recognition of the role childhood adversity and trauma play as a risk factor for psychosis. For example, in a meta-analysis of 18 studies, Varese et al., (2012) found that a history of childhood adversity (defined as sexual abuse, physical abuse, emotional/psychological abuse, neglect, parental death, and bullying) increased the likelihood of the development of psychosis as at least two fold in both case-control and population studies. Similarly, Matheson, Shepherd, Pinchbeck, Laurens, and Carr (2013) conducted a meta-analysis on the impact of childhood adversity on a subsequent diagnosis of schizophrenia, and found a threefold increase in diagnoses rates in participants with the adverse history. These findings highlight the critical importance of trainees learning to assess for childhood adversity when working with adolescents and adults diagnosed with SMI/SED.

**Differential Access to Treatment Related to Culture or Ethnicity.**

Language barriers, poverty, and cultural norms all impact on access to mental health treatment, and so they impact on access to appropriate SMI/SED treatment. At a most basic level, there is a dearth of psychologists who can conduct therapy in languages other than English; further, immigrant and some racial groups are disproportionally economically disadvantaged and are unable to afford care. In addition, there are data to suggest that even when culturally diverse populations access treatment, it may be substandard.

First, we consider SMI in adults. Salcedo, McMaster, and Johnson (2016) examined differences in mood stabilizer use and mental health service utilization between 163 adult English-speaking Hispanic and non-Hispanic white respondents with bipolar disorder. Demographics, symptom presentation, and
acculturation were examined as covariates. None of the 26 Hispanic respondents were taking mood-stabilizing medication, compared to 21% of non-Hispanic whites, and Hispanics were less likely to receive medications for emotional problems, see a professional for manic episodes, or attend psychotherapy. Even after accounting for differences in symptom profiles and sociodemographics, ethnicity continued to be a significant predictor of mood stabilizer use and psychotherapy attendance. Similarly, Horvitz-Lennon, McGuire, Alegria, and Frank (2009) examined Florida Medicaid data from a racially diverse sample of individuals who had at least two claims with a diagnosis of schizophrenia. Medicaid spending was much less for African Americans and Hispanics than it was for Caucasians, and much of this disparity was as a result of lower psychotropic medication costs for African-Americans. While these disparities exist, it is important to recognize that innovative mental health programs are being developed to address them, such as the CT Latino Behavioral Healthcare Program (Paris et al, 2016).

With regard to SED in children, Alegria, Vallas, and Pumariega, (2010) published a comprehensive review of ethnic and racial mental health disparities in children. They begin by saying “Despite the enormous toll that mental health problems take on the well-being of youth and families ($247 billion annually), disparities in access to and intensity of quality mental health services appear to persist for racial/ethnic minority children, who are more likely to receive less and inferior health services as compared to non-Latino white peers.” (p 759). School-based mental health is one way to allow a diverse group of youth to access the necessary mental health services. Kourkoutas and Xavier (2010) discuss the importance of using multiple contextual and theoretical models and strength-based assessments when developing school-based prevention and intervention programs for children who are at-risk for or have developed emotional disorders. This ecological and social model allows for better understanding of diverse backgrounds when assessing and treating children with SED within the schools. Bear, Finer, Guo, and Lau (2014) assessed a school-based mental health intervention program and its ability to reach a wide range of at risk students to reduce racial disparities in mental health services. These specific interventions and needs assessments are important in understanding the role that mental health services play within a culturally diverse population such as that found in the US.

How Knowledge is Acquired

Those working within the specialty have many venues for acquiring knowledge and guidance on diversity issues. Within APA, the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (2002) provide essential direction on appropriate attention to diversity issues for all clinicians, researchers, and faculty, including those working with individuals diagnosed with SMI/SED. The guidance from the APA Office of Ethnic Minority Affairs and the APA Socioeconomic Status Office also has significant relevance for SMI/SED populations. For example, the Office of Ethnic Minority Affairs Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations reminds psychologists of the importance of 1) recognizing cultural diversity; 2) understanding the role that culture and ethnicity/race play in the sociopsychological and economic development of ethnic and culturally diverse populations; 3) understanding that socioeconomic and political factors significantly impact the psychosocial, political and economic development of ethnic and culturally diverse groups; and 4) helping clients to understand/maintain/resolve their own sociocultural identification; and understand the interaction of culture, gender, and sexual orientation on behavior and needs. As individuals diagnosed with SMI/SED are disproportionately likely to come from racial and ethnic minorities, as well as from immigrant communities, these reminders are of particular importance. Similarly, many of those with an SMI/SED diagnosis have been adjudicated as disabled. The APA Socioeconomic Status Office highlights the association among poverty and disability status, as well as their correlates, including under-education and lack of access to resources (including appropriate medical and mental health treatment). These all have relevance when assessing, developing treatment plans, and intervening with individuals diagnosed with SMI/SED disorders.

In addition to research published in professional journals, the specialty also draws resources from SAMHSA, the Center for Mental Health Services, National Institute of Mental Health, National Mental Health Association, the UPenn Collaborative on Community Integration which is a Rehabilitation
Research & Training Center Promoting Community Integration of Individuals with Psychiatric Disabilities, and the University of South Florida’s Research and Training Center for Children’s Mental Health which studies and disseminates information to enhance provider’s cultural competence to work with diverse adults and youth diagnosed with SED/SMI. Multiple conferences offer opportunities for practitioners and researchers to gain more information about working with diverse populations diagnosed with SMI/SED. These conferences include opportunities to listen to engaging speakers during symposia, ask questions during panel discussions, and read and listen during paper and poster presentations. Furthermore, some companies and organizations also offer online courses or webinars that delve into topics related to diversity issues for children and adolescents with SMI/SED. Some of these are included below.

University of South Florida’s Research and Training Center for Children’s Mental Health: http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/availability/default.cfm


Processes in Place for Assessment

Cultural competence can be demonstrated in a variety of ways. There are data to suggest that self-evaluations of cultural competence often lack validity (Kaslow et al., 2004). To address this concern, most post-doctoral training programs emphasizing training in SMI/SED include attention to cultural differences as a key criterion for evaluation of clinical work, both in supervision and in review of written products (e.g., assessments, treatment plans, etc.). Supervisees should be able to incorporate a diversity framework into case conceptualizations, for example. They should also be able to demonstrate awareness of the cultural/language/intellectual limitations associated with any of the measures or interventions they are utilizing.

Although there are few measures available to assess the impact of supervision on supervisees and the clients served, Tsong and Goodyear (2014) reported on the development of the Supervision Outcome Scale (SOS) and its psychometric properties. Along with a measure of clinical competence outcome, it also offers an assessment of multicultural competence (as measured by the supervisee’s perspective). Its reliability and validity were affirmed, and the authors offer it as a valuable tool for use in training programs to evaluate the success with which multicultural issues are addressed in supervision and therapy. An additional resource is the attention paid to ethical dilemmas related to cultural diversity and globalization, and the recommendations made by Pettifor, Sinclair, and Falendaer (2014). They note that “Supervisees and supervisors can be powerful agents in bridging the gap across cultures and worldviews” (p. 207), but especially place on supervisors the responsibility for applying globally accepted ethical principles and the development of an international mindset to supervision.

Some programs also use formal assessment tools of cultural competence, such as the California Brief Multicultural Competence Scale. Furthermore, some states also have initiatives to support cultural competency when working with children diagnosed with SMI/SED. For instance, the state of Pennsylvania’s Office of Mental Health and Substance Abuse Services has a strategic plan to implement and assess culturally responsive community systems of care. Through the use of the Cultural Competence Advisory Committee the state recognizes its mission to provide effective treatment and services to children diagnosed with SMI/SED and assess cultural competency. New York and Connecticut also have similar statewide systems in place to support these youth. Further, state licensing boards include questions assessing cultural competency when psychologists are evaluated to be independent practitioners.

The Development of the Knowledge Base

With regard to the development of this knowledge base, National Institutes of Health and Department of Veterans Affairs grants require that minority status (ethnicity, race, and gender) be
considered in developing proposals and recruiting participants for funded research trials. Many mental health journals focus on understanding cultural differences in mental health issues. These include, for example, *World Psychiatry*, *International Journal of Culture and Mental Health*, *Cultural Diversity and Ethnic Minority Psychology*, *Social Psychiatry* and *Psychiatric Epidemiology*. Several mainstream psychology journals also publish articles pertaining to cultural diversity and SMI/SED issues. Appropriate treatment for all cultural and ethnic groups is an especially important area of concern. For example, the landmark meta-analysis of Griner and Smith (2006) demonstrated that culturally-adapted interventions may be more effective than those that are not, with an effect size of .45. Data on culturally adapted treatment for SMI/SED also show promise. For example, two sets of investigators have found that family interventions incorporating collectivist values are acceptable and effective with Hispanic families (Kopelowicz, Zarate, Smith, Mintz, & Liberman, 2003; Weisman de Mamani, Weintraub, Gurak, & Maura, 2014).

2. Describe how the specialty prepares psychologists for practice with people from diverse cultural and individual backgrounds (e.g., through coursework, supervised practice, continued professional development, etc.) and how competence is demonstrated.

As discussed in our response to Criterion 3, question 1, cultural issues impact on many aspects of SMI/SED, including differential rates of development of disorders due to factors such as migrant status and childhood adversity, differential rates of diagnoses based on ethnic group, and differential access to care based on social class and language. Given these disparities, it is essential that trainees have adequate exposure and training in issues around cultural diversity and the role it plays in influencing identification and treatment of mental health concerns. A key pre and post-doctoral SMI/SED training resource for developing cultural competency is available through SAMHSA’s Recovery to Practice Initiative which incorporates attention to cultural competence throughout the curriculum concerning the assessment and treatment of individuals diagnosed with SMI/SED (American Psychological Association & Jansen, 2014).

**How the Specialty Prepares Trainees for Work with People with Diverse Backgrounds**

Foundational diversity training for the SMI/SED population is typically embedded within the core curriculum of most clinical psychology doctoral and post-doctoral and fellowship training programs. This initial information and knowledge is incorporated in planned didactic seminars, classes, and practicum experiences. Many programs also offer SMI/SED journal clubs which highlight issues around diversity and culture. Applications of knowledge regarding cultural competence for the SMI/SED population primarily take place during initial clinical training experiences, such as practica, internships, and fellowship training. Thus, diversity training when working with the SMI/SED population is primarily practical and applied. Nevertheless, as Smith, Constantine, Dunn, Dinehart, and Montoya (2006) correctly observe, diversity training is even more effective when it is grounded in theory, and knowledge in this area continues to be developed. Continuing professional development opportunities regarding diversity issues include accessing published research as well as attending trainings at professional meetings such as the APA convention.

**Demonstrating Cultural Competence**

There are many strategies for evaluating cultural competence. Cultural competence, like competence in all other aspects of practice, can typically be evaluated through a combination of observation and assessment of trainee attitudes, values, and behaviors. These strategies can include:

- Observation of comments during class discussions
- Evaluation of clinical work through supervision
- Evaluation of clinical work through review of written products (e.g., assessments, treatment plans, etc.).
• Use of assessment tools such as the Supervision Outcome Scale (SOS) (Tsong and Goodyear, 2014) or the California Brief Multicultural Competence Scale (Gamst et al, 2004).

Good supervision requires “listening” with an ear that is closely attuned to discern nuances. Importantly, attention must be paid to how ethical dilemmas related to cultural diversity and globalization are presented and dealt with; the recommendations made by Pettifor et al,. (2014) offer an essential resource. They note that “Supervisees and supervisors can be powerful agents in bridging the gap across cultures and worldviews” (p. 207).

Just as the acquisition of cultural competence among trainees is an issue of importance, so too training programs benefit from assessment efforts to evaluate the broader impact of their instructional efforts. An example of a model for evaluating programmatic multicultural training is the one offered by Jones et al., (2013), who identified four competence domains (beliefs and attitudes, knowledge, skills, and advocacy). They recommended a number of teaching tools, and evaluation techniques for each domain. They suggested a yearly evaluation process that included student self-assessments, as well as objective measures aggregated by cohort or year. In this way programs could document changes over time. Faculty and doctoral students/interns have also been surveyed to assess their perceptions of the implementation of clinical training programs. Rodriguez-Menendez et al., (2017) surveyed 1,219 students and 30 faculty administrators through Time2Track regarding clinical training activities. Diversity education was one area in which improvements were recommended, as students rated their training lower than faculty for working with multicultural and lesbian, gay, bisexual and transgender populations.

3. Describe how the specialty is monitoring developments and has moved to meet identified emergent needs and changing demographics in training, research, and practice (e.g., through research, needs assessment, or market surveys).

It is becoming increasingly critical for clinicians working with the SMI/SED population to account for cultural factors in their engagement strategies, assessments, case conceptualizations, and interventions. An expanding body of literature suggests that a myriad of stressors, including early childhood adversity, migrant status, and poverty are risk factors for the diagnosis of SMI/SED, though there continues to be controversy about whether the actual occurrence of these disorders is heightened or whether this is an issue of over-diagnosis. Nevertheless, data suggesting that culturally adapted interventions are more effective (e.g., Griner & Smith, 2006) highlight the importance of psychologists working with the SMI/SED population staying abreast of developments in this area.

Psychologists have several venues with which to keep abreast of new developments in cultural diversity as it applies to individuals with an SMI/SED diagnosis. Journal articles are increasingly attending to these issues; for example, APA’s Division 18 (Psychologists in Public Practice) bestowed its 2016 best paper award on a publication entitled The Connecticut Latino Behavioral Health System: A culturally informed community–academic collaboration (Paris et al., 2016). Similarly, the Division has a multicultural diversity committee which keeps division members abreast of new findings through the Division newsletter and on listerves as well as by hosting open meetings at the annual APA convention. Typically the Division also sponsors 1-2 symposia each year at the APA convention on SMI/SED diversity issues—for example, in 2017, the Division hosted a symposium on women’s issues and SMI. The APA journal, Psychiatric Rehabilitation Journal, which publishes “original contributions related to the rehabilitation, psychosocial treatment, and recovery of people with serious mental illnesses” typically includes 10-15 papers per year focusing on cross-cultural issues in SMI/SED treatment and rehabilitation.

Examination of national trends in SMI/SED prevalence and correlates has been conducted through broad surveys of adult and child mental health indicators, as well as study of specific subgroups. With regard to adults, the National Survey on Drug Use and Health (NSDUH; Center for Behavioral Health Statistics and Quality, 2016) surveys approximately 70,000 adults annually, eliciting data on prevalence and correlates of substance abuse and mental disorders. The survey is supported by SAMHSA, the results are widely available on the Internet, and provide overall SMI rates (operationalized
using both diagnoses and functional impairment), and percentages related to age, gender, ethnicity, race, geographical location, and poverty level. With regard to children, a general overview is provided by the Federal Interagency Forum on Child and Family Statistics Report on America’s Children: Key National Indicators of Well-Being (2015). In the National Health Interview Survey, conducted by the National Center for Health Statistics, parents completed the Strengths and Difficulties Questionnaire regarding their child’s functioning. While the difficulties reported do not meet the Federal SED definition, nevertheless, these data are used by the Federal government for planning.

To reflect the development of knowledge of multicultural diversity and subgroups relevant to SMI/SED populations, some examples of more specific studies of trends and changing demographics follow. With regard to adults, Cantor-Graae, and Selten, (2005) conducted a review and meta-analysis on the relation of migrant status and development of psychosis in the UK, and found that rates of psychosis were elevated even in second-generation immigrant families, and that individuals emigrating from developing countries were at more elevated risk than those from developed ones. Dealberto (2010) reviewed the literature on migrant status and increased risk of schizophrenia throughout the world; the paper emphasized understanding the higher schizophrenia rates reported in persons of color. The investigator concluded that, in countries of both recent and longstanding immigration, schizophrenia was more frequent in immigrants than in native-born populations, and especially so in dark skinned immigrants. This comparative review suggested the presence of “a hidden epidemic of schizophrenia and psychosis in immigrants to North America and an unrecognized epidemic of schizophrenia in Black subjects living in North America” (p 325). Berg et al. (2015) found that, among those diagnosed with first episode psychosis, after controlling for education level, first-generation immigrants were less likely to recognize psychotic symptoms and viewed hospitalization and treatment by a psychiatrist as less beneficial than the non-immigrant group. The investigators concluded that interventions must be tailored to meet the needs of these diverse cultural groups to be effective.

Criminal justice involvement is an increasing concern for the SMI/SED population. Ascher-Svanum, Nyhuis, Faries, Ball, and Kinon (2010) used post-hoc analysis from a prospective one-year cost-effectiveness study of persons treated with antipsychotics for schizophrenia and related disorders in the US. Criminal justice system involvement was assessed using the Schizophrenia Patients Outcome Research Team (PORT) (Lehman & Steinwachs, 1998) client survey and the victimization subscale of the Lehman Quality of Life Interview (QOLI) (Lehman, 1998). Patients with and without justice involvement were compared on baseline characteristics and direct annual health care and criminal justice system-related costs. Overall, 278 (46%) of 609 participants reported at least 1 criminal justice system encounter. They were more likely to be substance users and less adherent to antipsychotics compared to participants without involvement. The two most prevalent types of encounters were being a victim of a crime (67%) and being on parole or probation (26%). The authors concluded that criminal justice system involvement appears to be prevalent and costly for persons treated for schizophrenia in the US. Findings highlight the need to better understand the interface between the mental health and the criminal justice systems and the related costs, in personal, societal, and economic terms.

With regard to children and adolescents, Fazel, Doll, and Langstrom (2008) reviewed the literature to determine the prevalence of children who were diagnosed with a mental health disorder and serving time in a correctional or detention facility. They found that adolescents who were in the facilities were 10 time more likely to suffer from a serious mental health concern (e.g., psychosis, depression, conduct disorder) than those in the general population. This illustrates the diverse range of children who may not be receiving necessary treatment in these settings. Moreno and colleagues assessed the national trends of bipolar diagnoses in children. The researchers found that the number of youth diagnosed with bipolar disorder increased from 25 children in 1994-1955 to 1003 in 2002-2003 per 100,000 people in the population. This increase in diagnosis illustrates a need for clinical research to determine these diagnoses as well as more training in assessment and treatment. Becker, Boustani, Gellaty, and Chorpita (2017) reviewed forty years of studies examining engagement of families in care. They noted that successful interventions demonstrated value and respect for the client’s culture; the therapists used cultural adaptations of EBTs or obtained the client’s view of how their culture influenced
the issues addressed. They also identified engagement strategies that were effective across minority populations (phone reminders, addressing treatment barriers, and motivational interviewing). They further recommended research to study how engagement could be enhanced in communities where mental illness is highly stigmatized or where the mental health system is distrusted. A study was conducted based on data from the Centers for American Indian and Alaska Native Health’s Building a Foundation for Quality of Care Research for American Indian Children and Adolescents research project (Podlogar & Novins, 2015). They interviewed youth patients and families to assess their perspectives on their treatment processes and outcomes, hoping to gain information to improve quality of care. Findings included observation that cultural identity varied among individuals and some of the youth experienced cultural ambiguity. Practitioners were cautioned not to over-rely on “highly abstracted cultural norms” (p. 119), and to be sensitive to variance among families and individuals.

A final, more macro-level issue centers on the ongoing debate in the scientific literature that involves an intersection of culture and diagnosis. Culture influences explanatory models individuals have for experiences such as hearing voices of those who are not present or feeling unsafe in the world. Many have argued that western models of diagnosis pathologize attitudes, beliefs, and behaviors that are acceptable (and often even normative) in other cultures, and that this phenomenon in part accounts for the higher level of diagnosed psychopathology found in the non-predominant cultural groups (Dutta, et al., 2007). There have been attempts to address this problem, including the publication of the Cultural Formulation Interview as part of DSM-5 (Lewis-Fernández, Aggarwal, Hinton, Hinton and Kirmayer, 2016) and expanding efforts to draw a more diverse set of clinicians into the field, but at the present time the concern remains.

4. Describe how the education and training and practice guidelines for the specialty reflect the specialty's recognition of the importance of cultural and individual differences and diversity.

APA has not yet developed formal practice guidelines for schizophrenia or bipolar illness. There are however, other more general guidelines that impact on care for individuals diagnosed with SMI/SED which direct the training of fellows in the diversity area. These would include the **APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations** and the **APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations** as well as the recommendations offered in the APA publication *Psychological Treatment of Ethnic Minority Populations* and on the website **Best Practices for Mental Health Facilities Working With LGBT Clients.** APA’s Board of Educational Affairs established a Virtual Working Group to address concerns about restrictions on diversity training in graduate education. The group issued a statement affirming commitment to transparency in a training program’s commitment to serving a diverse public (BEA Virtual Working Group, 2015).

Several governing bodies provide both training and practice guidelines in working with children diagnosed with SED while recognizing cultural and individual differences. The **Standards of Accreditation for Health Service Psychology** is one means of ensuring that throughout training clinicians are well versed in cultural and diversity training when working with SMI/SED populations. For example, internships, postdoctoral, and practicum opportunities require supportive environments training individuals to work with a variety of diverse individuals. More specific information can be found on the APA website: [http://www.apa.org/ed/accreditation/accreditation-roadmap.aspx](http://www.apa.org/ed/accreditation/accreditation-roadmap.aspx). Furthermore, there are also standards of practice specific to school psychologists through the National Association of School Psychology, which emphasizes the importance of understanding individuals’ differences and diverse characteristics; these can be found on the NASP website [https://www.nasponline.org/standards-and-certification/nasp-practice-model/nasp-practice-model-implementation-guide/section-i-nasp-practice-model-overview/nasp-practice-model-10-domains](https://www.nasponline.org/standards-and-certification/nasp-practice-model/nasp-practice-model-implementation-guide/section-i-nasp-practice-model-overview/nasp-practice-model-10-domains).

Additionally, APA has a set of guidelines designed for practitioners that reflect the importance of working with youth through culturally diverse practices. There are a wide variety of guidelines that can be used when approaching diversity related to children who are diagnosed with SED. One of the guidelines...
provides insight on how to work with transgender and gender nonconforming people; this guideline helps professionals provide care for this population. Another guideline focuses on working with girls and women from all social, ethnic, racial groups, and disability statuses. Further guidelines assist in multicultural education, offer education on psychological evaluations in child protection matters, and provide resources to work with lesbian, gay, and bisexual clients. These guidelines can aid practitioners in providing culturally diverse treatment when working with children diagnosed with SED. The guidelines are noted below and can be found on APA’s website: http://www.apa.org/practice/guidelines/index.aspx

Transgender and gender nonconforming people. Up for review in approximately 2022.
Psychological practice with girls and women. Up for review in approximately 2017.
Psychological practice with lesbian, gay, and bisexual clients. Up for review in approximately 2021.

Perhaps the closest we have to practice guidelines for psychologists are the recommendations from SAMHSA’s Recovery to Practice Curriculum (American Psychological Association & Jansen, 2014). Attention to diversity issues is a core feature of the curriculum, with modules on health disparities due to demographic factors, community inclusion, and issues with forensic populations. Additional attention to diversity issues is interwoven throughout the chapters on assessment and intervention. The curriculum is available from APA: www.apa.org/pi/rtp. In addition, the education and training guidelines developed for this specialty incorporate considerable information provided by the post-doctoral residency programs providing training in this area of specialization and incorporate information found in the responses to questions of this criterion. The specialty education and training guidelines are attached as Appendix I.

References


Fearon, P., Kirkbride, J. B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., ... & Mallett, R. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: Results from the MRC AESOP Study. Psychological Medicine, 36, 1541-1550.


http://dx.doi.org/10.1037/tep0000137


Criterion IV. Distinctiveness

A specialty differs from other recognized specialties in its body of specialized scientific knowledge and professional application.

Commentary: While it is recognized that there will be overlap in the knowledge and skill among various specialties in psychology, the petitioning organizations must describe the specialty in detail to demonstrate that it is distinct from other recognized specialties in the knowledge and skills required or the need or population served, problems addressed and procedures and techniques used.

1. Identify how the following parameters differentiate and where they might overlap with other specialties. Describe how these parameters define professional practice in the specialty.

   a. populations
   b. problems (psychological, biological, and/or social that are specific to this specialty):
   c. procedures and techniques

Introduction

As with all areas of specialization, the SMI/SED specialty has some overlap with other specialties. Those with the most overlap include Clinical, Counseling, and to a lesser extent, Clinical Child and School. Additional specialties that have some overlap include Behavioral & Cognitive, and Family. Clinical Health and Neuropsychology share some population overlap with SMI/SED, in that individuals diagnosed with an SMI/SED often have health or cognitive problems that merit attention, but like other existing specialties, typically Clinical Health psychologists and Neuropsychologists do not limit themselves solely to work with the SMI/SED population, many of the techniques used by Clinical Health or Neuropsychologists are not suitable for use with the SMI/SED population, and the SMI/SED population typically has much broader need than that typically provided by Clinical Health or Neuropsychologists. Specialties that have very limited overlap include Geropsychology and Police and Public Safety. While this specialty petition focuses on the issues, problems and interventions that pertain to persons in the forensic and criminal justice systems, the Forensic specialty does not overlap due to its emphasis on navigating the legal system rather than providing direct clinical services to individuals with SMI/SED who are incarcerated. The remaining specialties (Psychoanalysis, Industrial & Organizational, Sleep and Rehabilitation) do not share similarities with the SMI/SED specialty.

The similarities that do exist across the specialties arise from the fact that doctoral level training is broad and general and provides trainees with some exposure to a variety of populations. At the post-doctoral level however, there is limited overlap because post-doctoral trainees in most other specialty areas receive little or no in-depth exposure to individuals with SMI/SED, to the issues they confront, or to the assessments and interventions that have been developed and found efficacious for them. Although there is variation among post-doctoral programs in every specialty area, some generalizations can be made about Clinical, Counseling, Clinical Child, and School, the ones that have the most overlap with the specialty area of SMI/SED.

At the post-doctoral level, the Health Service Psychology specialties build on the broad exposure all psychologists receive, but most post-doctoral programs in Clinical and Counseling Psychology offer relatively little exposure to persons with SMI/SED, focusing instead on in-depth training for work with persons in the general population who have mood, eating, anxiety, substance use, personality and intellectual disorders using traditional assessment tools and techniques along with interventions such as individual and group psychotherapy. Additionally, in most Clinical Psychology post-doctoral programs, there is little if any exposure to the strengths based
assessments and EBPs and promising practices developed and tested specifically for the SMI/SED population. Counseling Psychology post-doctoral programs may have more exposure to the strength based assessment approaches that are the hallmark of the SMI/SED specialty, but Counseling Psychology does not focus on the population of persons with SMI/SED and its post-doctoral training does not include the EBPs that are specific to this population.

Similarly, the Clinical Child and School specialties also build on the broad exposure gained in a doctoral program but at the post-doctoral level, typically offers trainees relatively modest exposure to youth and young adults with early onset psychosis or the period when severe symptomatology is emerging prior to the onset of full blown psychosis, known as the prodromal period. Clinical Child fellowship programs typically offer trainees exposure to youth with mood disorders, developmental disabilities, eating disorders, neuropsychological disorders, and medical conditions, and similarly to the Clinical and Counseling specialties, provide more in-depth training in traditional assessment tools and techniques along with individual, family, and group psychotherapy, and in parent education. As more individuals with an early onset of psychosis are being given opportunities to remain in school as part of supported education programs, School psychologists have greater responsibility for conducting their educational assessments and developing their learning plans. However, in most schools, work with students with a SED psychosis or affective disorder diagnosis will be a relatively small proportion of the overall client load school psychologists are serving and they do not typically conduct comprehensive symptom assessments.

The SMI/SED specialty is designed to train psychologists to practice from a conceptual model that is distinct from traditional specialties such as Clinical, Counseling, and other post-doctoral specialties. While there are areas of overlap, especially for individuals whose illness is less severe or during periods of symptom remission and following recovery, there are many critical clinical distinctions between people who have SMI or SED and others who seek services from psychologists. Most obvious are the nature and degree of symptomatology, behaviors arising from symptomatology or because of delayed or omitted development, loss or unlearned functioning, social isolation and exclusion, adverse life events such as extreme abuse and trauma, etc.

The in-depth information provided below is offered to highlight the very real differences for the SMI/SED population, the problems they face, and the procedures and techniques developed specifically for those with SMI/SED and proven effective for them. Where there are similarities and/or differences with other specialties, we have noted these.

Please note that some of the information we present here, we also present in Criterion VI.

**Populations: Similarities and Differences with Other Specialties**

Individuals categorized as having an SMI are typically adults who are diagnosed with one of the following disorders: schizophrenia, schizoaffective disorder, bipolar illness, delusional disorders, other psychotic disorders, or depression with a significant impact on functioning. These individuals may have co-morbid, but not primary, substance use, exposure to trauma, or personality disorders. Individuals with SED are typically youth/adolescents who exhibit early warning signs of psychosis/and or symptoms related to the disorders outlined above and this early warning period is often referred to as the prodromal syndrome. More recently the terms “at-risk mental state” (ARMS) and ultra-high risk (UHR) are also used to identify youth at risk of impending psychosis (Tiffin & Welsh, 2013).

Those with SMI/SED are distinct from others with mental health disorders primarily because of the severity of their illnesses, the unique nature of their symptoms (i.e., positive symptoms such as hallucinations and delusions, negative symptoms such as anhedonia and apathy), the resulting pervasive nature of the functional limitations that occur, and the debilitating societal stigma and self-stigma that they experience. The incidence and prevalence of SMI and SED are similar across virtually every demographic that one can think of - SMI and SED strike people in all ethnic and racial groups,
socioeconomic groups, all genders, all religions, countries of origin or in which people live, those with other conditions/disorders/disabilities, and virtually any other variable of interest.

Health Service Psychologists have expertise to bring to the treatment and study of individuals diagnosed with SMI/SED. For many years, when less was known about specific information, attitudes, and skills which could promote recovery in people with SMI/SED, the basic level of knowledge obtained in clinical and counseling psychology training was often sufficient to make a contribution to the treatment of individuals diagnosed with these disorders. However, the proliferation of information and interventions to support recovery form SMI/SED now necessitates specialty training. In additional to demonstrating basic clinical/counseling skills, those treating individuals with SMI/SED must be able to:

1) Develop a therapeutic relationship with an individual who may be paranoid, have a high level of amotivation or apathy, and/or lack insight into why they are receiving treatment;

2) Conduct a careful and thorough assessment, which must range far beyond capturing the presenting problem, symptoms, strengths, and life circumstances to include assessing domains such as: community functioning (Can the individual use transportation? Care for personal hygiene? Economically support him/herself?), medication adherence, impact of the mental illness on physical health, family support and attitudes, need/have access to public resources, are there developmental lags due to illness, and what are the impacts of self-stigma and discrimination;

3) Make an accurate diagnosis when symptoms profiles are often similar across various SMI/SED disorders (e.g., psychosis can be present in schizophrenia, schizoaffective disorder, bipolar illness, and depression with psychotic features; negative symptoms and depression can often appear quite similar); it requires advanced training and expertise to distinguish between them;

4) Provide the specialized evidence-based assessment and intervention practices which have been established to be effective with this population (e.g., social skills training, cognitive-behavioral therapy for psychosis, illness management recovery, behavioral family therapy, etc.);

5) Monitor progress over time using carefully-selected assessment tools that capture the range of symptoms and deficits in functioning often seen in this population but also account for challenges consumers may have with accurate self-report;

6) Collaborate effectively with the larger treatment team, including prescribers, case managers, social workers, residential program supervisors, and perhaps other support individuals, who are typically involved when a person is diagnosed with an SMI/SED; and

7) Advocate for those who are having difficulty navigating complex social services systems (e.g., social security, housing authorities, food programs, criminal justice system) whose resources may be integral to sustaining the consumer and/or assuring his/her well-being.

Although other psychologists often work with children and adolescents with SMI/SED, psychologists with primary experience in SMI/SED bring the distinctive knowledge of the impact of the biological, cognitive, developmental, social, and emotional states of children and adolescents with SMI/SED across home, school, and other social contexts. Psychologists who have experience with children and adolescents with SMI/SED diagnoses differentiate themselves from several other specialties, although there is some overlap. Additionally, Clinical Child and School psychologists share an interest in the complex interaction of mental and physical health. Furthermore, Child Clinical psychologists focus on intervention with children, adolescents, and families. Therefore, there is an overlap of Clinical Child and School psychology with SMI/SED, but the SMI/SED specialty primarily focuses on the underlying concerns of serious mental health and populations that require more service and care, and collaboration with multiple child and family-serving agencies and organizations.
Psychologists must be prepared to engage in clinical activities with adults, children and adolescents with SMI/SED and their families within a variety of settings. These settings include private practice, home-based therapeutic settings, mental health clinics and centers, drop-in centers, schools, homes for aged and disabled, hospitals, community and public health agencies, adult and juvenile justice and service agencies, and advocacy organizations. Most importantly, psychologists working with the SMI/SED population must be able to identify and address the severe symptoms and pervasive functional deficits that reduce the quality and quantity of life of individuals diagnosed with SMI/SED. The complexity of these endeavors is typically not covered in a course of training in clinical or counseling psychology, or in other areas of specialty training.

Problems (Psychological, Biological, and/or Social that are specific to this Specialty)

Please Note: We present additional information and detail about the problems faced by this population in Criteria II and VI.

People diagnosed with SMI/SED face a multitude of problems and challenges that those without these disorders typically face much less frequently or intensely. Many of these problems may be faced by individuals with other mental health conditions either in less severe form, with different and presenting characteristics, or with less comorbidity. However, for people with SMI/SED the problems described below are more severe, often render treatment more difficult, and require specialized interventions. In recognition of this, evidence-based and promising practices have been developed and tested specifically for this population, highlighting the unique nature of the problems faced by people with SMI/SED and the specialized assessments and interventions needed to treat them.

In this section, we briefly outline the problems often experienced by individuals diagnosed with an SMI/SED; we discuss them in in much greater detail in Criteria II and VI.

Psychological Problems

The psychological problems faced by those with SMI/SED can vary but most frequently include severe symptomatology (the hallmark symptoms of hallucinations, delusions, extreme mood swings, disorganized thinking, and disordered or flattened affect) as well as neuropsychological problems, trauma sequelae, severe anxiety, depression, co-morbid substance use, and problems that arise as a result of incarceration or hospitalization in forensic psychiatric facilities.

The hallmark symptoms of SMI/SED constitute the sine qua non of SMI/SED and, because these are so well known by every mental health professional, we do not elaborate upon them here. Other psychological problems associated with SMI/SED but less frequently familiar to professional psychologists include:

• Neurologic/cognitive Deficits and Problems
• Psychological Problems Experienced as a Result of Trauma
• Severe Depression Resulting from Trauma or from Losses Following Onset of SMI/SED
• Co-morbid Substance Use
• Lack of Self-efficacy or Feelings of Agency in the World
• Internalized stigma

Biological Problems

While their etiology is not fully understood, most SMIIs are now understood to have a biological component, typically involving changes in either brain structure or function (Sekar, et al., 2016;
Schizophrenia Working Group of the Psychiatric Genomics Consortium, 2016). Genetics are implicated in these changes (Schizophrenia Working Group of the Psychiatric Genomics Consortium, 2014); however, environment also plays a role, as exposure to childhood adversity (Varesse et al, 2012) and traumatic exposure (Gibson, Alloy, & Ellman, 2016). also increase risk for psychosis.

While increased biological risk resulting from heritability may cause concern for some individuals and family members, it is now clear that increased and premature rates of medical problems, often resulting in early death, reflect significant underlying biological problem in those diagnosed with a SMI/SED. Some estimates place this earlier mortality at 25 years (Schroeder & Morris, 2010), some report it as 15 - 20 years (Thornicroft, 2011), some offer 10 - 15 years as the earlier mortality mark (Lawrence, Hancock, & Kisely, 2013; National Institute of Mental Health, 2012; Offson, Gerhard, Huang, Crystal & Stroup, 2015; Walker, Mcgee, & Druss, 2015), and others provide a large range between 13 – 30 years (De Hert, et al., 2011; Offson, et al., 2015). The World Health Organization presents the range as between 10 and 26 years, and indicates that for people with schizophrenia, the mortality rate is 2 to 2.5 times higher than the general population, while for people with bi-polar disorder, the mortality rate is thirty-five to fifty percent higher than for those in the general population (World Health Organization, undated; Goldstein, et al., 2015). Surprisingly, the mortality gap between those with SMI and the general population may be increasing (Cuijpers & Smit, 2002; Hiroeh, Kapur, Webb, Dunn, Mortensen, & Appleby, 2007; Joukamaa, Heliovaara, Knekt, Aromaa, Raitasalo, & Lehtinen, 2001; Kisely, Smith, Lawrence, Cox, Campbell, & Maaten, 2007; Lawrence, et al., 2007; Lawrence, Mitrou, & Zubrick, 2009).

**SMI/SED physiologic problems include:**

- Premature death by Natural Causes - Respiratory Diseases, Cancers, Diabetes and Cardiovascular Diseases: Primarily Attributable to Smoking and Obesity which may be exacerbated by medication side-effects
- Death/injury through Suicide
- Death/injury through Exposure to Violence

**Social Problems**

Unfortunately, the social problems experienced by people with SMI/SED are endemic. Some result from the core features of the disorders; for example, social withdrawal is a prominent symptom in schizophrenia and depression. However, other social problems ensue from the poor level of community functioning which often accompanies schizophrenia and bipolar illness. Those who cannot finish their education successfully or hold down a job often are doomed to a life in poverty, with limited access to safe housing, food, and basic life necessities. The physical health problems we mentioned above that cause premature disability and death are exacerbated by social issues such as stigma, physician prejudice, and inability to access health care, to name just a few. Substance use, poor executive functioning, and lack of access to basic resources often cause people with SMI/SED to become entangled with the criminal justice and forensic systems, resulting in the double stigmas of mental illness and criminality. Some of the social problems faced by people with SMI/SED include:

- Societal Stigma and Discrimination
  - Stigma and Health Care Issues
  - Stigma, Health Care, and Racial/Cultural Issues
- Criminal Justice and Forensic System Issues
  - Prevalence of SMI/SED in the Criminal Justice/Forensic Systems
  - Homelessness and the Criminal Justice/Forensic Systems
  - Substance Abuse and the Criminal Justice/Forensic Systems
The assessment and intervention knowledge and skills utilized by Clinical and Counseling psychologists, and specialists in Health, Neuropsychology, Behavioral/cognitive, Family, Clinical Child, and School psychology are the foundation for effective work with SMI/SED populations. However, specialized procedures and techniques grounded in these foundational skills are needed to meet the unique and broad ranging needs of this client group, and makes specialty training to meet the needs of the SMI/SED population essential. In addition to basic clinical/counseling skills, those treating individuals with SMI/SED must be able to diagnosis SMI/SED and provide the specific evidence-based practices which have been found to be effective with this population (e.g., social skills training, cognitive-behavioral therapy for psychosis, illness management and recovery, family therapy, etc.). In addition, they must also possess a high level of skill in areas such as:

- Advocacy for persons with SMI/SED
- Shared-decision-making
- Motivational interviewing
- Interfacing with medical professionals and supporting often-complicated pharmacological interventions
- Addressing issues related to prodromes, early onset, and aging with these disorders
- Strengths based assessment
- Differential diagnosis, to distinguish between psychosis consistent with a schizophrenia spectrum disorder, affective disorder, or substance use
- Recognizing cultural factors that may differentially impact on diagnoses, especially around issues of suspiciousness and experience and beliefs around unusual perceptual experiences in minority populations
- Establishing relationships with those with SMI/SED who experience high levels of suspiciousness and paranoia or do not believe they have an illness
- Intervening with self and societal stigma
- Overseeing or providing case management to address basic living needs, health issues, and criminal justice involvement
- Working with peer providers who have lived experience
- Tailoring treatment plans and interventions to overcome high levels of negative symptoms and/or cognitive impairments
- Managing exacerbations, relapses and hospitalizations

The complexity of these activities is typically not covered in a course of training in basic Clinical or Counseling psychology, or specialized training in Neuropsychology, School, Health, Behavioral/cognitive, Family, or Clinical Child psychology. Training in specialized interventions designed, developed and
empirically validated or adapted specifically for those with an SMI/SED diagnosis is needed. The 2009 Schizophrenia Patient Outcomes Research Team (PORT) study remains the most rigorous and undisputed summary of efficacious interventions to date (Kreyenbuhl, Buchanan, Dickerson & Dixon, 2010). The PORT study identified 8 evidence practices (EBPs) and 4 promising practices that are effective in schizophrenia and other SMI diagnoses. These include:

- Assertive community treatment
- Supported employment
- Family psychoeducation
- Cognitive behavioral therapy (CBT) and CBT for psychosis (CBTp)
- Token economy
- Skills training
- Psychosocial interventions for alcohol and substance use disorders
- Psychosocial interventions for weight management
- Medication/illness management
- Cognitive remediation
- Psychological treatments for recent onset schizophrenia
- Medication/illness management
- Cognitive remediation
- Psychological treatments for recent onset schizophrenia
- Peer support and peer-delivered services

With regard to bipolar illness, Vieta, et al., (2009) identified social rhythm therapy and group psychoeducation as evidence-based practices for bipolar illness in their review. In addition to the practices identified above for schizophrenia spectrum and bipolar illness, several other interventions developed or adapted for this population are the subject of continuing research with several considered effective. These include:

- Interventions for trauma
- Interventions for individuals with SMI and SED in the criminal justice system and forensic institutions
- Interventions for those who are homeless or at risk of homelessness
- Interventions to reduce stigma, social isolation, and community exclusion
- Suicide and violence prevention interventions

Training in other specialized topics including the following is also needed by psychologists who will work with this population:

- Effective strategies for engaging individuals with SMI and SED, their families and support systems in treatment
- Working with, and often leading, multidisciplinary teams required to meet the comprehensive set of needs many consumers diagnosed with SMI/SED experience
- Identifying the most appropriate methods for conducting research with and for this population, including engaging consumers diagnosed with SMI/SED in selecting research questions, designing studies, and evaluating results
- Methods for redesigning mental health systems to incorporate a recovery and psychosocial rehabilitation perspective
• Consulting with other professionals who work with this population (e.g., residential housing managers, hospital and emergency room staff, police and other safety officers, etc.)

• Advocacy to meet the needs of people with SMI/SED—both individually as well as at a systemic or governmental level

• Supervising trainees and helping them both learn effective assessment and intervention strategies with this population while also becoming comfortable interacting with persons who may be engaging in frightening or disturbing behavior (e.g., discussing delusional material, responding to internal stimuli, experiencing high levels of negative symptoms such as amotivation or alogia).

2. In addition to the professional practice domains described above, describe the theoretical and scientific knowledge required for the specialty and provide references for each domain as described below. For each of the following core professional practice domains, provide a brief description of the specialized knowledge that is required and provide the most current available published references in each area (e.g., books, chapters, articles in refereed journals, etc.) While reliance on some classic references is acceptable, the majority of references provided should be from last five years and should provide scientific evidence for the theoretical and psychological knowledge required for the specialty.

a. Assessment:

Please Note: Some of the information on assessment below is from Glynn and Mueser (in press), and from American Psychological Association and Jansen (2014). We provide greater detail about some assessments, especially those aimed at culturally relevant aspects of determining strengths, in Criterion VI. We also provide some additional assessment information in Criteria V and VI.

An essential aspect of most health services psychologists’ training is learning how to conduct a psychological assessment. Traditional psychological assessments focus on identifying deficits and problem areas, so they can be categorized and then remediated or guide the development of compensatory strategies. While identification of deficits and limitations is clearly important when working with individuals diagnosed with an SMI/SED, there is greater emphasis on identifying strengths and assets in this population. Understanding a person’s lived experience is also crucial to assisting the person with the recovery process. In order to do this, many psychologists and other mental health practitioners now acknowledge that a more comprehensive and positive assessment approach that looks beyond the individual and his or her symptoms and diagnosis is essential for helping the person think about the future, decide what his or her goals are, what kind of life the person wants to have, and determine the best ways to achieve those goals (Davidson, et al., 2008; Farkas, Sullivan Soydan & Gagne, 2000; Pratt & Mueser, 2002).

The hallmark of a strengths based assessment approach lies in the recognition that every individual has capabilities, accomplishments and potential. Positive factors in the person’s surrounding environment such as his or her natural support network including family strengths, community supports, and social service system network are also considered. Recognition that each person has the potential for future accomplishments that will facilitate continuing to attain the life he or she wishes to achieve is crucial (Davidson, et al., 2008; Farkas, Sullivan Soydan & Gagne, 2000). Determining an individual’s strengths and capabilities is important for children and young people as well. The Outcomes Roundtable for Children and Families (a consortium of researchers, youth, family members, providers, and policymakers) identified important outcomes that all families want for their children, and noted that families seeking services for children with mental health concerns want services that promote the development of competencies, and functional lifetime outcomes. This focus transcends symptom reduction, and goes beyond reduction of deficits (Bellonci, et al., 2012).

SMI/SED assessment serves a number of distinct purposes. First, as the diagnosis of a schizophrenia-spectrum or serious affective disorder has important treatment implications, a careful
assessment is necessary to ensure accurate identification of the disorder. Aside from undetected substance abuse or medical conditions that can lead to common symptoms of schizophrenia or mania, there is also great overlap with the symptoms of schizophrenia, schizoaffective disorder, bipolar disorder and major depression. The primary distinction between schizophrenia and mood disorders is drawn based on the course and co-occurrence of different symptoms (e.g., the presence of psychotic symptoms in people when depression or mania is absent suggests a disorder on the schizophrenia spectrum, while the presence of psychotic symptoms in people where depression or mania is present suggests a disorder on the affective spectrum), which requires obtaining accurate historical information and sound clinical judgment.

Second, assessment serves a critical purpose in identifying treatment needs and informing treatment planning. Although it was once thought that schizophrenia led to irreversible deterioration while bipolar illness (then known as “manic depression”) had a more intermittent, less corrosive course (Kraepelin, 1919/1971), it is now clear that, lacking effective treatment, individuals diagnosed with bipolar illness can also have a poor prognosis (Forte, et al., 2015), and that comprehensive interventions, grounded in a wide-ranging and thorough assessment, can improve outcomes in the SMI/SED disorders (Green, et al., 2013). In addition to the complex of symptoms present in schizophrenia and bipolar illness, and their impact on role functioning, social relationships, and self-care, other comorbidities are often present, including psychiatric, substance abuse, and medical disorders. These must also be assessed, and this can be a complicated endeavor in the context of an SMI/SED. For example, while trauma rates are thought to be prevalent in those experiencing psychosis (Gibson, et al., 2016), assessment of post-traumatic stress disorder (PTSD) in schizophrenia is optimally done using a version of the well-regarded Clinician Administered PTSD Scale (CAPS; Blake, et al., 1995) the probes of which are simplified to increase the validity of responses in individuals with the cognitive challenges that often accompany schizophrenia (CAPS-S; Gearon, Bellack, & Tenhula, 2004). Similarly, depressive and negative symptoms in schizophrenia often seem phenotypically similar, yet they are conceptually and etiologically distinct. Rather than utilizing a standard self-report measure for depression, SMI clinicians must be trained to use specialized instruments (in this case, the Calgary Scale for Depression in Schizophrenia (Addington, Addington, & Maticka-Tyndale, 1993; Addington, Addington, & Maticka-Tyndale, 1994) to assure accuracy of diagnosis of comorbid disorders.

Third, assessment is necessary in order to monitor the effects of treatments. Ongoing evaluation of targeted areas for treatment is critical in order to know whether alternative approaches are necessary, and when treatment goals have been achieved. Numerous different pharmacological and psychological treatments may impact on specific symptoms and areas of functioning, and thus many alternatives exist if treatment targets have not improved sufficiently.

An SMI/SED psychologist certainly may also attend to assessing cognitive/neuropsychological deficits or concerns about health, but this would typically occur within the context of a broader assessment and may involve a less elaborate evaluation of these domains than one conducted by a specialist in one of these other fields. For example, a forensic psychologist might conduct an assessment of the topics articulated above, but do so in the context of determining fitness to stand trial, suitability for release, or capacity to assist in the consumer’s defense – in other words, in the context of navigating the legal system. Assessments conducted by specialists in SMI/SED can be contrasted to those conducted by more general clinical/counselling psychologists and those in the in the Health, Neuropsychology, Behavioral/cognitive, School, Child Clinical or Family specialties fields as indicated below:

**Symptoms necessitate a broad-ranging and skilled assessment**

As we noted above, individuals diagnosed with an SMI/SED diagnosis typically experience a broad array of symptoms as well as deficits in many areas of community functioning. Both objective and subjective quality of life may also be impacted by their mental health challenges. Many also experience self or other stigma which impacts on both their life satisfaction and their capacity to achieve personal goals. Identifying strengths, resources, and life goals is also critical. Thus, a useful and accurate
SMI/SED assessment is typically much broader and more intensive than one conducted by a psychologist in another specialty.

An SMI/SED psychologist must utilize measures which capture both psychotic and non-psychotic symptoms. The most widely used standardized instrument for diagnostic interviewing is the *Structured Clinical Interview for DSM-5* (SCID-5) (First, Williams, Karg, & Spitzer, 2015a, 2015b). The SCID has demonstrated excellent reliability and validity for the diagnosis of schizophrenia and bipolar illness, although considerable training and clinical interviewing experience are required to administer it, and it is time-consuming to conduct, often requiring one to two or more hours to complete. The SCID is very comprehensive, permits a variety of psychiatric diagnoses to be made from the same interview, and is most often used as a research instrument. However, its potential for identifying the core disorder and comorbidities such as substance use or PTSD makes it an especially useful tool in the SMI/SED population.

Ongoing symptom monitoring can be achieved using tools such as the *Expanded Brief Psychiatric Rating* (Lukoff, Nuechterlein, & Ventura, 1986) or the *Positive and Negative Symptom Scale* (Kay, Opler, & Fiszbein, 1987), which assess both psychotic and non-psychotic SMI psychopathology. The assessment of negative symptoms is particularly challenging, and there are new tools to try to help clinicians do a better job in this domain -- the *Clinical Assessment Interview for Negative Symptoms* (CAINS) (Kring, Gur, Blanchard, Horan, & Reise, 2013) and the *Brief Negative Symptoms Scale* (BNSS) (Kirkpatrick, et al., 2011). There continues to be concern about the reliability of bipolar II diagnoses, with any tool (Miller, Johnson, & Eisner, 2009), and careful clinician attention to reports of mood changes and behavior changes is needed to improve accuracy.

The diagnosis of schizophrenia is made with the same criteria applied to children and adolescents as to adults (Kuniyoshi & McClellan, 2014). Structured interviews such as the *Schedule for Affective Disorders and Schizophrenia for School Aged Children* (K-SADS) are used as diagnostic instruments, although the K-SADS is long for clinical use. The *Children’s Interview for Psychiatric Syndromes* (ChiPS) was developed to decrease parent/child and interviewer burden, and was shown to be valid for clinical and research use (Young, Bell & Fristad, 2016). Other tools include the *Diagnostic Interview for Children and Adolescents* (DICA) (Reich, 2000), *Child and Adolescent Psychiatric Assessment* (CAPA) (Angold & Costello, 2000), *Schizophrenia Prediction Instrument Child and Youth version* (SPI-CY) by Schultz-Lutter and Koch (as cited in Tiffin & Welsh (2013) and the *Comprehensive Assessment of At-Risk Mental States* (CAARMS; Yung et al., 2005). In short, advanced training and expertise is required for an adequate assessment of SMI/SED symptoms.

**Necessity of assessing community functioning**

There is no consensus instrument used to assess SMI/SED community functioning, which is typically impaired in individuals with these diagnoses. The breadth of successful community functioning can range so dramatically for the SMI/SED population that tools designed to capture both very low and very high levels of functioning are needed. Several frequently used community functioning assessments, such as the *Social Adjustment Scale* (Weissman & Bothwell, 1976), lack items that sufficiently characterize the lives of adults diagnosed with an SMI. While some of these individuals have very adaptive community functioning (Cohen et al, 2016), many are adjudicated disabled and are unemployed, have limited social networks and few romantic relationships, have little scheduled productive time, and live in supervised housing. Useful assessment tools must be able to capture variability in experiences and situations even at the lowest extremes. Most published measures to tap SMI/SED community functioning are dimensional, with one to several items assessing different domains of functioning (e.g., social support, independent living). The scales vary in their length (from as few as 12 to as many as 70 items with multiple prompts for each one), level of training required for the assessment administrator, relative emphasis on global life domains (e.g., social support) vs. specific instrumental skills (e.g., ability to do laundry or ride the bus), whether original development of the scale was directed more for researchers (e.g., the *Social Adjustment Scale-II*; Schooler, Hogarty, & Weissman, 1979) or
practitioners (e.g., the Client Assessment of Strengths, Interests, and Goals; Wallace, Lecomte, Wilde, & Liberman, 2001), and whether the scales emphasize objective or subjective aspects of functioning. There is no one scale which will meet every need, so specialized training and expertise is required to select an optimal measure in each situation.

Finally, because most SMI/SED develops in adolescence or young adulthood, individuals diagnosed with these disorders miss critical development milestones (e.g., finishing high school or college, living independently, pursuing a career, finding a life partner). Symptom resolution alone or preventing relapse is an insufficient treatment goal. Even decades after the initial development of these symptoms, they may need help identifying personally-valued educational, vocational, or social goals. Typically, these can be elicited in a thorough clinical interview, and serve as the foundation for subsequent treatment, as will be highlighted under the intervention section below.

Less reliance placed on self-report data, compared to interview, observation, and collaborative reports

While psychologists with expertise in other specialties may conduct clinical interviews as core components of their assessments, they typically supplement these with self-report instruments such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Millon Clinical Multi-axial Inventory-iii (MCMI-iii), the Beck Depression Inventory, (BDI), or the Post-Traumatic Check List (PCL), to inform their case conceptualizations and treatment plans. Use of these self-reports is grounded in the assumption that individuals can reliably and validly report their internal experiences and their attitudes. With the SMI/SED population, there is less reliance on self-report instruments because of concerns that psychotic symptoms and cognitive difficulties lead to inaccurate self-report and thus result in unreliable, invalid measurement (Takeuchi, Fervaha, Remington, 2016). Thus, psychologists specially trained to conduct SMI/SED assessments rely more heavily on interview and observational data.

For observable behaviors, SMI/SED psychologists often incorporate obtaining collaborative reports from family members or clinical staff who know the consumer well. For example, the Multnomah Community Ability Scale (MCAS) (Barker, Barron, Bigebow, & McFarlane, 1994; Corbière et al., 2002; Hendryx, Dyck, McBride, & Whitbeck, 2001) is an informant-based scale designed to be completed by a staff member who is familiar with the adult client’s functioning in the community. Psychologists who work with children and adolescents with SMI/SED use parent and child interviews, data from school and medical records, observations, formal, age-normed psychological tests, behavior rating scales, and personality and neuropsychological assessments to evaluate concerns as well as developmental history across multiple contexts. Some specific examples include the Children’s Interview for Psychiatric Syndromes (Child Version ChIPS and Parent Version P-ChIPS; Rooney, Fristad, Weller & Weller, 1999), Diagnostic Interview for Children and Adolescents (DICA; Reich, 2000), and Child and Adolescent Psychiatric Assessment (CAPA; Angold & Costello, 2000).

All psychologists are, of course, interested in their client’s subjective appraisals of their circumstances. However, among psychologists working with SMI/SED individuals there is heightened interest in measuring the person’s own attitude toward his/her illness and his/her symptoms. In many ways, this focus reflects the growing influence of the recovery movement in mental health, and the premise that providing person centered care requires fully understanding the consumer’s viewpoint. With regard to assessment, this recovery focus highlights two essential domains of measurement: 1) the presence of recovery attitudes and 2) self-reported distress experienced from symptoms that others might assume (rightly or wrongly) are very disturbing.

Assessing recovery attitudes is a relatively new area of investigation, but there are now several tools to identify factors related to recovery in schizophrenia (Cavelti, Kvrgic, Beck, Kossowsky, & Vauth, 2012). Generally, these tools can be classified into one of two categories, i.e., ones assessing positive aspects of the recovery process, and ones assessing negative self-assessments related to a diagnosis of a significant mental illness. With regard to assessing a recovery orientation, one of the widely used
measures is the *Mental Health Recovery Measure* (MHRM) (Young & Bullock, 2005). The MHRM is a behaviorally-anchored self-report measure designed for use with persons who have serious and persistent mental illnesses such as recurrent major depression, bipolar disorder, or schizophrenia. Another widely used measure of recovery is the *Recovery Assessment Scale* (RAS) (Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995; Ralph, Kidder, & Phillips, 2000). An individual diagnosed with an SMI/SED is at risk for developing negative self-assessments related to a diagnosis. There has been much recent interest in creating measures to assess these negative self-appraisals, which have been labeled self-stigma or internalized stigma. Self-stigma is a particular concern, as it has been linked to poorer psychosocial treatment adherence (Fung, Tsang, & Corrigan, 2008), and higher rates of depression (Ritsher, Otilingam, & Grajales, 2003) in individuals diagnosed with schizophrenia. Several scales are available to assess self-stigma, including the *Self-Stigma of Mental Illness Scale* (SSMI) (Corrigan, Watson, & Barr, 2006), the *Internalized Stigma of Mental Illness Scale* (ISMI) (Ritsher et al., 2003), and the *Stigma Scale* (SS) (King et al., 2007).

In addition to judgments about the impact of a psychiatric illness on one’s sense of self (either positive or negative), a more person-centered approach to assessment has also highlighted the importance of understanding the client’s level of distress ensuing from symptoms. Those with lived experience of the symptoms of schizophrenia or bipolar illness do not necessarily find them distressing (Baumeister, Sedgwick, Howes, & Peters, 2017). For example, some individuals experience internal voices that they consider to be benign or even helpful, and may reject the idea that these experiences reflect the presence of a disorder or necessitate treatment. Thus, it is essential for clinicians to distinguish between the presence of a symptom and the distress the experience causes the client. The *Psychotic Symptom Rating Scale* (PSYRATS) (Haddock, McCarron, Tarrier, & Faragher, 1999) is a semi-structured 17 item interview which assesses multiple subjective dimensions of hallucinations and delusions. In contrast to other psychotic symptom measures, details are elicited by the respondent on several unique subjective aspects of delusions and hallucinations (e.g., perceived intensity, controllability, preoccupation, distress) on a 0–4 scale, with higher scores indicating more difficulty. It has been found to have excellent psychometric properties.

**Increased emphasis on including assessment of family attitudes and burden in a comprehensive evaluation**

Specialist Family psychologists are trained to work with families but most often do not have the expertise needed to help families with a member who has SMI/SED. Further, most non-family psychologists who work with adult clients will not meet their client’s relatives unless they are conducting conjoint therapy. However, assessing key relatives is a critical aspect of SMI/SED assessments. Work conducted in England in the 1950s-1970s (Brown, Birley, & Wing, 1972; Brown, Monck, Carstairs, & Wing, 1962) demonstrated that family attitudes reflective of high levels of distress measured at the time of a loved one’s psychotic relapse tended to predict greater rates of subsequent relapse, especially if the relative and client had more than 35 hours of contact per week. This high level of family distress has been labeled “high expressed emotion” (EE), and the relationship between high EE and subsequent relapse is among the most potent predictors of outcome in depression, schizophrenia and bipolar illness (Butzlaff & Hooley, 1998). EE is reflected in critical comments or tone or reported extreme self-sacrificing behavior during a semi-structured interview (the *Camberwell Family Interview*) at the time of the initial relapse (Leff & Vaughn, 1985), and is likely evidenced in actual interactions with the client (Mueser et al., 1993; Strachan, Leff, Goldstein, Doane, & Burtt, 1986).

The measurement of EE requires an extensive research assessment and scoring procedure, which is outside the time capacities of most clinicians. However, SMI/SED clinicians can develop clinical acumen in recognizing signs of extreme distress, criticism, and self-sacrificing behavior on the part of the relative during interactions with the clinician, provided they have these interactions. High EE might be reflected, for example, in frequent calls to the clinic for assistance, repeated complaints about the client, or tearfulness in a relative. Hooley and Parker (2006) suggested that one feasible method for assessing EE is to ask clients how critical their relative is of them. An alternative measure to ratings of perceived
criticism is the *Patient Rejection Scale* (PRS) (Kreisman et al., 1988; Kreisman, Simmens, & Joy, 1979). This 24-item scale consists of both positively and negatively worded items reflecting feelings of love and acceptance, criticism, disappointment, and rejection; it can be considered an analogue of the critical comments and hostility factors composing the concept of EE.

The impact of caregiving on the families of individuals with serious psychiatric illnesses is also of concern. There is no consensus measure of family burden, and many of the measures used with families of individuals diagnosed with schizophrenia and bipolar illness were developed for use in other disorders (e.g., the Zarit Burden Scale) (Zarit, Reever, & Bach-Peterson, 1980) or are interview-based and quite intensive to administer, such as the *Family Experiences Interview Schedule* (FEIS) (Tessler & Gamache, 1996). One measure which appears to have good potential to capture burden in the families of those with SMI/SED is the *Burden Assessment Scale* (BAS) (Reinhard, Gubman, Horwitz, & Minsky, 1994), which may have particular value as it does not require interviewer training and is designed to focus on the experience of burden, and is not confounded with issues of coping or skill in illness management.

b. Intervention

Please Note: Some of the information on interventions below is from the APA Curriculum (American Psychological Association & Jansen, 2014). We provide some additional information in Criterion V and greater detail about some interventions in Criterion VI.

To be successful as an SMI/SED psychologist, both the appropriate intervention skills and the right attitudes are required. To be effective in this field, psychologists must believe that individuals diagnosed with SMI/SED can live rich, full lives (whether they experience symptoms or not) and have the professional competencies to help these individuals build these lives. Unfortunately, most specialty training (other than SMI/SED specialty training) does not nurture the attitudes or the expertise to work with the SMI/SED population (Mueser, Silverstein, & Farkas, 2013). Further those with specialty training in related areas of relevance to this population — Clinical, Counseling, School, Health, Behavioral/cognitive, Neuropsychology, Clinical Child and Family psychologists — typically have a delimited set of skills that may benefit a person with SMI/SED, but are inadequate to address the breadth of the issues impeding their recoveries. Specialist training focused on helping trainees remediate this lack of expertise is essential; a more general training program or a highly specialized program in another area does not typically provide the attention or time to develop these perquisites to proving optimal care to this population.

**Developing recovery-oriented attitudes**

Studies over the past several decades have shown that many adults with serious mental illnesses can and do improve when they are provided with supports and services that assist them to gain the skills needed to live a satisfying and productive life (Green, et al., 2013). In fact, despite long held beliefs that SMIs are chronic deteriorating illnesses, several meta analyses and summaries of published studies have appeared and all continue to document that many individuals diagnosed with SMIs can, and do recover from the effects of their illness (Warner, 2010), and indeed that many have the potential to achieve long-term remission and functional recovery (Zipursky, Reilly & Murray, 2012).

Psychological treatment can be a key intervention to produce better outcomes in SMI/SED. Provision of services within the context of an empathic, genuine, trusting relationship where the person with SMI is involved in a partnership involving developing an agreement on and design of the components of services he or she will receive, is generally considered to be important for the success of recovery oriented interventions (Anthony, Rogers & Farkas, 2003; Mueser, 2012).

Effective SMI/SED psychological services are guided by the following principles (American Psychological Association & Jansen, 2014):
• Recognition that recovery and return to a satisfying and productive life are possible;
• Provision of interventions that are grounded in research and achieve results;
• Acceptance that, to the greatest extent possible, those with SMI/SED and their families are full partners with the service delivery system and determine the services they will receive.

Several additional principles have been identified as important for provision of effective recovery-oriented services. These were originally specified by participants in the National Consensus Conference on Mental Health Recovery and Transformation (U.S. Department of Health and Human Services, 2006) and recently updated to reflect the importance of culture, trauma, and inclusion in family and social networks. These are:

• Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.
• Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals.
• Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds – including trauma experiences – that affect and determine their pathway(s) to recovery.
• Recovery pathways are highly personalized: They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches.
• Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks.
• Recovery is holistic: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community.
• Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.
• Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.
• Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations - including values, traditions, and beliefs - are keys in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual’s unique needs.
• Recovery is supported by addressing trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues.
• Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.
• Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

The evidence supporting the importance of these principles for recovery is quite consistent and
comes from first person accounts of people who have received services. Whenever they are asked about the elements of service provision that made a difference to them, the principles outlined above are often referenced (Deegan, 1988; Jacobson, 2001; Mead & Copeland, 2000; Ridgway, 2001; Wisdom, Bruce, Saedi, Weis, & Green, 2008). To be effective, recovery oriented psychological interventions must be designed with these as the basis for service provision.

**Developing expertise in essential intervention skills**

*The utility of manualized evidence-based and promising practices*

Clinical, Counselling (and most other specialty) psychologists typically focus their intervention work on eliminating symptoms. Often, these problems are relatively circumscribed. Clinicians may, for example, utilize systematic desensitization or prolonged exposure to address anxiety, or help correct erroneous thinking patterns to address depression, or teach distress tolerance to manage emotional upheavals. The scope of the therapeutic challenge in SMI/SED is often much larger, and typically requires a broader, more comprehensive intervention framework. The knowledge base about the range of interventions shown to be effective in SMI/SED has developed considerably over the past twenty-five to thirty years. Evidence-based interventions such as social skills training, illness management and recovery, cognitive remediation, behavioral family therapy, social rhythm therapy, and cognitive behavioral therapy for psychosis can all be helpful, depending on the consumer’s circumstances and presenting problems. Foundationally, trainees must be provided with instruction and supervised experience in the relevant evidence-based interventions for this consumer group; most are listed under item 1c above.

Because most SMI/SED develops in adolescence or young adulthood, individuals diagnosed with these disorders typically not only experience troublesome symptoms, but also miss critical development milestones (e.g. finishing high school or college, living independently, pursuing a career, finding a life partner). Strategies and interventions to identify and address these challenges must also be a core component of specialty training. Even after an acute symptom episode has resolved, the consumer is often left with persisting symptoms and a history of not achieving valued life goals in a timely fashion. This situation is often complicated by the presence of comorbid disorders, such as substance abuse, as well as limited economic and social resources. Thus, an effective SMI/SED psychologist needs training in a broad array of specific interventions, as well education in working with other formal or informal team members (e.g., prescribers, case managers, relatives, etc.), and instruction in intervening in a broader life context. Just resolving symptoms is typically not sufficient to help an individual diagnosed with SMI/SED achieve a satisfying life. Beyond addressing symptoms, attention to helping individuals with these disorders develop life skills and work towards valued personal goals is often required.

All psychologists, and indeed, practitioners in every health and mental health field, value evidence-based treatments. With specific reference to children, the Society of Clinical Child & Adolescent Psychology created a website to summarize evidence-based treatments for a broad range of child and adolescent mental health diagnoses. While many of these therapies are used for children and youth with SED, and therapies for children/youth with bipolar disorder are presented (effectivechildtherapy.org), the site does not include interventions for children/youth with psychotic-like symptoms or schizophrenia, further strengthening the need for specialty training.

Virtually all mental health practitioners, including psychologists, want to do the best they can to assist the people they work with achieve the best outcomes possible. However, far too few mental health practitioners have been trained to provide services from a recovery oriented perspective and consequently; most do not know how to translate the guiding principles of recovery into practice. Further, too few mental health service delivery systems provide integrated and coordinated services; these are needed to avoid omission of needed services, duplication of service provision, and confusion for service recipients. Importantly, research evidence has been accumulating that an integrated approach that combines multiple interventions within a recovery oriented context may be the most effective approach.
(Lyman, et al., 2014; Spaulding & Deogun, 2011) and scholars are increasingly calling for such an integrated, recovery oriented system (Davidson & Chan, 2014). Such an approach must be targeted to the unique needs of each individual including those in forensic and criminal justice systems (Epperson, et al., 2011; Strauss, 2014).

A useful intervention paradigm to integrate services

An overall framework for serving individuals with serious mental illness is critical to organizing services (Anthony, Cohen, Farkas & Gagne, 2002; Anthony, Howell & Danley, 1984; Farkas & Anthony, 1989). The model presented below is an approach to working with people with serious mental illness and is titled the Choose, Get, Keep method. The authors offered this conceptualization:

Psychiatric rehabilitation interventions are currently a mixture of evidence-based practices, promising practices and emerging methods that can be effectively tied together using the psychiatric rehabilitation process framework of helping individuals with serious mental illnesses choose, get and keep valued roles, and together with complementary treatment orientated psychosocial interventions, provide a broad strategy for facilitating recovery.

A review of recovery oriented psychological interventions must therefore take into account the aim of psychiatric rehabilitation (i.e., improving role performance in a chosen environment) within the overall mission of enhancing recovery (Farkas & Anthony, 2010.)

A process framework for psychiatric rehabilitation has been proposed, with activities both for the person receiving services and the provider.

Person level processes

• Choosing a valued role
• Getting a valued role
• Keeping a valued role

Provider Processes

• Engaging
• Linking with existing worker/worker/student/residential/social role opportunities
• Assessing critical skill and/or support strengths and deficits
• Assessing and developing readiness
• Creating worker/worker/student/residential/social role opportunities
• Person-centered planning
• Setting an overall goal
• Developing skills to succeed in the preferred role
• Developing supports to succeed in the preferred role (Farkas & Anthony, 2010)

The process is designed to help people decide on the goals they wish to achieve, help them identify what skills they have and what skills they need to learn, and identify the resources or supports they already have and those they need to develop in order to achieve their goals. The next steps are to help them develop the skills and resources they need (Anthony & Farkas, 2009). This process is one that has been incorporated into many aspects of service delivery. For example, people receiving medical and mental health pharmacotherapy often are taught medication use; individuals who receive case
management services are given support to access the services they need and people who receive supported employment learn skills to succeed vocationally.

The model is built on the premise that recovery and rehabilitation efforts have two foci: facilitating success and satisfaction in the performance of personally preferred and valued roles, and creating or promoting an increase in opportunities for participation in society. This is accomplished by assisting individuals to achieve their full functional capacity. For some individuals with SMI/SED, this means reduced inpatient stays, while for others it may mean a return to educational training, employment or a more satisfying personal life. Helping people with SMI/SED achieve their goals is accomplished by ensuring that the person has the skills and supports necessary for success and satisfaction and is a basic principle of recovery-oriented psychological intervention (Anthony, et al., 2002; Farkas, Jansen, & Penk, 2007).

**The importance of person involvement in planning and evaluating services/shared decision making**

While person-centered involvement and shared decision making are not interventions, they deserve special mention because they are seen as an integral component of the method for delivering recovery oriented psychological services. A central premise of recovery oriented practice is that the individual is a full partner in making decisions related to which interventions are desired and deemed to be most useful (Deegan & Drake, 2006). Interventions for people with SMI/SED are provided within a person-centered approach with full involvement of the individual receiving services. Professionals may resist full involvement of people with SMI in the decision-making process, but research has shown that most individuals prefer shared decision making (Adams, et al., 2007); without such involvement services cannot be considered to be recovery oriented.

Research on involvement in general health care has shown that consumers who believe they have been actively involved in decisions about the services they received generally have better outcomes (Greenfield, Kaplan, Ware, Yano, & Frank, 1988; Stewart & Brown, 2001). Conversely, those who felt they had little input or control over their services were less likely to be involved with their services, rated their health as poorer, and evidenced greater illness burden (Seeman & Seeman, 1983). Similarly, active participation by consumers of mental health services has also been shown to have several benefits, including increased satisfaction with services and decreased symptom burden (Adams & Drake, 2006; Swanson, Bastani, Rubensetin, Meredith, & Ford, 2007). Research data have also suggested that rehabilitation outcomes are better for people who are partners in the planning and delivery of services (Majumder, Walls & Fulmer, 1998). Additional benefits have been identified including the person’s increased level of knowledge about their condition, increased self-efficacy, greater planning for coping with difficult situations, and increased knowledge of alternatives (Patel, Bakken & Ruland, 2008). Consumer involvement in designing and delivering mental health services (e.g., program planning, implementation, and evaluation) is increasingly seen as a critical component of a quality management system for any mental health service (Blackwell, Eilers & Robinson, 2000). Because there may be times when people with SMI cannot make sound decisions due to symptom flare ups, preparation of an advance directive that provides guidance about the person’s preferences in different situations has been recommended (Deegan & Drake, 2006). Most authors also note that research on the complexities and benefits of shared decision making is relatively recent and additional research is recommended (Adams & Drake, 2006; Patel, et al., 2008).

**The value of gender-specific services**

Most mental health services, like general health care services, were designed with men from the majority culture in mind. While many assume that a “one size fits all” approach is acceptable, gender and cultural considerations are essential if the service system is to be helpful to those who need services. Women are a sizeable proportion of those with SMI/SED and are the most vulnerable adults served within the mental health system. The service needs of women clients can be very different than those of
While many assessments and treatments are understood to be useful for both men and women diagnosed with an SMI, it is also clear that each gender has particular challenges dealing with mental health issues. Men are more likely to become homeless, for example, (Usall et al, 2001) while women report higher levels of child abuse and trauma (Forchuk, Jensen, & Csiernik, 2009). Women who do become homeless are poorer, often have additional stressors due to child care responsibilities, and are more vulnerable to physical or sexual assault (Harris & Bachrach, 1990). Women are more often poorer and more vulnerable and are more likely to be unable to control sexual situations potentially exposing them to HIV/AIDS and other sexually transmitted diseases (Darves-Bornoz, Lemperiere, Degiovanni & Gaillard, 1995). Thus, the service needs of male and female clients may be very different (Bently, 2005). Furthermore, the appropriate treatment settings for the two genders often differ. Women who have been abused by men will likely be unable to work through those issues initially in mixed gender groups, and may even reject male therapists. While later treatment in a mixed gender group may be a component of healing, premature entry into a mixed gender group may actually exacerbate female clients’ trauma. A range of services, including single gender and, later, mixed gender groups, is essential for women who have been abused, both to help them recover and to avoid exacerbating their trauma.

A more recent area of interest is understanding the association between SMI/SED and non-binary or transgendered status. There has been some suggestion that there may be a higher rate of psychosis in individuals with a gender identity disorder (see, for example, Rajkumar, 2014), and case descriptions of treatment programs for individuals diagnosed with schizophrenia and a gender identity disorder (Baltieri, & De Andrade, 2009.) or gender dysphoria (Meijer, Eeckhout, van Vlerken, & de Vries, 2017) have been published. However, the preliminary nature of the research in this area does not yet support recommendations on the need for specific services for this population.

The importance of culturally sensitive services

As we noted in our discussion of cultural issues in Criterion III, race and ethnicity, and cultural/immigrant status can play a dramatic role in the genesis of a psychiatric disorder as well as in influencing appropriate treatment. While much of our data in SMI/SED prevalence comes from epidemiological studies of western cultures, mental health problems among non-white, minority cultural groups can be great, and the actual prevalence may be higher than reported due to a reluctance to access services or to report problems. For example, suicide rates among people from Aboriginal backgrounds are three times higher than among the general population, yet the problems often go unreported or untreated (Kirmayer, et al., 1993). Similarly, an increased risk of schizophrenia among first and second-generation immigrants, especially those from developing countries, has been noted (Kuniyoshi & McClellan, 2014). Cultural discontinuity and oppression have also been linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the most dramatic impact on youth (Kirmayer, Macdonald & Brass, 2000).

In light of the psychosis risk factors associated with minority and immigrant status, it is not surprising that investigators are now attempting to understand service utilization by these groups, and the problems identified thus far are concerning. Lack of culturally and linguistically appropriate services has been reported as a reason for the failure to access services by non-majority groups (Elliott, 2003). Additionally, many culturally distinct groups are not used to speaking frankly about problems and may speak in metaphors or use less descriptive words to describe their life situation or problem (Vasiliadis, et al., 2005), which often complicates treatment by professionals who may not understand the subtleties of these communications. Minority problems and issues are often not recognized by traditional service providers; this speaks to the importance of outreach to ensure access so that appropriate services are available for all who need them, and to the importance of specialized training for service providers, including psychologists. Nevertheless, it is important to note that culturally informed treatment can be very effective, and models such as those proposed by Paris et al. (2016) for U.S. Latinos are noteworthy for their innovation and success.
c. Consultation

The format of consultation conducted by most health service psychologists and that conducted by SMI/SED psychologists is similar; typically, it is the content and with whom they confer that distinguishes SMI/SED specialists. Similar to other psychological specialists, SMI/SED psychologists have many opportunities to consult with others, most particularly with other mental health professionals treating those with whom they work, as well as with the relatives of the persons whom they are treating. SMI/SED psychologists often must also confer with members of the legal and criminal justice system, as well as those who help individuals access resources such as social security disability payments, housing vouchers, appropriate health services, etc. With the growing emphasis on integrating behavioral and physical health services, SMI/SED psychologists have an increasing opportunity to consult with internists and general medical practitioners who are managing the medical care of individuals diagnosed with SMI/SED. Psychologists with specialized training and experience in SMI/SED are more likely than other psychological specialists to consult with social service agencies and the families of the persons they are working with, as these consumers are often dependent on these resources. If the persons with whom they work are living in a restrictive setting (e.g., locked hospital ward or residential facility), SMI/SED specialists may be asked to consult on the development of behavioral intervention plans to be implemented by paraprofessional staff. Psychologists working with children and adolescents diagnosed with SED consult with a wide variety of professionals including pediatricians, child psychiatrists, child protection workers, teachers, nurses, social workers, school and community counselors, lawyers, and others concerned about the child or adolescent.

To be effective consultants on SMI/SED issues, psychologists must have the theoretical and scientific knowledge to provide relevant disorder-specific information on symptoms, diagnosis, prognosis, etc. tailored to the need and sophistication level of those to whom they consult. They must also possess the assessment and intervention knowledge described immediately above, as well as expertise in the professional practices mentioned under point 3 below. In addition, SMI/SED psychologists must have knowledge of the roles of other professionals with whom they interact (e.g., medication prescribers, case managers, legal and medical personnel, vocational counsellors, etc.) to facilitate relationship building and appropriate professional boundaries. The SMI/SED psychologist must be comfortable and capable of working in the unique environments in which consultation is conducted, (e.g., hospitals, medical clinics, mental health centers, courts and juvenile justice agencies, public welfare agencies, etc.). They must be knowledgeable about basic forms of consultation and models which may be acquired from formal study, from modeling experienced consultants, and from supervised experience.

d. Supervision

Psychologists who work with individuals diagnosed with an SMI/SED and their families include trainees (interns, post-doctoral residents and scholars, practicum students, psychiatric residents and psychology fellows), other psychologists, other members of interdisciplinary health teams, and peer support specialists. Like all trainees, post-doctoral residents need training and supervision to acquire the basic skills of psychological therapeutic work — tasks such as active listening, validation, making an accurate diagnosis, developing and implementing a treatment plan, assessing for suicide and homicidal ideation or plans, etc. Providing training in the basics of manualized evidence-based interventions and assisting the trainee in developing a professional role and identity are also important supervision tasks.

In addition to fostering the acquisition of basic clinical skills which would be found in all psychological practitioners, competent supervision in the SMI/SED specialty requires additional knowledge and competencies. For example, those who are supervised often need assistance in implementing interventions outside of office or agency settings. Severity of some client/patient behaviors may require that the supervisor address such issues as how to interact therapeutically with those engaging in bizarre speech or experiencing delusions or hallucinations so that the care provider is neither invalidating nor colluding with the person. The supervisor may also need to assist supervisees with strategies for managing clients/patients engaging in disturbing behavior in public, engaging in aggressive
behavior, becoming paranoid or suspicious of the clinician, or engaging in risky behavior. Finally, the SMI/SED specialist supervisor also is typically charged with assisting trainees in learning to collaborate with peers with lived experience, who have an increasing role in providing services to those diagnosed with an SMI/SED (Chinman et al., 2017).

Training programs have been urged to devote more attention to the effect of cultural factors on the therapeutic process, and to assist trainees to manage complex cultural dynamics (Goode-Cross, 2011). While cultural competence is essential in therapeutic interventions with all types of clients/patients, this may be of particular importance in distinguishing unusual behaviors from culturally divergent ones, and may have profound impact on understanding and assisting diverse clients with SMI/SED as they develop therapeutic alliances, and as they face stereotypes, oppression, and bias in the community. An additional challenge faced by supervisees may be the need for supervisor support and assistance as they engage in patient advocacy and social justice interventions. Supervisors may need to assist trainees to gain skills in combining the practitioner role with community engagement, and learning strategies to promote organizational change (Toporek & Vaughn, 2010). The supervisee may also need assistance in addressing particular challenges to engaging patients/clients with SMI/SED and prevent attrition from care. Monitoring the capacity of the supervisee to maintain a recovery-oriented perspective and instilling hope for recovery are important aspects of a supervisor’s stance and assumptions (British Psychological Society’s Center for Outcomes Research and Effectiveness (CORE), 2016). Emphasizing a strengths-based approach and building on competencies are also essential attitudes and skills, with which supervisees often need assistance to implement in a meaningful way (McCammon, 2012).

There is an increasing recognition of the importance of, and the challenges inherent in, providing clinical supervision to those conducting psychotherapy with individuals diagnosed with serious psychiatric illnesses. For example, Yerushalmi and Lysaker (2014) have written eloquently about inculcating a recovery orientation in trainees, and outline a parallel learning process between therapist and client/patient and supervisor and supervisee. They suggest girding SMI/SED supervision in three principles (1) clients or supervisees, with their own decisions and interests, are at the center of the rehabilitation therapy and supervision; (2) mutuality in the rehabilitative/supervisory relationship and ongoing discussion of the interactants’ power and authority; and (3) the promotion of positive and empowering narratives and self-perceptions in the process of rehabilitation/supervision. In an even more complex paper, Hamm and colleagues (2016) write of the supervisory importance of fostering trainees’ capacity to maintain an open stance with individuals experiencing psychosis. Key goals of the supervision include helping trainees avoid hierarchical power relationships in the therapy and conceive of psychosis as something that can be understood and from which something can be learned. They identify four potential therapeutic roles that an SMI/SED therapist might adopt which will interfere with the psychotherapeutic relationship when working with individuals diagnosed with a SMI/SED. They note these roles—therapist as arbiter of reality, a spokesperson for the consumer, the ambassador of health, and the minister of comfort — should be addressed in supervision should they occur. While other professionals may disagree with these prohibitions, this discussion highlights the complexity of conducting supervision with SMI/SED psychological trainees; trainees may need specific encouragement and guidance to experience empathy and true understanding of the individuals with whom they work.

There has been little research on supervision practice in community-based children’s mental health settings. Accurso, Taylor, & Garland (2011) surveyed supervisors and supervisees and found that although children with disruptive behavior problems are the youth most often referred to public mental health services, supervision sessions do not often focus, or only briefly address practice elements of evidence-based treatments for disruptive behavior problems. Working with children and youth with SED and their families requires learning to navigate professional systems, participate in multi-professional teams, and manage professional boundaries. Supervisors must assist learners in working collaboratively with clients and other team members (British Psychological Society’s Center for Outcomes Research and Effectiveness (CORE), 2016).
e. Research & Inquiry

Becoming proficient in consuming and conducting research is an important element of most psychologists’ training, and those with a specialty in SMI/SED are no different. With the improvements being made in both psychological and pharmacological treatments as well as our greater understanding of neuroscience and the brain, advances continue to be made to enhance prognosis for these disorders. Whether or not he or she actually conducts research, an SMI/SED psychologist must be able to understand how to evaluate the design of published research and to assess the validity of how reported data are interpreted. Those conducting research in this area must be knowledgeable about research issues, including procedures for studying high risk and diagnosed populations, using longitudinal designs, conducting randomized clinical trials, selecting measures which are sensitive enough to detect change even at the extremes in domains such as community functioning, minimizing research attrition, managing comorbidities, determining how to handle pharmacology in a psychosocial clinical trial, etc. SMI/SED researchers investigate the onset, course, and outcome of behavioral, emotional, social, and cognitive difficulties in children, adolescents, and adults with SMI/SED diagnoses. They also research family etiology factors and psychopathology, and assist in the development, standardization, and validation of assessment measures. They study risk and protective factors of development and maintenance of disorders, as well as effective treatment. Those conducting research on the SED population must also understand developmental psychology, and all SMI/SED researchers must also have a thorough understanding of research ethics.

Besides investigating a unique content area, there are two issues which have even more salience when conducting research with the SMI/SED population than with most other patient groups. The first of these involves assuring one has obtained informed consent (or assent if working with children) for research participation. Adults diagnosed with SMI often have cognitive difficulties which might preclude them thoroughly comprehending the procedures and intent of a research project for which they are eligible. It is essential that SMI/SED researchers take extra precautions to assure studies are adequately explained to potential participants and that these participants are queried about what they understand about the study prior to joining it in order to assure they are giving free and informed consent as they enter (Appelbaum, 2006). Fortunately, Fischer, et al., (2013) published a recent paper demonstrating that if careful recruitment and consent procedures are followed, individuals diagnosed with schizophrenia can understand and retain the information about a study through one-year follow-up.

The second issue involves including individuals with lived experience, that is, with a diagnosis of SMI/SED, as part of the team designing and conducting the research trial. This effort reflects the greater community-based participatory research initiative. Over approximately the last 10 years, there has been growing advocacy, especially within the SMI/SED consumer movement, to include service users on research teams. Standard operating procedures are being crafted (Evans et al, 2013), and a Lived Experience Research Network was established (https://livedexperienceresearchnetwork.wordpress.com). However, for many researchers in the area, this has not been an easy transition, and more support is needed to assist SMI/SED researchers in including service users in their work (Staley, Kabir, & Szmukler, 2013).

f. Public Interest

Similar to all licensed psychologists, psychologists with a specialty in SMI/SED follow the ethical principles set forth by APA as well as the state regulations required by their licensure. As any reading of The APA Monitor or materials from the APA practice organization will attest, psychologists also have a long and rich history of advocacy to protect the public welfare. Most recently, for example, psychologists assumed a leadership role in fighting the repeal of the Affordable Care Act and for passage of the 21st Century Cures Act.

While the form of advocacy typically does not differ between SMI/SED and non-SMI/SED psychologists, the specific issues of concern are often distinct. Psychologists who work with those with
SMI/SED are especially sensitive to issues of social injustice, discrimination, and health care disparities because they work with consumers who often have limited financial resources, may be dependent on the greater society for their upkeep, livelihood, and medical care, and who are frequently stigmatized by society. While these psychologists often must advocate for the specific needs of those whom they treat, many SMI/SED psychologists have also assumed a role in wider advocacy work. For example, the Division 18 Psychologists in Public Service SMI/SED section raised concerns within APA about provisions in early versions of the 21st Century Care Act that might have led to coercive treatment of clients; these concerns were addressed in the final version of the bill. APA also has a component of the governance structure, the SMI/SED Task Force, which works closely with its parent group (the Board of Professional Affairs) around advocacy activities, especially regarding federal legislation.

SMI/SED psychologists have also formed productive partnerships with other community stakeholders, including the National Alliance on Mental Illness (NAMI), the Mental Health Association, and consumers groups, to develop public health and educational campaigns. Psychologists concerned about the use of excessive police force in interactions with seriously mentally ill individuals were instrumental to the development of the Critical Incident Training program in Memphis (Watson & Fulambarker, 2012), which has spread nationally and internationally. Psychologists with special interest in SMI/SED issues have assumed a role in developing public policy through the work of federal employees such as Robert Heinssen, Ph.D. Director, Division of Services and Intervention Research, National Institute of Mental Health; psychologists in the Department of Veterans Affairs have fostered the development and dissemination of recovery oriented care and evidence-based practices within in the VA. There are several prominent thought leaders/psychologists with lived experience of SMI such as Drs. Fred Frese, Pat Deegan, and Nev Jones who all demonstrate through their scholarship, public advocacy, and lives that recovery from serious psychiatric illness is possible. A key aspect of SMI/SED education is acquainting trainees about all of these efforts by psychologists working to improve the public welfare, and helping trainees make linkages with relevant groups, such as Division 18, Psychologists in Public Service, should the trainee wish to affiliate with them.

g. Continuing Professional Development

As advances in our understanding and treatment of SMI/SED continue apace, specialists who have completed their formal training still must continue learning and improving their skills. There are many ways this can happen. They can keep abreast of findings published in relevant resources such as:

Texts:

- *Clinical Handbook of Schizophrenia* (Mueser & Jeste, 2008)
- *Manic-Depressive Illness: Bipolar Illness and Recurrent Depression* (Goodwin & Jamison, 2007)

Articles found in journals such as:

- *British Journal of Psychiatry*
- *British Journal of Psychology*
- *Early Intervention in Psychiatry*
3. Identify professional practice activities associated with the specialty in each of the following domains and how they differentiate and where they might overlap with other specialties.

Most SM/SED trainees and mental health professionals with an interest in this specialty will be clinicians who have also had general training, so there is naturally some overlap in general and specialty practices. In general, SM/SED specialty practices involve more in-depth assessment or use of specialized intervention techniques tailored to the needs of a population dealing with positive, negative, and affective symptoms of such severity that they can interfere with day-to-day functioning.

Psychologists working with children and youth with SM/SED are especially likely to employ skills in collaboration, cooperation, and joint care planning with partners within the system of care, to provide intervention and offer support in various components of the child’s environment: home, school, social
services, juvenile services, and education. As Ziporsky et al. (2012, p. 1368) noted, the poor social sequelae of such disorders as schizophrenia are not the inevitable outcomes of the illness course, but “highlight the challenges we face in providing the needed services and supports.” Studies show that adults with SMI have experienced high rates of child sexual abuse, forced sexual trauma, and childhood physical abuse (Subica, 2013), so knowledge and skill in dealing with these complexities, in terms of the child/youth experiences and the various intervention agencies and systems, is required.

Below, we list practices commonly used by psychologists which are likely also to be used by those with a specialty in SMI/SED, followed by those that are more distinct as they are specialized SMI/SED practice. In the intervention section, we also note specialty practices needed for effective work with persons with SMI/SED in forensic and criminal justice settings.

Assessment

Professional Practices Commonly Engaged in by Psychologists with a Specialty in SMI/SED and Likely to Overlap with Other Clinical Specialties

- Utilizing standardized assessment instruments as manualized and appropriate to the clinical concern
- Conducting an initial clinical interview, including assessing life history, current life circumstances, psychopathology, strengths and resources, physical health, history of prior mental health treatment, etc.
- Recognizing and diagnosing psychopathology validly and reliably
- Assessing the potential risk for suicide and violence to self or others
- Assessing the internal and external resource available to the person and his/her ability to utilize available resources
- Assessing an individual’s readiness and desire for psychosocial interventions
- Understanding the etiology of mental health disorders, including comorbid trauma and substance use disorders
- Accounting for diversity related to age, cultural, spiritual/religious beliefs, etc. in diagnosis and treatment planning
- Assessing exposure to trauma and presence of PTSD and other sequelae
- Writing accurate and accessible reports based on assessment data as needed
- Imbuing interactions with hope
- Assessing for medication adherence and barriers to adherence
- Follow through on “duty to warn” prescriptions as assessments merit

Professional Practices Likely to Distinguish SMI/SED Psychologists

- Conducting comprehensive assessments to determine functional capacities for life in the community
- Utilizing standardized assessments in ways that may require modification in light of the fact that these assessments were not developed or normed using persons with SMI/SED
- Administering specialty assessments such as the Structured Clinical Interview (SCID for DSM), the Positive and Negative Syndrome Scale (PANSS), the Brief Psychiatric Rating Scale (BPRS), and the Brief Psychiatric Rating Scale for Children (BPRS-C) as needed and appropriate
- Conducting strengths based and functional capability assessments
• Conducting an initial clinical interview with a person who is paranoid or preoccupied with internal stimuli
• Assessing positive/psychotic and negative symptoms
• Recognizing psychosis, mood swings, and thought disorder and understanding the nuances of each condition considered within the purview of SMI/SED
• Screening for potential cognitive deficits that are core areas of dysfunction for people with SMI/SED including processing speed, verbal memory, attention, and social deficits
• Recognizing the limitations posed by cognitive impairments associated with SMI/SED and the potential for lessened insight
• Conducting behavioral observational assessments that accurately account for limitations posed by cognitive deficits
• Recognizing and understand etiology of comorbid trauma and substance use disorders in SMI/SED disorders
• Being competent in differential diagnosis of SMI/SED and similarly presenting diagnoses such as PTSD and personality disorders
• Integrating diversity features related to age, cultural, spiritual/religious beliefs, etc. as they apply to the presentation of SMI/SED
• Recognizing the level of capacity and competence of an individual diagnosed with SMI/SED in order to make appropriate recommendations regarding interventions
• Referring to appropriate specialty services including those provided by other disciplines (e.g., nutritionists, pharmacists, etc.)
• Carefully considering issues around validity of self-report measures with a psychotic population prior to selecting and administering these assessments
• Conducting behavioral assessments in the community as needed to determine functional level
• Assessment of a child or adolescent for purposes of placement outside the home
• Identifying adolescents with prodromal symptoms, who may be especially prone to misidentification (compared to adults). Tiffin and Welsh (2013, p. 1157) noted that many clinicians “do not feel confident in identifying young people potentially at risk.”

Interventions

Professional Practices Commonly Engaged in by Psychologists with a Specialty in SMI/SED and Likely to Overlap with Other Clinical Specialties
• Developing, monitoring, and updating an effective treatment plan
• Integrating all information into a case formulation that presents an opportunity for use of psychosocial interventions designed to promote recovery and attainment of the goals articulated by the consumer
• Providing evidence-based therapy such as cognitive behavioral therapy, family therapy, and supportive therapy with fidelity to the manual
• Utilizing motivational interviewing
• Employing shared decision-making
• Utilizing health psychology approaches to address problems such as obesity, smoking, and a sedentary lifestyle
• Developing behavioral tailoring strategies to support medication adherence
• Knowing medication side-effects and conveying that information to consumers as needed
• Developing therapeutic rapport
• Repairing breaches and disruptions in the therapeutic relationship
• Developing a relationship with the individual based on trust and respect

Professional Practices Likely to Distinguish SMI/SED Psychologists
• Demonstrating comprehensive knowledge of psychosocial rehabilitation interventions designed to foster recovery and meet the needs identified by each person.
• Knowing community resources and ability to intervene to help with access to care (e.g., family members trying to get members into care and navigate complex social systems)
• Implementing interventions tailored to adults living with schizophrenia or bipolar illness and their social networks
• Providing evidence based and promising practices for SMI/SED
  ◦ Assertive Community Treatment – knowledge of fidelity criteria and ability to implement intervention and participate on team
  ◦ Supported Employment – knowledge of fidelity criteria and ability to implement intervention, and participate on team
  ◦ CBT, CBTp, and CBSST – knowledge of differences between cognitive-behavioral therapy, (CBT), cognitive behavioral therapy for psychosis (CBTp), and cognitive-behavioral social skills training (CBSST) and ability to competently practice them as appropriate
  ◦ Family intervention/psychoeducation – knowledge of fidelity criteria and ability to implement intervention and participate on team
  ◦ Social skills training - knowledge of fidelity criteria and ability to implement interventions tailored to adults living with schizophrenia or bipolar illness to improve adaptive functioning
  ◦ Social learning programs (Token Economy) – knowledge of intervention, its appropriate use, critical need for extensive training and supervision of staff, and ability to implement intervention and participate on team
  ◦ Integrated dual diagnosis treatment (IDDT)/Concurrent disorders treatment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
  ◦ Weight management and smoking cessation approaches – ability to competently implement appropriate interventions and tailor them to individuals living in residential settings and/or with high levels of positive or negative psychotic symptoms
  ◦ Illness self-management including illness management and recovery (IMR), Wellness Recovery Action plans (WRAP), and peer support programs
  ◦ Cognitive remediation and Social cognition training – knowledge of interventions, ability to competently practice
  ◦ Comprehensive specialty care (CSC) interventions for first episode psychosis (RAISE) – knowledge of and ability to implement intervention and participate on team
  ◦ Social Rhythm Therapy – knowledge of fidelity criteria and ability to implement interventions tailored to adults living with bipolar illness
• **Conducting additional interventions to address critically important problems for people with SMI/SED**
  - Stigma/Self-stigma interventions -- demonstrating knowledge of, and ability to implement interventions to change attitudes among consumers and to decrease discriminatory attitudes behaviors among health providers and the public at large
  - Developing and implementing interventions to address concerns about suicide risk or self-harm – ability to recognize when individuals may be at risk and provide high levels of support, refer for medical intervention/crisis intervention/hospitalization, provide treatment for depression in order to reduce hopelessness, utilize strategies to address psychotic symptoms that maybe increasing risk for suicide (e.g. command hallucinations)
  - Working to reduce likelihood that the individual may be the recipient or cause of violence – ability to recognize when individuals may be at risk and institute plans for protection
  - Interventions to decrease homelessness and/or food insecurity – ability to provide a comprehensive array of services designed to facilitate supported housing, trauma informed care, relapse prevention for substance abuse, and access to life-sustaining resources
  - Motivational interviewing tailored to those diagnosed with SMI/SED – ability to competently implement motivational interviewing with individuals experiencing psychosis and/or high levels of amotivation and who may have difficulty with logic and linear thought patterns
  - Creating opportunities for people to meet and interact with others, build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion

• **Specific interventions used by psychologists working with children and adolescents with SED**
  - Psychoeducation especially in the context of working with the family, and collaboration/coordination with other professionals and agencies involved in the plan of care, and interventions developed for early onset or first episode of schizophrenia
  - Individual family psychoeducation (IFP) and multifamily psychoeducation groups (MFPG) designed for outpatient children with major mood disorder and their families (Fristad & MacPherson, 2014; MacPherson, Fristad, & Leffler, 2014)
  - Collaboration, coordination, and joint care planning with staff in inpatient settings and with psychiatrists for provision of medications and monitoring for medication side effects, as reviews of controlled trials of atypical antipsychotic agents for use with early-onset schizophrenia have been conducted, and have found that many of the youth do not respond adequately, and are vulnerable to such adverse events as metabolic side effects (McClellan, Stock, and the AACAP CQI, 2013)
  - Coordination between child-serving and adult-serving care settings (Tiffin & Welch, 2013)
  - Psychosocial treatments such as cognitive remediation, social skills training, relapse prevention, basic life skills training, problem-solving skills or strategies, treatments for co-morbid problems (e.g., substance abuse), and educational/vocations programs are recommended (McClellan, et al., 2013)
  - Cognitive remediation, cognitive behavioral therapy, and psychoeducation and family intervention for very early and early-onset schizophrenia (Armando, Pontillo, & Vicari, 2015)
  - Comprehensive, integrated care for first episode psychosis in the NIMH RAISE initiative (Mueser et al., 2015; Rosenheck, et al., 2016; Rosenheck, et al., 2017)
Professional Practices Engaged in by Psychologists with a Specialty in SMI/SED who Work in Forensic and/or Criminal Justice Settings that are Distinct from Practices of more Generally Trained Psychologists Working in these Settings

- Demonstrating knowledge of the factors that impact on success for forensic and criminal justice populations with SMI/SED
- Providing transition planning and follow-up for criminal justice/forensic settings – ability to implement adequate and appropriate transition planning and follow up for individuals being released into the community
- Providing evidence based and promising practices for SMI/SED
  - Forensic Assertive Community Treatment (FACT) – ability to implement intervention and participate on team
  - Cognitive-behavioral therapy, (CBT), cognitive behavioral therapy for psychosis (CBTp), and cognitive-behavioral social skills training (CBSST) in the criminal justice system – knowledge of differences between cognitive-behavioral therapy, (CBT), cognitive behavioral therapy for psychosis (CBTp), and cognitive-behavioral social skills training (CBSST) and ability to competently practice them as appropriate in this setting
  - Integrated Dual Diagnosis Treatment (IDDT)-/Concurrent disorders treatment for those in criminal justice/forensic settings – knowledge of the specialized needs of people with SMI/SED in these settings, ability to provide integrated mental health and substance use services targeted to the population
  - Trauma interventions for those in criminal justice/forensic settings (trauma informed and trauma specific care) – recognition of trauma as the norm for those diagnosed with SMI/SED in the forensic and criminal justice system, ability to competently provide trauma specific interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care, including services for those at highest risk
  - Supported housing interventions for those in criminal justice/forensic settings – ability to implement comprehensive services to assure supported housing is available for individuals being released into the community

Consultation/Training

Professional Practices Commonly Engaged in by Psychologists with a Specialty in SMI/SED and Likely to Overlap with Other Clinical Specialties

- Effectively presenting information and developing treatment recommendations that are understandable to the person, his or her support team, and in accord with his or her goals
- Ability to consult with families about their family member’s illness and the role of family in treatment
- Ability to consult with prescribers and others on the treatment team to develop and implement an effective treatment plan

Professional Practices Likely to Distinguish SMI/SED Psychologists

- Collaborating competently with an interdisciplinary team and presenting information about persons with SMI/SED, psychosocial functioning, and recovery so that team members can understand and learn from the presentation
- Applying specialty knowledge and expertise concerning SMI/SED symptomatology and diagnosis to problems that arise in professional settings
• Education and instructing mental health staff on all aspects of the recovery paradigm and psychosocial rehabilitation assessments and interventions

• Assisting team members in the management of difficult behaviors

• Integrating the knowledge, values, and attitudes critical for successful work with people with SMI/SED into interdisciplinary team settings to facilitate shared decision making

• Working with staff in specialized facilities such as supported housing, etc. to help them recognize and deal appropriately with symptoms and problem behaviors to help individuals with SMI/SED thrive in the community

• Educating and training other staff in the best ways to help people with SMI/SED manage symptoms, set and achieve goals for themselves, and use resources available to them. Some examples of potential issues include limit setting, stigma, empathy, delusions/hallucinations, reflective listening, crisis intervention - at all levels of training from front-line behavioral health staff through to highly trained staff and managers/administrators

• Consulting with the consumer and his/her support network to access resources and care (e.g., family members trying to get members into care and navigate complex system)

• Understanding of the complexity of systems change issues and ability to promote personal resiliency as resistance is encountered

• Educating and training staff in facilities and on specialized units for youth, young adults, and older persons where knowledge and expertise is lacking about behavior health particularly SMI/SED

• Consultation with judges, attorneys, and children advocates in SED placement decisions

• Consultation with teachers and other school staff about behavior and SED learning problems

• Consultation in navigating and shaping systems of care, and advancing a system of care philosophy and practices (Stroul, Blau, & Friedman, 2010); promoting the implementation of an array of services, provided in partnership with youth and families, that are individualized and coordinated across agencies and programs, and delivered with cultural and linguistic competence; consultation on incorporate use of evidence-informed practices, and continuous improvement to enhance the wellbeing of children, youth, and families (Stroul, et al., 2010).

Supervision

Professional Practices Commonly Engaged in by Psychologists with a Specialty in SMI/SED and Likely to Overlap with Other Clinical Specialties

• Socializing trainees so they continue to develop a professional identity as a psychologist

• Imparting comprehensive information about psychopathology to trainees

• Imparting comprehensive information on mental health treatment and systems of care to trainees

• Imparting comprehensive information on evidence-based interventions for mental health disorders to trainees

• Imparting knowledge about the importance of hope, respect, positive regard, and acceptance of person’s goals and wishes with development of the therapeutic relationship to trainees

• Helping trainees and supervisees recognize incremental improvements and utilize the process of shaping in goal setting and recovery

• Using standard tools for EBP fidelity measures and supervising trainees in their use

• Using live or audiotaped feedback to review and provide feedback to trainees
• Making supervision a safe place to discuss challenges
• Eliciting and being open to supervisee and trainee feedback
• Helping trainees begin to acquire supervisor skills

Professional Practices Likely to Distinguish SMI/SED Psychologists
• Imparting knowledge about specialized SMI/SED psychosocial assessments and interventions to trainees and supervising their use (including specialized assessments and interventions mentioned in 3a and 3b, and in Criterion VI)
• Providing education and training for mental health staff on all aspects of the recovery paradigm and psychosocial rehabilitation interventions to trainees
• Imparting knowledge about the importance of hope, respect, positive regard, and acceptance of person’s goals and wishes even when these plans and wishes do not align with the clinician/trainee
• Facilitating an understanding of the pace and common non-linear process for recovery and ability to develop reasonably positive expectations for the person’s progress despite the combination of social, functional, and cognitive impairments that are common in SMI/SED
• Providing more comprehensive SMI/SED illness education to trainees
• Imparting information on the phenomenology of the disorders of SMI (e.g., auditory hallucinations, negative symptoms such as diminutions of basic drives, etc.)
• Helping supervisees address disruptive or troublesome behaviors (consumers with poor hygiene, bizarre speech, abnormal movements, response latency)
• Supervising effective goal setting that is often different in quality (i.e., level of difficulty) and outcome (i.e., type of goals set) when working with individuals diagnosed with SMI/SED
• Promoting self-examination of fear and pre-conceived notions about people diagnosed with SMI/SED
• Teaching and supervising trainees about appropriate boundaries and role of using the self as a model to normalize experiences when working with SMI/SED populations
• Providing feedback on live or recorded sessions to illustrate the often-complex nuances of work with persons with SMI/SED (e.g., addressing paranoia, speech latency, tangential speech, etc.) as trainees learn EBPs
• Supporting trainees as they learn to work with peer specialists
• Supervising a range of other mental health providers (e.g., psychiatrists, peers, nurses, social workers, occupational therapists, BA level line staff) as appropriate to the setting and task
• Modeling enthusiasm about work with the SMI/SED population

Research and Inquiry

Professional Practices Commonly Engaged in by Psychologists with a Specialty in SMI/SED and Likely to Overlap with Other Clinical Specialties
• Keeping abreast of the scientific literature in the field
• Comprehensive understanding and use (as needed) of research designs and statistics
• Understanding/using single case designs (disorders may be persistent over time and multiple baselines provide a clearer picture of the impact of different treatment components and their helpfulness with individuals)
• Maintaining up to date knowledge of the latest assessments and interventions in mental health
• Being a good consumer of research, by being able to correctly evaluate if authors’ interpretation of their data is supported by those data
• Following APA ethical practices when conducting human subjects research

Professional Practices Likely to Distinguish SMI/SED Psychologists
• Incorporating persons with lived experience of an SMI diagnosis into all aspects of research and evaluation from conception to completion and publication. This includes formulation of hypotheses, study questions and design, determination of statistical methods, participants to be recruited, etc.
• Incorporating family members and first-degree relatives into research designs as participants or as a source of collaborative data (research provides insight into how the illness manifests in individuals vs. family members looking at the phenotypes in individual and family)
• Utilizing research/evaluation knowledge to adapt/modify assessments and interventions that have excluded persons with SMI and recognizing when fidelity to the original practice is essential and where procedure variability is permissible
• Recognizing and understanding the needs of vulnerable populations vis a vis their participation in research efforts
• Recognizing and understanding of the ability of persons with SMI/SED to provide informed consent and when other safeguards to protect them are required.
• Informing and educating IRBs about the type of intervention research common with SMI populations, as well as the needs and capacities of the population
• Understanding the unique needs of persons with SMI/SED to prevent/minimize attrition which can be especially high in SMI/SED studies; recognizing that 1) drop outs tend to be doing worse and 2), severe economic disadvantages impact people with SMI disproportionately 3), follow up studies need to include more time (>1 year) due to the episodic nature of the illness
• Conducting multifactorial designs of programs as these are the norm with SMI populations; understanding of the importance of controls for non-specific factors
• Identifying appropriate measures for research and program evaluation work due to broad nature of quality of life, psychosocial functioning, and recovery
• Undertaking program evaluation so that implemented programs can be improved; this can be challenging because systems in which SMI/SED persons are seen often more difficult to work with in structured research settings due to multiple stakeholders, community settings, and lack of resources
• Obtaining buy-in from multiple under-resourced clients and stakeholders
• Addressing unique challenges in studying long-term outcome of early onset schizophrenia (Clemmensen, Vernal, & Steinhausen, 2012)

Public Interest

Professional Practices Commonly Engaged in by Psychologists with a Specialty in SMI/SED and Likely to Overlap with Other Clinical Specialties
• Knowing community social services that may assist the persons whom they treat
• Participating in anti-discrimination activities to change stigmatizing attitudes about mental health challenges among health providers and the public at large
• Keeping abreast of public laws that pertain to mental health
• Keeping abreast of changes in ethics and licensure regulations and state laws as they pertain to mental health

Professional Practices Likely to Distinguish SMI/SED Psychologists
• Knowing community resources and ability to reach out to these as a means of expanding access to services for people with SMI/SED
• Advocacy to improve the lives of individuals diagnosed with SMI/SED
• Keeping abreast of public laws that pertain to SMI/SED
• Keeping abreast of changes in ethics and licensure regulations and state laws as they pertain to SMI/SED

Continuing Professional Development

Professional Practices Commonly Engaged in by Psychologists with a Specialty in SMI/SED and Likely to Overlap with Other Clinical Specialties
• Joining and maintaining membership in professional organizations such as APA
• Keeping abreast of new mental health findings through reading professional journals and attending conventions and conferences
• Meeting CE standards for state licensing

Professional Practices Likely to Distinguish SMI/SED Psychologists
• Joining and maintaining membership in professional organizations which focus on SMI/SED such as the SMI/SED section of APA’s Division 18, Psychologists in Public Service or the Schizophrenia Special Interest Group of the Association for the Advancement of Behavioral and Cognitive Therapies
• Keeping abreast of activities in the consumer advocacy movement
• Keeping abreast of first person accounts of SMI/SED; often available on social media
• Keeping abreast of advances in the evolution of the recovery movement
• Partnering with child and family teams to develop family-driven, youth-guided, and culturally and linguistically competent services (Stroul, Blau, & Friedman, 2010)
• Emphasizing an individualized, flexible approach to services (Stroul, Blau, & Friedman, 2010)
• Advocating for identification of natural supports and building on child/adolescent and family strengths (Stroul, et al., 2010; McCammon, 2012).

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Criterion V. Advanced Scientific and Theoretical Preparation

In addition to a shared core of knowledge, skills and attitudes required of all practitioners, a specialty requires advanced, specialty-specific scientific knowledge.

Commentary: Petitions demonstrate how advanced scientific and theoretical knowledge is acquired and how the basic preparation is extended.

1. Specialty education and training may occur at the doctoral (including internship), postdoctoral or post-licensure levels. State the level of training of the proposed specialty.

   This specialty is designed to be at the post-doctoral level.

2. Training at the doctoral level is assumed to be primarily broad and general. If specialty training occurs in whole or in part at the doctoral level, describe that training. If there is specialty specific scientific knowledge that is typically integrated with aspects of the broad and general psych curriculum (e.g., biological bases of behavior, cognitive-affective bases of behavior, individual bases of behavior, ethics (science and practice) rather than taught as a freestanding course or clinical experience, specify how this integration occurs.

3. If specialty training occurs in full or in part during a formal postdoctoral program describe the required education and training and other experiences during the postdoctoral residency. Are there any doctoral level prerequisites beyond an APA-accredited degree in professional psychology required for postdoctoral training?

   Note 1: Please also see the Training Guidelines for Post-Doctoral Psychology Residency Programs in Serious Mental Illness/Severe Emotional Disturbance (SMI/SED), attached as Appendix I and available on the Specialty Council website (http://www.psychtrainingsmi.com).

   Note 2: Please see also Criterion VII for information regarding admission evaluation, sequence of training, sample curriculum, resident evaluation, sample reading list, etc.

   Advanced scientific and theoretical knowledge is acquired via specialized didactic and experiential training that builds on and extends basic preparation in health service psychology. The specialized training needed to develop competence to treat persons with SMI/SED builds on, and expands doctoral level foundational and functional competencies, and includes: additional assessment methods that assess strengths and functional capability rather than solely symptomatology and deficits, evidence-based and promising practices designed specifically for this population, interventions modified and found to be effective with people in this population within the forensic mental health system, research methods adapted for populations such as this, and systems transformation methods specific to large mental health systems that serve this population, to name but a few – these are the major areas of specialized training needed by psychologists to work with individuals with SMI/SED.

   Training for post-doctoral residents in this specialty takes place via several principal avenues: primary and secondary placements, seminars, didactics, research, supervision, consultation, teaching, and administration. While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training experiences should exist across all programs. These may be called by different names but the content should be focused on learning how to use the psychosocial rehabilitation assessments and interventions specifically designed to help people with SMI/SED recover and attain their full functional capability.
The goal of psychosocial rehabilitation is an individual's recovery, measured not only as a reduction in symptoms but also as improved functioning and life satisfaction, and participation in environments of one's choice. The majority of services provided are psychosocial rehabilitation interventions, although residents in this specialty also provide traditional treatments such as illness management and supportive therapy. Embedded in this model is an interprofessional approach based on a recovery model that empowers individuals to develop personalized goals and choose from a menu of treatment program opportunities, including inpatient and outpatient services. The goal of services is to improve community functioning and quality of life for persons with SMI/SED. Ensuring an active partnership with consumers and community partners is an important element of this work.

Training is sufficiently broad to build on and enhance the foundation of knowledge, skills, and proficiencies that define professional health service psychology, and of sufficient depth to develop more focused competence and expertise in the specific area of SMI/SED. This is accomplished through involvement in focused didactics and clinical experiences on an SMI/SED team/unit. More general placements and didactics with post-doctoral psychology residents in other specialty areas (where these exist at a given academic training site) will also be offered.

Each resident’s training plan should be individually created to meet the specific training needs of the resident and to develop competence in a full range of mental health and psychosocial rehabilitation skills specifically designed for individuals with SMI/SED. Training activities include attention to advancing development of core skills such as: specialized assessments, treatment interventions developed and researched specifically for this population, consultation and interprofessional teamwork, research and scientific inquiry, supervision and teaching, ethics, program management and administration, and cross-cultural and diversity sensitivity. Residents leave their residency well-prepared to function successfully as independent scientist-practitioners and work effectively with persons with SMI/SED. Another goal of the residency is to train residents to function in leadership positions working with persons with SMI/SED. As a result, the resident should also be prepared to transition to practice with an interprofessional team, promoting client-centered, recovery oriented care and interprofessional collaboration for specialized assessment and treatment of persons with SMI/SED.

**Required Education and Training and Other Experiences**

1. **Required Primary Placement**

Residents should expect to spend approximately 20 hours per week in a supervised, primary placement setting. As residents increase their skill, confidence, and levels of responsibility, they should receive more complex cases, provide more independent clinical work, pursue their own training goals, and take on additional roles if desired. Residents also typically work with pre-doctoral interns and practicum students, and are involved with the hierarchical supervision of these interns and students along with their clinical responsibilities on their rotations. The intensity and level of these activities would be determined in a collaborative nature between trainee, supervisors, and the Directors of Training.

The primary placement could take place in an outpatient program or on an in-patient unit. The focus of the team should be on recovery-oriented psychosocial rehabilitation for those with SMI/SED. Residents would conduct screening, provide diagnostic clinical and strength based functional and resource assessments, work on initial goal-setting, provide psychoeducation to meet the person's expressed needs, help motivate individuals to engage in treatment, provide evidence-based and promising practices specific to persons with SMI/SED, and assist in data collection, program evaluation, and quality improvement. Residents will also participate in individual (and possibly group) supervision regarding specialized psychosocial rehabilitation and related clinical activities for the SMI/SED population in an appropriate and effective manner. Residents learn about recovery-driven systems and the kinds of services provided and are members of interprofessional teams. Residents and other trainees also typically meet with peers, teams, and training faculty to review cases and process their experiences.
They would also have the opportunity to lead rounds and facilitate discussions, offering supervision and team leading experiences.

Core components that psychosocial rehabilitation and recovery oriented units/teams would include (Each residency program would determine which are best suited for the program):

- **Individualized assessment/re-assessment** including intakes, diagnostic clarifications, cognitive screening, functional assessment, rehabilitation readiness assessment, etc., and recovery/treatment planning;

- **Individual or group psychotherapy** such as CBT for psychosis (CBTp), intensive case management, social skills training, anger management skills, relationship skills, family psychoeducation, cognitive behavioral social skills training (CBSST), cognitive enhancement therapy, interpersonal psychotherapy, weight and smoking interventions, and solution-focused approaches including *Wellness Recovery Action Planning* (WRAP), etc.;

- **Community integration skills** including interviewing skills, leisure/recreation skills, finding and retaining housing, practice applying the skills learned or developed in groups; working with community partners (e.g., NAMI; libraries, community recreation centers, senior centers, legal clinics, etc.);

- **Evidence-based and promising practices** such as family psychoeducation, assertive community treatment, supported education and supported employment particularly the individual placement and support model, co-occurring disorders treatment, social cognition and cognitive remediation, early intervention and psychosocial treatments for recent onset psychosis, trauma informed and trauma specific care, illness management, issues and interventions for those in criminal justice and forensic settings, among others.

2. Secondary Placements and Other Training Experiences

During the remaining 20 hours of the week, residents would participate in additional rotations, didactic seminars, supervisory sessions, and other experiences designed to round out their understanding and knowledge of SMI/SED service provision. We describe these below.

For their secondary placement, SMI/SED post-doctoral residents should also participate as members of an interprofessional team on one or more units or teams that that are different from the primary placement, but that also focus on recovery and provision of psychosocial rehabilitation services. These should be selected to broaden the resident’s training experiences. Examples could include outpatient clinics or community programs where interventions such as family psychoeducation and social skills training are offered, or short stay units where treatment services for acute episodes of psychiatric illness are offered and where an individual is helped to stabilize, his or her level of functioning is improved, and connections with outpatient treatments that promote community integration are established. A number of distinct clinical programs should be available to residents for secondary placements, and to the greatest extent possible, these should operate from a recovery and psychosocial rehabilitation orientation. Within each of these, residents would work closely with a wide range of allied healthcare providers (nurses, social workers, psychiatrists, occupational therapists, vocational specialists, recreational therapists, medical residents, dietitians, art therapists, peer support specialists, etc.), family members, and other partners. Clinical supervision should be provided by a licensed psychologist.

3. Topics and Concepts that Should be Covered

In addition to completing required primary and secondary placements, residents would also be required to attend seminars, didactic presentations, and supervision sessions. Readings are provided to
enhance discussion during seminars. In order for residents to gain experience in teaching, participants would be encouraged to teach at least one session on an area of interest, and to submit abstracts for talks to be given at relevant conferences such as those of the Psychiatric Rehabilitation Association, Association of Behavioral and Cognitive Therapies, the American Psychological Association convention and/or local, state, or regional conferences with an interest in SMI/SED. If applicable, time is devoted to teaching the mechanics of giving PSR presentations, and providing feedback to participants as they rehearse these talks for presentation to larger audiences.

**Content that Should be Covered in Seminars, Workshops or Other Training Opportunities** *(Note: We describe below in seminar format; may be covered in Seminars, Workshops or Other Training Venues)*

- **Principles of Psychosocial Rehabilitation**: This didactic seminar mirrors the training philosophy of the scientist-practitioner model and is designed to provide participants with a broad and thorough understanding of psychosocial rehabilitation interventions, principles, theories, and current research in clinical and community psychology. Sessions focus on: current evidence-based and promising practices designed, developed, and empirically validated for persons with SMI/SED, stigma, ethics and boundaries (and how they differ from those in traditional mental health), and other relevant topics.

- **Interprofessional Case Assessment Seminar**: This seminar should focus on learning and applying the unique assessment skills of each discipline to effectively work in a collaborative manner to create and provide a comprehensive, recovery-focused, holistic and interprofessional approach to treatment for persons with SMI/SED. In order to facilitate this learning, residents would be paired with other disciplines to conduct assessments outside of the seminar meetings. Residents would be expected to work collaboratively with each other throughout the entire process of the assessment, which includes selecting assessment tools, scheduling times to conduct the assessment, writing the assessment report and presenting feedback to the treatment team, the individual, family members and other stakeholders. Residents would be assigned at least one case, and preferably two or more, as part of the interprofessional team.

- **Systems Change Seminar**: A didactic seminar comprised of discussions about leadership, management styles and organizational development. Residents should meet with a range of leaders and managers, who lead discussions on topics ranging from mentoring, decision-making, workforce development, negotiation styles, politics in organizations, leadership in education and community organizations, all with an eye toward effecting systems change to reflect relevant mental health policies for recovery and rehabilitation for persons with SMI/SED.

- **Diversity Seminar**: While targeted diversity training is required, note that diversity training for all those working with persons with SMI/SED is primarily practical and applied. Issues related to the full range of human diversity should be incorporated into all aspects of training including primary and secondary placements, seminars, lectures, and supervision sessions.

  - This seminar could incorporate case presentations by residents. Topics and speakers are selected to increase self-awareness and improve delivery of care. While topics and speakers will likely cover a broad range, those that are particularly pertinent to persons with SMI/SED should be highlighted. Among others, important topics include: the poor attention often given by health care providers to physical health complaints of persons with SMI/SED, discriminatory practices including failure to follow treatment guidelines when people of color and diverse cultural backgrounds are seen, and need for attention to language barriers, traditional beliefs about mental illness, and religious/cultural issues.

    - Understanding of psychiatric disability as part of diversity.

    - Training is provided in terms of addressing ethical issues, as well as attitudes, knowledge, and skills in relation to all aspects of human diversity.
• Residents are expected to make a substantial effort to recognize, understand, appreciate and discuss topics such as age, sex, gender, ability/disability/illness, culture, ethnicity, race, language/culture of origin, sexual orientation, socioeconomic status, and religious/spiritual beliefs and attitudes, among others, as well as the intersection of these and how they are considered and integrated in provision of services.

• While topics and speakers will likely cover a broad range, those that are particularly pertinent to persons with SMI/SED should be highlighted including:

  • Poor attention to physical health complaints by health care providers, misattributions of legitimate health concerns to psychotic symptoms, discriminatory practices including failure to follow treatment guidelines when people of color and diverse cultural backgrounds are seen, and need for attention to language barriers, traditional beliefs about mental illness, and religious/cultural issues.

  • The exploration of power differentials, dynamics, and privilege should be at the core of understanding issues of diversity and impact on social structures and institutionalized forms of discrimination that may influence the person's perception of her/his potential for improved quality of life.

• **Laws and Ethics Seminar**: Each of the topics below should be discussed for its relevance to, and in the context of persons with SMI/SED

  • Informed consent
  • HIPAA
  • Confidentiality
  • Reporting laws
  • An individual's access to his or her own medical record
  • Code of conduct
  • Acting ethically / Avoiding ethical complaints
  • Patient-therapist relationship issues
  • Record keeping guidelines
  • Forensic issues
  • Research ethics, and
  • Other topics that may be of timely interest such as forced treatment, etc.

• **Research / Program Evaluation and Dissemination Seminar**: Each resident should be expected to design, develop, and implement an academic project that can be presented at a relevant national, regional or local conference. This seminar is designed to assist in the formulation and execution of the project and would focus on topics such as overviews of research and evaluation of PSR assessment and intervention, research and evaluation methods, research dissemination, and critical reviews of research. The purpose of this project is to disseminate novel approaches to psychosocial rehabilitation for people with SMI/SED. Projects could include designing a new psycho-educational group or program, implementing a focus group, evaluating an existing treatment program, participating in an ongoing research study and presenting research findings, writing a literature review manuscript, submitting a grant application, developing an impact statement or a policy initiative, designing and evaluating a new group or program, etc.

Residents should gain experience in identifying, reviewing, and contributing to the scientific literature and knowledge base. This can be accomplished by helping residents to:

  • Locate evidence in the literature from scientific studies relevant to the SMI/SED population, apply knowledge of research design and statistical methods to the evaluation of study findings,
and select appropriate evidence on diagnostic and therapeutic effectiveness to improve patient care;

- Demonstrate familiarity with current scientific literature in psychosocial rehabilitation and related clinical activities for SMI/SED population; evaluate the relevance of scientific literature relevant to specific questions or patients;

- Demonstrate familiarity with methods of integrating scientific literature and clinical information regarding psychosocial rehabilitation and related clinical activities for SMI/SED population in the service of patient care and program development;

- Demonstrate knowledge of resources available to locate information on psychosocial rehabilitation and related clinical activities for SMI/SED population relevant to patient care and program development;

- Demonstrate understanding of how to use knowledge of research design and statistical methods to identify the level of evidence in published information when applying to psychosocial rehabilitation and related clinical activities for SMI/SED population;

- Develop and implement research questions in psychosocial rehabilitation and related clinical activities, and in health-care systems to improve the organization, delivery and effectiveness of SMI/SED-driven care;

- Demonstrate knowledge of ethical, legal, and regulatory standards for conducting research with human subjects with SMI/SED diagnoses;

- At the program’s discretion, residents could also be responsible for leading a research seminar or colloquium for interns and others who may be interested including practicum students, members of psychology staff, and interprofessional team members in specific disciplines. Such a resident-led seminar could include topics such as review and critical analysis of published research, assistance with study design, development of presentations or papers for publication, etc. Additional supervision of undergraduate students who work with faculty and residents on a wide variety of research projects may also be available. In addition, residents may provide assistance in teaching seminars with faculty members.

- **Consultation Seminar:** This seminar should provide didactic training and opportunities to discuss issues pertaining to consultation at the individual, team, and system levels. Residents provide feedback to each other about their consultation efforts. Leaders, faculty, and staff from other disciplines should be involved to serve as discussants to provide multiple perspectives.

  - Within the bounds of confidentiality and privacy, residents must be able to listen, understand, communicate, and display excellent rapport and proficiency with relevant stakeholders including: persons with SMI/SED, family members, relevant community members, interprofessional staff and other healthcare providers within and outside of the system, and community agencies and partners;

  - Residents must demonstrate an ability to effectively present information and develop treatment recommendations that are understandable to the person, his or her support team, and in accord with the individual’s goals;

  - Residents are able to competently work with an interprofessional team and present information about persons with SMI/SED so that team members can understand and learn from the presentation;
• Residents regularly provide consultation to interprofessional teams within the medical and or academic setting on how to implement EBPs for SMI/SED, best practices in psychosocial rehabilitation and community integration, and recovery-oriented mental health care;

• Consultation services include the provision of educational trainings on SMI/SED, the principles and strategies of psychosocial rehabilitation and recovery-oriented services for staff, partner agencies, organizations, and trainees from psychology and other disciplines;

• Residents provide consultation to community providers working with individuals with SMI/SED (examples may include providing training, technical assistance, case consultation, etc.).

4. Teaching and Supervision

Residents should perform clinical supervision of pre-doctoral practicum students and doctoral interns (where the residency setting also has interns and pre-doctoral students), be supervised themselves by experienced clinical trainers, and take part in workshops or other training opportunities to develop their own supervisory skills. They should also have the opportunity to present talks and seminars.

• Demonstrate knowledge of methods of teaching specific to psychosocial rehabilitation and related clinical activities for SMI/SED population, e.g., in case conferences, seminars, didactics, and journal clubs. Effectively translate knowledge of specialized psychosocial rehabilitation and related clinical activities for SMI/SED population to interprofessional audiences;

• Demonstrate knowledge of methods of providing supervision to other psychology trainees that emphasizes skill building in providing patient care, consulting with other professionals, identifying relevant scientific data and conducting research, and practice management specific to psychosocial rehabilitation and related clinical activities for SMI/SED population. Topics include: models of supervision, clinical competency, goals of supervision, reducing anxiety in supervision, silence, countertransference, supervision and ethics, risk management, self-care for the therapist and supervisor, and diversity awareness.

5. Supervision Meetings

Group Supervision Meetings. These meetings provide residents opportunities to learn more about how to work with those who have SMI/SED and can include processing past group or individual sessions, reviewing skills, role playing exercises, and learning more about various theories as well as practice tools and techniques.

• Residents may also participate in formal learning activities related to specialized psychosocial rehabilitation and related clinical activities for the SMI/SED population and participate in interprofessional educational activities such as patient-care rounds, case conferences/team meetings, and/or formal educational opportunities;

• Individual Supervision with Training Faculty. Residents should have the opportunity to meet with a faculty member to discuss program matters including administrative needs, educational plans, professional development, systems issues, and other matters of individual interest.

6. Professional Development Seminar

This seminar would be a monthly meeting for all psychology post-doctoral residents at the site that focuses on professional development. Topics could include: applying for a career development award, general licensure requirements, both broadly and specific to the jurisdiction of the residency,
7. Didactic Content Covered in Seminar or Lecture Format

Note 1: Please see Criterion VI for information and details of the culturally informed, strengths based, and functional assessments listed below and the intervention approaches also listed below.

Note 2: The assessment and intervention topics below are examples and could not all be covered in depth in a one year post-doctoral residency program, although residents should be made aware of the breadth of assessments and interventions available and provided information about them. A good overview reference is APA’s curriculum (American Psychological Association & Jansen, 2014) which provides information about many relevant recovery-oriented assessments and most of the evidence-based and promising psychosocial rehabilitation practice interventions. Each residency program would decide which of the following would be required and/or emphasized.

Assessments and Interventions specific to SMI/SED

Assessment – general

• Selection, administration, scoring and interpretation of psychological tests for persons with SMI/SED

• Integrating data and preparing written reports specific to SMI/SED population
  Dissemination of psychological test findings to individual and relevant stakeholders

Assessment – specific

Please Note: See Criterion VI for more comprehensive information and detail concerning many of the following assessments, especially those designated as culturally informed, the strength based assessments, and some of the functional capability assessments. For an excellent overview of assessments, see the chapter by Glynn and Mueser (in press) which presents a comprehensive review of the many instruments available along with information about their psychometric properties.

The following are topical headings and titles only.

• Culturally informed assessment
  The DSM 5 Cultural Formulation Interview

• Symptom assessment / diagnostic assessment
  Structured Clinical Interview for DSM-5 (SCID-5)
  The Brief Psychiatric Rating Scale (BPRS)
  Scale for the Assessment of Negative Symptoms and Positive Symptoms (SANS-SAPS)
  The Positive and Negative Syndrome Scale (PANSS)
  The Revised Behavior and Symptom Identification Scale (BASIS-R)
  Mini International Neuropsychiatric Interview (MINI)
  Clinician Administered PTSD Scale (Schizophrenia) (CAPS-S)
  Clinical Assessment Interview for Negative Symptoms (CAINS)
  Brief Negative Symptoms Scale (BNSS)

• Cognitive screening / evaluations
  Mini–Mental State Examination (MMSE)
Montreal Cognitive Assessment (MoCA)
Brief Neurocognitive Assessment (BNA)
Cognitive Assessment Inventory (CAI)
The MATRICS Consensus Cognitive Battery (MCCB)
Standard neuropsychological measures

- **Decision making capability / capacity**
  
  Aid to Capacity Evaluation (ACE)
  MacArthur Competency Assessment Tool for Treatment (MacCAT-T)

- **Strengths-based assessment**
  
  The Self-reported Quality of Life Measure for People with Schizophrenia
  The Client's Assessment of Strength, Interests, and Goals (CASIG)
  The Psychosocial Rehabilitation Services Toolkit

- **Readiness assessments**
  
  Psychiatric Rehabilitation Training Technology - Readiness Assessment

- **Functional assessment**
  
  University of California San Diego Performance-based Skills Assessment (UPSA-B)
  Specific Levels of Functioning (SLOF)
  The Multidimensional Scale of Independent Functioning (MSIF)
  The Maryland Assessment of Social Competence (MASC)
  Camberwell Assessment of Need (CAN)
  Social Adjustment Scale-II (SAS-II)
  MIRECC-GAF
  Psychiatric Rehabilitation Training Technology - Functional Assessment
  The Social Performance Schedule
  The Social Functioning Scale (SFS)
  The Social-Adaptive Functioning Evaluation (SAFE)
  The Independent Living Skills Inventory (ILSI)
  The DSM-IV Social and Occupational Functioning Assessment Scale (SOFAS)

- **Risk assessment** – (Note: the predictive accuracy of instruments in this category “remains a source of considerable uncertainty” (Fazel, Singh, Doll, & Grann, 2012)
  
  Hare Psychopathy Checklist-Revised (PCL-R)

**Goal Setting and Treatment Planning**

- Recovery paradigm and model of care
- Methods for engaging individuals with SMI and SED, their families and support systems in treatment
- Client centered and shared decision methods
- Treatment and recovery planning methods that differ from traditional treatment planning

**Interventions and Related Content**

Please Note: See Criterion VI for comprehensive information and detail concerning evidence based and promising practices. Following are intervention titles only.
• Assertive Community Treatment (ACT)
• Family therapy - includes Behavioral Family Therapy
• Family Education Workshops
• Multi-Family groups
• Supported Education and Employment, Individual Placement and Support (IPS) model
• Psychosocial treatments for recent onset schizophrenia (RAISE/NAVIGATE protocol)
• Structured/focused psychotherapy (CBT & CBT for psychosis (CBTp))
• Acceptance & Commitment Therapy, Dialectical Behavior Therapy)
• Skills training
• Illness Management and Recovery, including Wellness Recovery Action Plans (WRAP),
  Psychosis Support Group
• Cognitive Behavioral Social Skills Training (CBSST)
• Social Skills Training (SST), including Anger Management for people with SMI/SED, Behavioral
  Management for Auditory Hallucinations – Managing Voices
• Token Economies
• Cognitive Remediation
• Social Cognition and Interaction Training
• Issues and Interventions for Individuals with SMI/SED in the Criminal Justice and Forensic
  Systems
• Interventions for those who are homeless or at risk of homelessness.
• Interventions to reduce stigma, social isolation, and community exclusion
• Interventions for suicide prevention
• Interventions for bipolar disorder including Interpersonal and Social Rhythm Therapy (IPSRT)
  and Family Focused Treatment (FFT)

Implementation and Dissemination Strategies Specific to SMI/SED Interventions

Other content specific to SMI/SED

Etiology / epidemiology

• Stress-vulnerability model of SMI/SED
• Neurobiological/neurophysiological/neurocognitive phenomena
• Biopsychosocial model
  Premorbid / prodrome
  1st episode
  Untreated psychosis
  Residual
  Older adult/aging
  Physical health/common health problems/health behaviors

Co-occurring conditions (substance use, trauma, suicidality, personality disorders)

• Trauma Specific Interventions, (e.g., Cognitive Processing Therapy, Prolonged Exposure, CBT for
  PTSD)

Psychopharmacology for SMI/SED (medications, side effects / iatrogenic effects of treatment,
  treatment adherence)

• Psychosocial interventions for weight management and for stopping smoking

Peer Services (including peer support and peer delivered services)
History/community advocacy/ethics/diversity/other issues

- History of treatment of persons with SMI/SED
  Deinstitutionalization, history of coercion, clubhouse model, empowerment movement, etc.)
- Advocacy groups/community resources (advocacy, Assertive Community Treatment)
- Diversity/individual differences
- Ethics
- Legal considerations/civil rights/criminal justice
- Violence and aggression – by persons with SMI/SED and against persons with SMI/SED
- Systems of care/settings for care provision
- Criminal justice and forensic issues
- Discrimination and stigma
- Self-stigma
- Decision Making Capacity

4. If specialty training occurs in full or in part post-licensure, describe the required education and training during this training. Are there any doctoral level prerequisites beyond an APA-accredited degree in professional psychology required for post-licensure training?

   While specialty training could occur post-licensure, it is anticipated that a psychologist desiring this specialized training would complete a post-doctoral specialization to obtain the didactic and experiential training described in this petition in order to be fully competent to work ethically and effectively with people with SMI/SED. For already practicing psychologists, this may be impractical or not possible. At a minimum, completion of didactic and experiential training in the concepts of recovery from SMI/SED and training in the assessments specific to this population along with training in the PSR evidence based and promising practices designed and researched for this population would be needed, along with supervised experience, to ensure competency.

References


Appendix I

Appendix I: Training Guidelines for Post-Doctoral Psychology Residency Programs in Serious Mental Illness/Severe Emotional Disturbance (SMI/SED)
Criterion VI. Advanced Preparation in the Parameters of Practice

A specialty requires the advanced didactic and experiential preparation that provides the basis for services with respect to the essential parameters of practice. The parameters to be considered include: a) populations, b) psychological, biological, and/or social problems, and c) procedures and techniques. These parameters should be described in the context of the range of settings or organizational arrangements in which practice occurs. If the specialty training occurs at more than one level (e.g., doctoral, postdoctoral, post-licensure) please list the levels of preparation separately.

Commentary:

A) Populations. This parameter focuses on the populations served by the specialty, encompassing both individuals and groups. Examples include but are not limited to the following: children, youth and families; older adults; workforce participants and those who seek employment; men and women; racial, ethnic, and language minorities; gay, lesbian, bisexual and transgender individuals; persons of various socioeconomic status groups; religion; and those with physical and/or mental disabilities.

B) Psychological, Biological, and/or Social Problems. This parameter focuses on symptoms, problem behaviors, rehabilitation, prevention, health promotion and enhancement of psychological well-being addressed by the specialty. It also includes attention to physical and mental health, organizational, educational, vocational, and developmental problems.

C) Procedures and Techniques. This parameter consists of the procedures and techniques utilized in the specialty. This includes assessment techniques, intervention strategies, consultative methods, diagnostic procedures, ecological strategies, and applications from the psychological laboratory to serve a public need for psychological assistance.

1. Describe the advanced didactic and experiential preparation for specialty practice in each of the following parameters of practice:

   a. populations (target groups, other specifications):
   b. problems (psychological, biological, and/or social (including symptoms, problems behaviors, prevention, etc.)):
   c. procedures and techniques (for assessment, diagnosis, intervention, prevention, etc.):

Please Note: Some of the information presented below is also presented Criterion II and IV. Criterion IV also contains some additional information, particularly with respect to assessments. Much of the information presented in this Criterion is adapted from the APA curriculum we referred to previously in this petition (American Psychological Association & Jansen, 2014).

Populations

Individuals with SMI are typically adults who have the following psychiatric disorders: schizophrenia, schizoaffective disorder, bipolar illness, delusional disorders, other psychotic disorders, or depression with a significant impact on functioning. These individuals may have co-morbid, but not primary, substance use, exposure to trauma, or personality disorders. Individuals with SED are typically youth/adolescents who have early warning signs of psychosis or early onset psychosis related to the disorders above. For youth with early warning signs, this period is often referred to as the prodromal syndrome.
Those with SMI/SED are distinct from others with mental health disorders primarily because of the differences in symptomatology, the severity of their illnesses, the resultant functional limitations that occur, and the debilitating societal stigma and self-stigma that they confront. The incidence and prevalence of SMI and SED are similar across virtually every demographic that one can think of – SMI and SED strike people in all ethnic and racial groups, socioeconomic groups, both genders and gender preferences, all religions, countries of origin or in which people live, those with other conditions/disorders/disabilities, and virtually any other variable of interest.

Psychologists must possess the skills to recognize the symptoms of the disorder, correctly diagnose each person, and recognize and understand the unique aspects of these illnesses, and challenges faced by individuals with these disorders, including additional challenges that may co-exist or interact with the primary disorder. Persons with SMI/SED often face multiple challenges that add to the complexity of their illness and to their treatment, such as co-occurring physical conditions, gender identity/preference issues, socioeconomic status/difficulties. All of these can affect the behaviors and needs of an individual and can affect the way others, including health and mental health professionals, respond to them. We discuss the specialized didactic and experiential training required for psychologists to competently work with this population under c) Procedures and Techniques. This specialized didactic and experiential training is not typically provided in doctoral or post-doctoral psychology programs.

Problems

People with SMI/SED face a multitude of problems and challenges that those without these disorders do not face. These are described below according to the question posed (psychological, biological, social). Many of these problems may be faced by individuals with other mental health conditions either in less severe form or with different presenting characteristics. However, for people with SMI/SED the problems described below are more severe, make treatment more difficult and require specialized interventions. In recognition of this, evidence based and promising practices have been developed and tested specifically for this population, highlighting the unique nature of the problems faced by people with SMI/SED and the specialized assessments and interventions needed to treat them.

Psychological Problems

The psychological problems faced by those with SMI/SED can vary but most frequently include severe symptomatology such as hallucinations, delusions, extreme mood swings, disorganized thinking, and disordered or flattened affect, neuropsychological problems, trauma and severe anxiety, depression, co-morbid substance use, and problems that arise as a result of incarceration or hospitalization in forensic psychiatric facilities.

The hallmark symptoms of SMI/SED (hallucinations, delusions, extreme mood swings, disorganized thinking, and disordered or flattened affect) constitute the sine qua non of SMI; because these are so well known by every mental health professional, we do not further elaborate on them here. Other psychological problems associated with SMI/SED but less frequently familiar to professional psychologists are discussed below.

Neurologic/cognitive deficits and problems

Problems in neuropsychological functioning are common for those with SMI/SED resulting in impaired cognition and memory and an inability to function well in social, educational, and work settings (Couture, Penn & Roberts, 2006; Hurford, Kalkstein, & Hurford, 2011; Nasrallah, Keefe, & Javitt, 2014). With respect to executive functioning, learning, memory, attention, concentration, and those executive functions that control and regulate adaptive abilities and behaviors, such as initiating, monitoring and changing behavior as needed are most often affected (David, Zammit, Lewis, Dalman, & Allebeck, 2008; Green, Kern, Braff, & Mintz, 2000). In addition to these executive function deficits, aspects of cognition that are critical for social functioning and interpersonal relationships are also typically affected. Examples
of social cognition that are affected in SMI/SED include affect perception, perception of social (behavioral) cues, theory of mind, and attributional style or ability to correctly attribute the cause of events (Couture, Penn & Roberts, 2006; Galletly & Rigby, 2013). Deficits in both executive functioning and in social cognition present unique and serious obstacles to individuals who are struggling to recover from the effects of their illness and regain functional capability for education, work, and everyday social/community functioning because of their relationship to one’s ability to function well in these settings (Harvey & Strassnig, 2012; McGurk, et al., 2015).

**Psychological problems experienced as a result of trauma**

Trauma and severe anxiety are highly prevalent in people with SMI/SED; it has been estimated that as many as 90 percent of those with SMI have experienced trauma and many have had multiple exposures (Rosenberg, et al., 2001). Trauma experiences are some of the most devastating life experiences encountered by people with SMI/SED because so much of this comes at the hands of people the individual knows and trusts. Trauma can be from many sources including physical, sexual, and emotional abuse, combat or war experiences, major illness, witnessing abuse or other traumatic events happening to others, catastrophic events, etc.

Experiencing a psychotic episode for the first time can be highly traumatic and can lead to full PTSD or to PTSD symptoms. The trauma can emanate from terror experienced as a result of the psychotic symptoms themselves or from experiences encountered in the treatment system, or both (Mueser, Lu, Rosenberg & Wolfe, 2010). Many individuals are traumatized by the mental health system itself due to the stigma, lack of respect, uncaring attitudes and sometimes dehumanizing and even abusive practices that are demonstrated even today by some mental health professionals.

The severity of the trauma experienced by the majority of those in the mental health system was summarized by Jennings, 2008:

The kinds of trauma experienced by persons who are or who become recipients of public mental health services are usually not associated with “single blow” traumatic events (Terr, 1991) such as natural disasters, accidents, terrorist acts, or crimes occurring in adulthood such as rape and domestic violence (Giller, 1999). Rather, the traumatic experiences of adults, adolescents and children with the most serious mental health problems are interpersonal in nature, intentional, prolonged and repeated, occur in childhood and adolescence, and may extend over years of a person’s life. They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional and psychological abuse....They are traumatized further by coercive interventions and unsafe psychiatric environments (Jennings, 1994; Cusack, et al., 2003; Frueh, et al., 2000; Frueh, et al., 2005; Grubaugh, 2007; Robins, 2005) and at times sexual and physical abuse in inpatient or institutional settings, jails, and prisons (p. 2).

And with respect to childhood abuse/trauma, this excerpt from Herman:

The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants. Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992, p. 22).

Children and adolescents affected by traumatic experiences including severe adversity (sexual abuse, physical abuse, emotional/psychological abuse, neglect, parental death, and bullying) can develop PTSD, which is highly prevalent in those who have experienced trauma. There is accumulating
evidence that children who experience severe adversity, physical abuse and especially those who are repeatedly abused are at increased likelihood for developing psychosis (Frounfelker, Vorhies Klodnick, Mueser & Todd, 2013; Rosenberg, Lu, Mueser, Jankowski & Cournos, 2007; Shevlin, Dorahy & Adamson, 2007; Varese, et al., 2012) and that sexual trauma may even be a contributing factor in the development of psychosis for some individuals (Thompson, et al., 2014). Additionally, the more trauma a child experiences the greater the likelihood of increased severity of psychotic symptomology (Lu, et al., 2013).

Not everyone who witnesses or experiences trauma develops PTSD or less severe trauma reactions, but many do. Estimates of those who have experienced or witnessed trauma and subsequently developed a traumatic reaction range from 27 to 74 percent with reactions ranging from somatic concerns, non-specific distress, anxiety, depression, and simple or complex PTSD (Norris, 2005). Individuals experiencing their first psychotic episode who experienced physical or sexual abuse more often attempted suicide and had poorer treatment outcomes than those without similar histories of abuse (Conus, Cotton, Schimmelmann, McGorry, & Lambert, 2010). Epidemiologic research indicates that several factors play a part in determining whether or not an individual will develop a trauma related disorder. These include age at which the trauma was experienced with children being most vulnerable, emotional resilience, socio-economic status (developing versus developed country status), and severity of the traumatic event (Norris, Byrne, Diaz & Kaniasty, 2002).

Women who have experienced violence, physical, emotional, and sexual abuse and trauma often have co-occurring mental health and substance abuse problems and are at special risk (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions, 2006; Elklit & Shevlin, 2011). Homeless women are more vulnerable than homeless men, are poorer, and often have additional stressors due to child care responsibilities (Harris & Bachrach, 1990; Lenon, 2000). Homeless women with SMI have reported rates of victimization between 77 and 97 percent (Davies-Netzley, Hurlburt, & Hough, 1996; Goodman, Dutton, & Harris, 1995). Due to their increased vulnerability and poverty, women may be more often exposed to HIV/AIDS and other sexually transmitted diseases (Darves-Bornoz, Lemperiere, Degiovanni & Gaillard, 1995; German & Latkin, 2012; Jansen, Watts, Ellsberg, Heise, & Garcia-Moreno, 2002; World Health Organization, 2002; Wyatt, et al., 2002).

Severe depression resulting from trauma or from losses following onset of SMI/SED

Severe depression and despair may also result from abuse and trauma. Following onset of SMI/SED, many experience multiple losses that result in depression and can lead to despair. Losses include loss of friends, family ties, educational and work possibilities, poverty, homelessness, loneliness, poor physical health, hopelessness and loss of self-esteem – all common for people with SMI/SED and all factors that complicate the treatment of people with SMI and SED (Yanos, Roe, & Lysaker, 2010). The confluence of these factors can lead to attempted or completed suicide (Birchwood, Iqbal, & Upthegrove, 2005; Bolton, Gooding, Kapur, Barrowclough, & Tarrier, 2007; Fialko, et al., 2006; Saha, Chant, & McGrath, 2007). For people with SMI/SED, mortality due to suicide has been found to be greater than ten times that in the general population (Chesney, Goodwin, & Fazel, 2014). Additionally, and somewhat not surprisingly, research has identified depression as having a substantial impact on functional capability in persons with SMI (Sabbag, et al., 2012). Social a-motivation and anhedonia are also prominent features of SMI and both may also be related to severe depression in this population (Harvey & Strassnig, 2012; Kollias, 2008).

Co-occurring substance use

People with SMI/SED often have co-occurring substance use disorders; prevalence rates of co-morbidity range between 13 – 45% for those in contact with mental health services living in the community (Rush & Koegl, 2008). Estimates for the prevalence of concurrent substance use and mental health disorders overall range from 27 percent to more than 90 percent; the true prevalence is difficult to pinpoint exactly because many of these individuals do not access the mental health treatment system for
a variety of reasons (discussed in the section on social problems below). Most authors of literature reviews note that the prevalence of concurrent disorders in North America is quite high (Health Canada, 2002; Margolese, Malchy, Negrete, Tempier & Gill, 2004; Mueser, et al., 1998; National Alliance for the Mentally Ill, 2005; Watkins, et al., 2004). Use of psychoactive substances exacerbates the symptoms of mental illness, is a risk factor for co-morbid medical conditions, and can impede assessment and treatment for both medical conditions and for SMI/SED (Dickey, Norman, Weiss, Drake, & Azeni, 2002).

**Psychological problems associated with bipolar disorder**

It is only fairly recently that bipolar disorder (both I and II) has begun to be studied as a psychological problem. We present a very short overview of basic information about bipolar disorder because it is a serious mental health disorder for which psychosocial treatments have been developed for use in conjunction with pharmacotherapy.

A detailed discussion of the differences between bipolar disorder I and bipolar disorder II is beyond the scope of this short overview; for the purpose of this specialty petition, we consider these two variants of bipolar disorder as one disorder. The psychological problems associated with bipolar disorder include mood swings between severe depression and mania, and may include psychotic episodes, anxiety, attention-deficit hyperactivity disorder (ADHD), and substance use (National Institute of Mental Health, 2016). Because these problems are well known by psychologists, we do not discuss them further here; we present the psychosocial interventions shown to be effective for bipolar disorder later in this section under Interventions.

**Biological Problems**

The biological problems faced by individuals with SMI/SED relate to the fact that heritability is thought to account for some proportion of causation of these illnesses and investigators have found that schizophrenia may be linked to a physical process where connections between parts of the brain are “pruned” away causing brain changes that may lead to the disorder (Schizophrenia Working Group of the Psychiatric Genomics Consortium, 2014; Sekar, et al., 2016.).

Anxiety related to heritability can cause anxiety for individuals and family members potentially affected, but the main problems are physiologic ones that become apparent once the illness is manifest. In this section, we will focus on these physiologic problems. These are discussed below.

As we reported in Criterion II, the most widely recognized physiologic problem for people with SMI is the fact that on average, they die much earlier than those in the general population. Some estimates place this earlier mortality at 25 years (Schoedler & Morris, 2010), some report it as 15 - 20 years (Thornicroft, 2011), some offer 10 - 15 years as the earlier mortality mark (Lawrence, Hancock, & Kisely, 2013; National Institute of Mental Health, 2012), and others provide a large range between 13 – 30 years (De Hert, et al., 2011; Olsson, Gerhard, Huang, Crystal, & Stroup, 2015). The World Health Organization (WHO) reported the range to be between 10 - 26 years. The WHO also reported the mortality rate for schizophrenia as 2 – 2.5 times higher and thirty-five – fifty percent higher for those with bipolar disorder than for those in the general population (World Health Organization, undated). Investigators believe these reports also indicate that the mortality gap between those with SMI and the general population is widening (Cuijpers & Smit, 2002; Hiroeh, et al., 2007; Joukamaa, et al., 2001; Kisely, et al., 2007; Lawrence, Holman, & Jablensky, 2001; Lawrence, Mitrou, & Zubrick, 2009).

There appear to be three principal reasons for these premature deaths: clinical risk factors, socioeconomic factors, and health system factors (Aron, Honberg, Duckworth, et al., 2009; Mitchell, Delaffon, & Lord, 2012). Clinical risk factors are usually discussed in terms of natural causes such as cancer, cardiovascular diseases, respiratory diseases, HIV/AIDS, diabetes, etc., and unnatural causes such as suicide, injuries from violence or other traumatic events, and accidents (De Hert, et al., 2011; Horvitz-Lennon, Kilbourne, & Pincus, 2006; Mazi-Kotwal & Upadhyay, 2011).
Natural causes - respiratory diseases, cancers, diabetes and cardiovascular diseases – primarily attributable to smoking and obesity

According to one report, “80% of people with schizophrenia die from natural causes, … compared with 97% of the general population. The higher rates of the deaths from unnatural causes are largely attributable to accidents and suicide, which tend to occur more often in early than late adulthood” (Thornicroft, 2011, p. 441). We present these below; additional factors such as stigma and associated self-stigma, physician bias, racial and cultural factors, are discussed in the section on Social Problems.

Smoking

The excess rate of death from natural causes is primarily attributable to the effects of smoking and obesity. Similarly to the general population, these lead to the respiratory diseases, cancers, diabetes, and cardiovascular diseases, that cause much of the premature morbidity and mortality seen in this population (Parks, Svendsen, Singer & Foti, 2006; Schroeder & Morris, 2011). Later in this Criterion, we will also discuss the screening disparities people with SMI/SED experience for diseases such as cancer; these disparities also have obvious consequences for mortality (Howard, et al., 2010).

Almost half of the Americans who die annually from smoking related disorders have co-morbid substance use disorders and SMI/SED (Schroeder & Morris, 2010). Smoking prevalence increases with the severity of mental illness (DeLeon & Diaz, 2005; Grant, Hasin, Chou, Stinson, & Dawson, 2004; Lasser, et al., 2000). As we noted in Criterion II, the reasons for the high rate of smoking in this population are not known fully. However, smoking offers the same rewards that it does for the general population, i.e., reduction in stress, anxiety, and boredom, and opportunities for social interaction with other smokers. The postulated genetic and neurobiologic mechanisms we presented in Criterion II coupled with the highly addictive properties of nicotine, are likely the reasons why smoking is so prevalent and why, for this population in particular, it is so difficult to stop.

Obesity

Similarly to smoking, obesity is far more prevalent in people with SMI/SED than in the general population (Dickerson, et al., 2006; Parks, Svendsen, Singer & Foti, 2006). Poverty, homelessness, lack of cooking facilities, and cognitive difficulties, coupled with the iatrogenic effects of psychotropic medications which induce weight gain (Ellingrod, et al., 2012) all contribute to the prevalence of obesity.

Obesity leads to musculoskeletal disorders, pain, and resultant inability to remain active, which in turn can lead to diabetes, insulin resistance, and cardiovascular disorders; these can ultimately lead to metabolic syndrome with its increased risk of type 2 diabetes, heart attack, and stroke (Allison, et al., 2009; Parks, et al., 2006). The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study found that people using antipsychotic medications had much higher rates of metabolic syndrome than people in the general population (McEvoy, et al., 2005), putting them at significantly greater risk of the cardiovascular events that can result from the syndrome. Investigators have also suggested that second generation anti-psychotic medications may put people at risk of sudden cardiac arrest and death (Manu, 2011).

Like smoking, losing weight for people taking anti-psychotic medications has proven to be very difficult. The following from an article entitled “Do we truly appreciate how difficult it is for patients with schizophrenia to adapt a healthy lifestyle?” sums these issues up concisely:

Their efforts to eat healthfully are undermined by the appetite stimulating effect of their medications. Besides, the atypical antipsychotic medications may also promote their responsiveness to external eating cues. For these patients quitting smoking is also harder than it is for individuals without schizophrenia. Nicotine provides greater stimulation and state-
enhancement for them than it does for healthy individuals. They also have a poorer appreciation of the risks associated with smoking. Recurrent episodes of acute psychosis are frequent in patients with schizophrenia and disrupt any efforts they might make towards a healthful lifestyle.... What is unique to patients with schizophrenia is their greater difficulty in breaking the pattern of unhealthful lifestyle and preventing its consequences due to factors related to their illness and its treatment (Hasnain, Victor & Vieweg, 2011, p. 409).

Unnatural Causes

Although most deaths are from natural causes (Brown, Kim, Mitchell & Inskip, 2010), people with SMI/SED are also at increased risk of dying from unnatural causes (suicide, violence and accidents), with the majority attributable to suicide and violence (Harris & Barraclough, 1997; Hiroeh, Appleby, Mortensen & Dunn, 2001; Ösby, Correia, Brandt, Ekborn, & Sparen, 2000). Alcohol and other drug use is often a complicating factor, especially in accidental deaths (Bossarte, Simon & Barker, 2006; Khalsa, et al., 2008). Rates of premature death from suicide and violent crime have been increasing compared to the general population since the 1970s (Fazel, Wolf, Palm & Lichtenstein, 2014). Fazel and colleagues also found that compared to the general population, both men and women with schizophrenia were eight times more likely to die prematurely (before age 56), highlighting the need for much closer follow up and better treatment for this population who are at substantially elevated risk of adverse outcomes.

Suicide

The risk of suicide is greatly increased for those with SMI/SED (Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Pompili, et al., 2007). The seminal works of Harris and Barraclough (1997 and 1998) reported this risk to be 9 – 10 times greater than the risk for people in the general population; this work continues to be the most often cited on this topic today. Risk factors include previous suicide attempt or previous attempts to harm oneself, presence of depressive symptoms, involvement with the police, and being a young male at time of inpatient admission, (Appleby, Dennehy, Thomas, Faragher, & Lewis, 1999; Bakst, Rabinowitz & Bromet, 2010; Kan, Ho, Dong, & Dunn, 2007; King, et al., 2001; McKenzie & Wurr, 2001; Pompili, et al., 2007; Sinclair, Mullee, King & Baldwin, 2004). The most important clinical risk factors include:

Hopelessness, social isolation, hospitalization, deteriorating health after a high level of premorbid functioning, recent loss or rejection, limited external support, and family stress or instability are risk factors for suicide in patients with schizophrenia (Pompili et al., 2007, p. 1).

Suicide risk is greatest immediately following discharge from hospital, within 90 days of discharge (Olffson et al., 2016), and greater for those without a previous admission during the year, compared to those hospitalized more than three times in the previous year (Geddes & Juszczak, 1995; Goldacre, Seagroatt, & Hawton, 1993; Heila, et al., 1997; Lee & Lin, 2009). This is an especially difficult time for those hospitalized for the first time (Appleby, et al., 1999; Bakst, Rabinowitz, & Bromet, 2010; Lee & Lin, 2009; Pompili, et al., 2011; Walter, 2017). Pompili et al., (2007) report that the suicide risk is three times higher for adolescents or young adults with schizophrenia than for adults with this disorder.

Violence

Individuals with SMI/SED are exposed to high rates of interpersonal violence, including homicide (Carmen, Rieker & Mills, 1984; Goodman, et al., 2001; Greenfield, Strakowski, Tohen, Batson, & Kolbrener, 1994; Lipschitz, et al., 1996; Mueser, et al., 1998; Mueser, et al., 2004).

Risks for both suicide and violence are greater during the first episode of psychosis and for those who have not received treatment. Given that this appears to be a critical period for these events and that onset of SMI typically occurs during adolescence or young adulthood, it is particularly important to monitor young people closely especially following discharge from hospital.
Biologic/physiologic problems associated with bipolar disorder

The major physiologic problems experienced by individuals with bipolar disorder are a disruption in the sleep-wake cycle and the resultant difficulties that occur in maintenance of daily routines, and due to the presence of mania and depression, disruptions to energy and activity levels are also affected. Disruptions to activity and energy levels can result in concentration problems, an inability to focus and complete tasks, and other problems such as family alienation, and an inability to maintain work, education, or social relationships.

Social Problems

The social problems experienced by people with SMI/SED are many and varied. These problems are exacerbated by the psychological and physical health problems of individuals with SMI/SED. As we will show, the physical health problems that cause premature disability and death (discussed above) are exacerbated by social issues such as stigma, physician prejudice, poverty, and inability to access health care, to name just a few. The psychological, social, and health problems of people with SMI/SED who are involved with the criminal justice and forensic systems are even more difficult and are complicated by homelessness, substance abuse, physical health problems, and the double stigmas of mental illness and criminality. In the remainder of this section on social problems, we discuss some of the social problems faced by people with SMI/SED.

Stigma – the many problems that occur as a result of stigma

The impact of societal stigma and internalization of that construct on a person’s perception of self-worth, competence, and hope for the future cannot be overstated. Internalization of external stigma is often referred to as self-stigma (Corrigan & Rao, 2012; Lucksted & Drapalski, 2015). Stigma toward people with SMI/SED is experienced at all levels of society and in many settings including medical services (community clinic and hospital), housing, educational and vocational settings, social and leisure pursuits including attempts to develop intimate relationships, and more mundane daily activities such as shopping for groceries and household items, and exercising legal rights such as attempting to vote or register to vote (Walker, Klein, Hemmens, Stohr, & Burton, 2016).

Most of us are influenced by the media and unfortunately, the media perpetuates the notion that people with SMI/SED are dangerous, violent, and responsible for most mass murders. In a random sample of news articles published in the US between 1995 and 2014, McGinty, Kennedy-Hendricks, Choksy, & Barry, (2016) found an increased likelihood to mention mass shootings by people with mental illness during the time frame and many fewer news stories, only 14%, about treatment despite the remarkable advances in treatment effectiveness over the period. These authors reported that their findings mirror those from similar studies in other countries including Canada, the UK, New Zealand, and Spain. The unfortunate reality is that news coverage linking mental illness with violence increases the stigma associated with SMI/SED and can contribute to public policies that limit the rights of individuals with these disorders as well as influencing decisions about treatment funding, and funding for other needed services such as housing and substance abuse initiatives, to name but a few (McGinty, Webster, & Barry, 2013).

There are very real consequences for people with SMI/SED as a result of the stigma they experience from most members of society, including professionals, family members, legal entities, the media, and members of the community at large. While stigma, fear, and the discrimination that can result may seem obvious to many and are thought to underlie attitudes, beliefs, and actions at personal, institutional, and structural levels (Corrigan, Druss, & Perlick, 2014), these are constructs that are difficult to link directly to overt action. Most studies have been undertaken in the health care arena; below we review those that focus primarily on this setting.
**Stigma and health care issues**

Access to health care is impacted by stigma from health care systems and health outcomes are negatively affected (Anderson & Kurdyak, 2016). People who are stigmatized internalize that stigma and can be reluctant to seek treatment and adhere to treatment recommendations leading to increased illness severity. Self-stigma leads to decreased self-esteem, quality of life and social support (Livingston & Boyd, 2010) and can result in reluctance to pursue educational, vocational and social goals (Clement, et al., 2014; Corrigan, et al., 2014; Corrigan & Shapiro, 2010). Illness identity, or the internalization of being an ill person affects self-esteem and sense of hope, leading to depression, isolation, and suicidal ideation. Yanos, et al., (2010) characterized this by the figure below which describes these relationships.

Impact of Illness Identity on Recovery-Related Outcomes (Yanos, Roe, & Lysaker, 2010).

Those with SMI/SED face considerable discrimination and stigma in the health system and this includes the mental health system from treatment providers (Corrigan, et al., 2015; Druss, Bradford, Rosenheck, Radford, & Krumholz, 2000; Joy, Clement, & Sisti, 2016; Koroukian, Bakaki, Golchin, Tyler, & Loue, 2012; Sullivan, Han, Moore, & Kotrla, 2006; Thornicroft, 2013). In the discussion we presented in Criterion II we mentioned a highly publicized study that bears repeating here. Joy and colleagues (2016) found some professionals using electronic medical information systems to code the records of individuals with psychiatric disorders who are seen frequently with various icons or other notations, including using icons designating these individuals are “frequent flyers”. Such disparaging labelling can influence the way people are treated by professionals at all levels in the health and mental health system.

Poverty, unemployment, homelessness, and lack of health insurance are characteristic of persons with SMI/SED and have been shown to negatively affect health (Bergland, 2016; Pickett & Wilkinson, 2015; Rözer, Kraaykamp, & Huijts, 2016; U.S. Government Accountability Office, 2007). Stress associated with social exclusion can have pronounced psychological effects and impact negatively on physical health status. Most now acknowledge the power of social support; people lacking friends, a sense of community, and social support tend to have more physical health problems and adverse outcomes (Cacioppo & Hawkley, 2003; Cattell, 2001; Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Holt-Lunstad, Smith, & Layton, 2010; Szreter & Woolcock, 2004; Toussaint, Shields, Dorn, & Slavich, 2016).

As we have previously noted in this section and elsewhere in the petition, people with SMI/SED have poorer health status. The reasons for this range from cognitive impairment/deficits, to medication side effects, and also include such social factors as social disadvantage, racial bias, language or other cultural factors, physician stigma leading to somatic complaints not taken seriously, and self-stigma, leading to individuals’ embarrassment and reluctance to make and keep genera medical appointments.

**Stigma, health care, and racial/cultural issues**

Disparities in mental health and physical health care are influenced by a variety of factors, including the race/ethnicity of the individual.

The Supplement to the U.S. Surgeon General's report (1999) reported:

Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality.... A major finding of this Supplement is that racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their over-all health and productivity (U.S. Department of Health and Human Services, 2001, p. 3).

Since publication of the Supplement, multiple authors have offered similar conclusions (Alexandre, Martins & Richard, 2009; Atdjian & Vega, 2005; Compton, et al., 2009; Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006; Mallinger, Fisher, Brown & Lamberti, 2006; Moran, 2014; Rost, Hsieh, Xu, Menachemi, & Young, 2011; Snowden, 2003; Whitley & Lawson, 2010; Williams & Mohammed, 2009).

African Americans and Hispanics are less likely to receive guideline-based treatment (Wang, Berglund, Kessler, 2001; Wang, Demler, & Kessler, 2002; Whitley & Lawson, 2010; Young, Klap, Sherbourne & Wells, 2001); this extends to prescription of antipsychotic medication, as ethnic minorities are less likely than non-ethnic minorities to receive newer antipsychotic medications (Puyat, et al., 2013), and African Americans often do not receive appropriate medications or the appropriate dose of a medication (Blazer, Hybels, Simonsick & Hanlon, 2000; Chung, Mahler & Kakuma, 1995; Kuno & Rothbard, 1997; Lawson, 1999; Mallinger, et al., 2006; Melfi, Croghan, Segal, Bola & Watson, 2000; Sclar, Robinson, Skaer & Galin, 1999; Snowden & Pingatore, 2002; Walkup, et al., 2000).

There is evidence that physicians and other providers hold biases that impact their interpretation of presenting behaviors and symptoms, and these biases subsequently impact on the clinical judgments they make (Moy, Dayton & Clancy, 2005). Several authors have suggested practitioner bias as one of the major reasons why people with SMI/SED and those from racial and ethnic minorities more often receive sub-standard care (Ahn, Proctor & Flanagan, 2009; Atdjian & Vega, 2005; Osborne, 2001; Snowden, 2003). Practitioners may not recognize their own biases and if they do, are likely to be reluctant to admit it (Burgess, van Ryn, DoVIDio & Saha, 2007). Provider bias can be especially important when consumer characteristics such as poverty, reluctance to accept treatment, take medications, or “adhere” to recommendations are expressed (Mazi-Kotwal & Upadhyay, 2011; Snowden, 2003).

The pervasive effects of stigma and the vulnerability of individuals who are ill can make it difficult for people with SMI/SED to seek help (Mazi-Kotwal & Upadhyay, 2011; Thorncroft, 2011); they may miss appointments, drop out of treatment (Atdjian & Vega, 2005), or appear hostile, fearful and uncooperative, reinforcing a provider’s biases. When racial and ethnic differences or language barriers are added, the result can be less than optimal and potentially damaging for the person who needs assistance, ultimately leading to the observed disparities in treatment.

**Criminal justice and forensic system issues**

Please Note: There are often critical distinctions within the forensic and criminal justice systems. For the most part, forensic psychiatric hospitals provide at least minimal levels of treatment, i.e., psychotropic medications (sometimes over medicating individuals), traditional assessment, and varying kinds and levels of interventions. In some jurisdictions, the forensic system refers to inpatient settings while in
others, it refers to the totality of the criminal justice system. In some settings, jails, prisons, mental health courts, jail diversion programs are considered to be part of the forensic system, while in others, they are called by a different system name. On the other hand, jails and prisons, despite their status as the largest “warehouser” of individuals with mental health disorders, often provide little to no treatment (although in rare cases, some jails/prisons have become designated mental health providers) and sometimes keep individuals (particularly those with disabilities of all kinds) in isolation, padded cells, etc., with no access to toilet facilities, fresh air, exercise, medication, or other essentials of human life, except for food passed through a small opening in the door. We use these terms interchangeably in the petition to avoid the lengthy discussion of these distinctions that would be required if both systems were discussed separately.

People with SMI/SED confront many challenges with respect to the criminal justice and forensic systems. Many individuals with SMI/SED are homeless or are at risk of becoming homeless, use alcohol or other drugs, are likely to be poor, socially isolated, and vulnerable; most have been abused and traumatized. They are at high risk of incarceration, often for vagrancy or petty crimes (Draine, Salzer, Culhane, & Hadley, 2002; Greenberg & Rosenheck, 2008).

Authors of a 2014 systematic review of studies looked at the prevalence and intersection of mental illness, homelessness, gender, victimization, and involvement with the justice system and found high consistency among the studies reviewed for the prevalence of these variables within a majority of the population. The authors noted the high levels of victimization in this population, especially among women, reinforcing the need for gender specific trauma services for this population. The authors also noted the paucity of literature on victimization contrasted with the much greater literature on perpetration of crime, calling attention to the double stigma surrounding mental illness and involvement with the justice system. The high rates of contact with the criminal justice system among people with SMI/SED who are homeless also serves as a call for urgent attention to ensuring stable housing for this population. (Roy, Crocker, Nicholls, Latimer & Ayllon, 2014). Because of the complexity and overlap of the multitude of problems faced by people with SMI/SED in the forensic/criminal justice system, we discuss each of these issues separately.

**Prevalence of SMI/SED in the criminal justice/forensic systems**

As we indicated in Criterion II, the prevalence of people with SMI/SED in justice related settings is considerable. It is higher than the overall prevalence of persons with SMI/SED in the population with incarceration rates estimated to be about 20% (American Psychiatric Association, 2000). Cusack, Morissey, Cuddeback, Prins & Williams (2010) summed this up as follows:

Recent estimates suggest that over one million people with serious mental illness (SMI) are booked into U.S. jails each year resulting in an overall prevalence rate of 15% for men and 31% for women (Steadman, Osher, Robbins, Case, & Samuels, 2009). In fact, the odds of a person with SMI being jailed are significantly greater than the odds of being hospitalized (Morrissey, Mayer, & Cuddeback, 2007). Individuals displaying symptoms characteristic of mental illness were found to have a 67% higher probability of being arrested than individuals not displaying such symptoms (Teplin, 1984, 2000). Moreover, after this initial arrest, individuals with SMI are more likely to be detained in jail (as opposed to released on own recognizance or have cases dismissed), and once jailed, stay incarcerated 2.5–8 times longer in comparison to their non-mentally ill counterparts (Council of State Governments, 2005, p. 356–357).

Seventy five percent of those in these systems who have SMI/SED have co-occurring substance use disorders, most are in poor physical health, many are homeless or at high risk of homelessness, most have a history of exposure to severe trauma, and more women and African American men with mental health disorders are incarcerated (Almquist & Dodd, 2009; American Psychiatric Association, 2000; Beck, Karberg & Harrison, 2002; Cusack, et al., 2010; Durose, 2003; Gunter, et al., 2008; Harrison & Beck, 2002; Harrison & Karberg, 2003; Konrad, 2002; McNiel, Binder & Robinson, 2005; Parsons &
Sandwick, 2012; Peters, Bartoi & Sherman, 2008; Prins & Draper, 2009). These factors are further complicated by the fact that the offenses committed by ill people who are incarcerated range from petty crimes (sometimes committed to obtain money for drugs or deliberately to obtain shelter in jail), to very serious crimes such as murder, rape, severe assault and battery, arson, etc. Sometimes people with SMI/SED are picked up by police simply because their symptomatic behavior is mistaken for criminal activity.

**Homelessness and the criminal justice/forensic systems**

While many mental health professionals are aware that people with SMI/SED are often homeless or at high risk of becoming homeless, the fact that many homeless individuals with SMI/SED also end up in the forensic/criminal justice system is less well recognized.

In a country where there is no jurisdiction where minimum wage earners can afford the lowest Fair Market Rent, and where rates of homelessness are rapidly growing, it is increasingly difficult to avoid jail as a substitute for housing (The National Coalition for the Homeless and the National Law Center on Homelessness & Poverty, 2002).

Since the closing of the large state mental hospitals in the mid to late 1960s and the failure of the community mental health movement largely due to inadequate funding, many people who would otherwise have been in the state hospitals find themselves living on the street and increasingly addicted to alcohol and or drugs. People who are homeless are often picked up for vagrancy, petty crimes, drunkenness or behavior resulting from drug use, or because they appear to be a danger to themselves or to others. In addition to being homeless, these individuals are often seriously ill, addicted, and most have experienced severe trauma (Folsom, et al., 2005; Greenberg & Rosenheck, 2008; Wenzel, Koegel & Gelberg, 2000). The fact that many are poor, socially disadvantaged, and often unemployed, compounds their situation (Draine, et al., 2002) and increases their chance of re-offending.

**Substance abuse and the criminal justice/forensic systems**

According to SAMHSA’s GAINS Center:

People with co-occurring mental health and substance abuse disorders are often excluded from treatment programs. Consequently many get caught up in the criminal justice system....In addition to a range of negative consequences (e.g., more frequent hospitalizations and higher suicide rates), co-occurring mental health and substance abuse disorders are also associated with poor social functioning, homelessness, violence, arrest, and incarceration. Criminal offenders with co-occurring disorders often display aggressive and violent behavior, have long histories of institutionalization, and exhibit a diminished ability to function independently in jail, prison, or community correction settings (undated, p. 2).

A very high proportion of those with SMI/SED who are incarcerated have co-occurring substance use disorders with estimates ranging from 50 to 78% (American Psychiatric Association, 2000; Gunter, et al., 2008; McNiel, et al., 2005; Peters, Bartoi & Sherman, 2008; Prins & Draper, 2009). Because use of alcohol and other drugs can lead to risky health behaviors and criminal behavior, timely assessment and treatment are critical but unfortunately, this is not typically the case (Peters, et al., 2008). The chief reason is that the criminal justice system is not well-equipped to address the multiple needs of this population. The system does not have adequately trained mental health personnel, few specialized treatment programs exist in forensic settings, resources for proper transition planning and follow up are lacking, risk management is seen as the principal mandate, and like other social services, the budget is cut repeatedly (Peters, et al., 2008; Prins & Draper, 2009). Partly due to these factors, those with co-occurring mental illness and substance use disorders who have been incarcerated continue to fall through the cracks, and continue using alcohol and other drugs. Those using drugs but not taking prescribed medication have been found to be responsible for more violent crimes, leading to the
sensationalization of news stories about people with SMI/SED (McNiel, et al., 2005; Reuland, Schwarzmfeld & Draper, 2009).

**Trauma in the criminal justice/forensic systems**

A large majority of people with SMI/SED who have been incarcerated have experienced trauma either before being incarcerated, during incarceration, or both (Kooymann, Dean, Harvey & Walsh, 2007). The rate of exposure to violence and the traumatic effect of this exposure is so high for people involved in the criminal justice system, and in particular for women, that most consider it the norm rather than the exception (Osher & Steadman, 2007; Saxena, Messina, & Grella, 2014; Wright, Van Voorhis, Salisbury, & Bauman, 2012). Once inside prison, both men and women with mental health disorders are also often subjected to physical violence and are more likely to be victims of violence than incarcerated persons without mental illnesses (Blitz, Wolff & Shi, 2008). Although less frequent, this can also be the case for those in forensic psychiatric hospitals.

Because jails and prisons (and to a lesser extent forensic psychiatric hospitals) can be highly dangerous environments and particularly so for people with SMI/SED, individuals often develop adaptive behaviors that help them survive (Rotter, McQuiston, Broner & Steinbacher, 2005). Most treatment providers are unaware of the need for such adaptation and the ensuing behavioral and attitudinal changes that these individuals must make to survive. The result is that providers see such behaviors as resistance, lack of motivation, pathology, or symptoms of the person’s mental illness making communication and establishment of trust difficult, and impeding treatment provision and transition to successful community life. Mental health providers need to be educated about life in correctional facilities and need to understand the reasons why people adopt the attitudes and behaviors they do in order to survive in these frequently abusive situations. The effects of trauma are so severe that psychologists and other mental health providers must use extreme care to avoid re-traumatizing individuals.

Due to the deplorable conditions people with SMI/SED encounter in jails and prisons, severe traumatization occurs frequently. We provided this excerpt from Fellner (2006) in Criterion II; we believe it is worth repeating here:

All too often, seriously ill prisoners receive little or no meaningful treatment. They are neglected, accused of malingering, or are treated as disciplinary problems. Without the necessary care mentally ill prisoners suffer painful symptoms and their conditions can deteriorate. They are afflicted with delusions and hallucinations, debilitating fears, and extreme and uncontrollable mood swings. They huddle silently in their cells and mumble incoherently or yell incessantly. They refuse to obey orders or lash out without provocation. They assault other prisoners or staff. They beat their heads against cell walls, smear themselves with feces, self-mutilate, and commit suicide (p. 137). ... Security staff typically view mentally ill prisoners who break rules and act out as difficult and disruptive. Whether as punishment or simply an administrative housing decision, officials often place them in barren high-security solitary confinement units. The lack of human interaction and the limited mental stimulus of twenty-four-hour-a-day life in small, sometimes windowless segregation cells, coupled with the absence of adequate mental health services, dramatically aggravate the suffering of the mentally ill. Some deteriorate so severely that they must be removed to hospitals for acute psychiatric care. But after being stabilized they are returned to the same segregation conditions, and the cycle of decompensation begins again. The penal network is thus not only serving as a warehouse for the mentally ill, but, by relying on extremely restrictive housing for mentally ill prisoners, it is acting as an incubator for psychiatric breakdowns (p.140).
According to Disability Rights Washington (2013):

People with mental illness, developmental disabilities, and traumatic brain injuries are being held in county jails from several weeks to months awaiting evaluation or restoration of their competency to stand trial (p. 3).

In 2006, a national study by the Bureau of Jail Statistics found jail inmates with mental illness were twice as likely as those without to have been charged with facility rule violations (19% compared to 9%) (James and Glaze, 2006). … The study further showed individuals in local jails with diagnosed mental health issues can be subject to sexual or physical abuse by higher functioning inmates. Jail inmates who had a mental health issue (24%) were three times as likely as jail inmates without (8%) to report being physically or sexually abused in the past. As a result, individuals with mental health issues are more likely to be placed in segregation or have even more restrictions on their movement (Disability Rights Washington, 2013, p. 8).

Traumatization of people with SMI/SED, and indeed people with disabilities of all kinds, is significantly increased when they are subjected to the conditions imposed on them by most jails and prisons in the US.

There are few if any forms of imprisonment that appear to produce so much psychological trauma and in which so many symptoms of psychopathology are manifested as isolation (Haney, 2003).

A recent report from Disability Rights Washington (2016) reinforced the psychological trauma experienced by people subjected to the harsh conditions imposed on them:

Research reveals that inmates placed in these harsh conditions often experience intense mental and physical distress; for inmates with mental illness, these conditions can have a catastrophic impact. Inmates in segregation routinely report extreme sensory deprivation, sleep deprivation, psychiatric decompensation, hallucinations, and behaviors relating to self-harm and even suicide (http://solitarywatch.com/2014/08/04/what-solitary-confinement-does-to-the-human-brain/).

Because prison staff that work on these units often have little to no training related to working with inmates with mental illness, reports have found it is not unusual for prisons to employ chemical agents such as pepper spray or physical restraints to curtail or control the behaviors of inmates with mental illness in segregation (American Civil Liberties Union, 2014) (Disability Rights Washington, 2016, p.16).

**Women in the criminal justice/forensic systems**

For reasons that are not clear at present, the prevalence of women with SMI/SED is higher in forensic populations than that of men, typically estimated to be roughly twice as high at approximately 31 percent compared to 15 percent for men (Almquist & Dodd, 2009; Blitz, Wolff, Pan & Pogorzelski, 2005; Ditton, 1999; Parsons & Sandwick, 2012; Sabol & Minton, 2008; Steadman, et al., 2009).

We noted previously that due to their increased vulnerability, women with SMI/SED are at special risk for physical and sexual violence, trauma, risky sexual encounters, and incarceration (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions, 2006; Darves-Bornoz, et al., 1995; Elklit & Shevlin, 2011). Compared to non-incarcerated women with mental health disorders in the forensic/criminal justice system, they have more symptoms related to addiction, antisocial personality disorder, and post-traumatic stress disorder. Incarcerated women are more likely to have had traumatic experiences, including early sexual and physical abuse, than incarcerated men but equally likely to have substance abuse disorders (Lewis, 2006; Saxena, et al., 2014). For women with SMI/SED who are in contact with the justice system, severe abuse and trauma are considered the norm and more women than men with SMI/SED are abused in prisons (Wolff, Blitz, & Shi, 2007). Researchers have found that 97% of homeless women with mental illness experienced severe physical and/or sexual abuse; 87%
experienced this abuse both as children and as adults (Goodman, et al., 1995; 1997; Wright, et al., 2012).

Racial and cultural factors in the criminal justice/forensic systems

Both African Americans and Hispanics are over-represented in forensic psychiatric hospitals and in jails and prisons. Researchers have reported these settings to be some of the largest treatment venues in the US for people with SMI/SED (Lindsey & Paul, 1989; Rosenhan, 1984; Whitley & Lawson, 2010).

There are many cultural factors that must be considered when an individual with SMI/SED interacts with the forensic/criminal justice system. Cultural factors may influence the responses an individual provides and the way in which law enforcement personnel and mental health professionals respond to and interact with the individual. The impact of a person’s cultural background can have profound effects on many areas of his or her life.

People who are not from the majority (White) culture are often perceived and treated differently by criminal justice authorities and the forensic system in the US. Social determinants of health, education, employment, housing, socio-economic status, mental illness and other aspects of life in the US confound these perceptions and treatment. (Primm, et al., 2010; Thompson, 2011). African Americans are more likely to be labeled as criminals when they are suffering from SMI/SED; this may account for their overrepresentation in the system (Foulks, 2004). African Americans of all ages are also more likely to be the victims of serious violent crime than are Caucasians (U.S. Department of Health and Human Services, 2001). African American and Hispanic individuals who have SMI/SED and are incarcerated also report higher rates of sexual victimization than White individuals with similar illnesses who are incarcerated (Wolff, et al., 2007).

People of color often leave the criminal justice system without having had an assessment or any treatment for their illness and without needed medications, funds to pay for living expenses, or referral to health services. As a result, many find themselves repeatedly recycling through the criminal justice system (Foulks, 2004).

Religion, beliefs about mental illness, its etiology, and its acceptability may influence the individual’s willingness to speak with professionals about his or her life circumstances. The beliefs and values that a person is taught and grows up with can have considerable influence on the ways behavior is viewed, acceptability of seeking or accepting mental health services, the ability of women and young people to speak for themselves, establish goals, determine skills they wish to develop, etc. Language barriers have a profound effect on ability to communicate the many important facets of a person’s life and background.

Immigrants and refugees in the criminal justice/forensic systems

More than 350,000 immigrants are detained by immigration officials each year. It is not known how many of those individuals have a mental health disorder, nor is it known how many are detained even though a court has found they need inpatient mental health treatment. Many of these persons are sent to detention centers, jails or prisons where they frequently are not provided assessment or medication, receive little care and are often segregated in isolation (Venters & Keller, 2012). As we have seen, segregation and isolation further exacerbates mental illness.

The experience of refugees deserves additional discussion. In addition to the multitude of problems experienced by immigrants and other newcomers, most refugees have endured extreme abuse at the hands of those in authority (Birman, et al., 2005; Ellis, Miller, Baldwin & Abdi, 2011). As a result, refugees generally do not trust people in authority or those who work in institutions or systems where the rules and procedures are determined by someone seen as having power. This is highly relevant and
important for people who are detained in the forensic/criminal justice system. Refugees may experience extreme fear and perceive that they and their families are in imminent danger.

For several reasons, immigrants and refugees risk being sent into the forensic/criminal justice system. Lack of language capability, cultural factors that may impede cooperation with authorities, intense fear, and little understanding of what is happening to them and their families, especially when SMI/SED is present, all make for a situation that easily leads to incarceration. Several investigators have reported that an estimated 92% of immigrants and refugees who need mental health services will not receive them (Birman, et al., 2005; Ellis, Lincoln, Charney, Ford-Paz, et al., 2010; Kataoka, Zhang & Wells, 2002).

**Homelessness**

Having a place to live is one of the most fundamental and important aspects of life. Yet, people with SMI/SED are often either homeless or at risk of becoming homeless (Padgett, 2007). Many believe that having decent, stable, affordable housing of one’s choice is the first step toward achieving recovery. For this reason the slogan “Housing First” has developed as one of the cornerstones of recovery services and the approach is taking hold across the US. (Koh & O’Connell, 2016).

The impacts and challenges of being homeless or at risk of losing a place to live can be overwhelming. These include obtaining and storing basic necessities such as food and water, obtaining safety and shelter, ensuring children are safe, warm, have food, and other essentials, are among just some of the daunting challenges faced. If one has SMI/SED, access to health care and other services may be restricted without an address, enhancing the probability of increasing symptomatology (Koh, & O’Connell, 2016). Homelessness is a serious complicating and additive factor for those with SMI/SED due to the added insecurity, fear, and trauma from risks such as victimization, physical and sexual abuse, and criminal activity (Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011; Hopper, Bassuk, & Olivet, 2010).

**Biologic/Physiologic Problems Associated with Bipolar Disorder**

The social problems experienced by individuals with bipolar disorder are a result of the physiologic problems of the disorder (disruption in the sleep-wake cycle, disruptions to energy and activity levels) that result in disruptions to daily routines, family alienation, concentration problems that lead to an inability to focus and complete tasks, often resulting in loss of education and work opportunities, and loss of friends and other social relationships.

As with other serious mental illnesses, all of these difficulties frequently lead to stigma and self-stigma, social isolation, poverty and increased vulnerability.

c) **Procedures and Techniques:**

Please Note: Additional information and resources for procedures and techniques can be found in Criteria IV, V, and VI and in the APA Curriculum we previously referenced (American Psychological Association & Jansen, 2014).

**Didactic Training**

The didactic preparation required for treating this population differs markedly from that required to treat individuals with other mental health disorders and includes the following:
Specialized assessment instruments to determine:

- The strengths of each person
- The functional challenges faced
- Resources available to or needed by each person
- The impact on individual, family, and friends as a result of the person’s symptoms and society’s reaction to these symptoms.

Specialized interventions designed, developed and empirically validated or adapted specifically for this population to help individuals as they work to ameliorate the very different challenges they face. The 2009 Schizophrenia Patient Outcomes Research Team (PORT) (Kreyenbuhl, Buchanan, Dickerson & Dixon, 2010) study remains the most rigorous and undisputed summary of efficacious interventions to date. The PORT study identified 8 evidence based practices (EBPs) and 4 promising practices. These are:

- Assertive community treatment
- Supported employment
- Family psychoeducation
- Cognitive Behavioral Therapy (CBT) and CBT for psychosis (CBTp)
- Token economy
- Skills training
- Psychosocial interventions for alcohol and substance use disorders
- Psychosocial interventions for weight management
- Medication/illness management
- Cognitive remediation
- Psychosocial treatments for recent onset schizophrenia
- Peer support and peer-delivered services.

In addition to the 12 practices identified by the PORT study, several other interventions developed or adapted for this population are the subject of continuing research with several considered effective. These include:

- Interventions for trauma
- Interventions for individuals with SMI and SED in the criminal justice system and forensic institutions
- Interventions for those who are homeless or at risk of homelessness
- Interventions to reduce stigma, social isolation, and community exclusion
- Suicide and violence prevention interventions.

Training in other specialized topics including the following is also needed by psychologists who work with this population:

- Methods for engaging individuals with SMI and SED, their families and support systems in treatment
- Treatment planning methods that differ from traditional treatment planning
- The most appropriate methods for conducting research with and for this population
- Methods for changing mental health systems to incorporate a recovery and psychosocial rehabilitation perspective.

In order to impart knowledge in these specialized areas, training materials that are up to date, fully referenced and that adequately address the relevant topics must be used. A few examples of training materials include the following:

**Texts such as:**

- *Clinical Handbook of Schizophrenia* (Mueser & Jeste, 2008)
- *Illness Management and Recovery Implementation Resource Kit* (Gingerich & Mueser, 2010)

**Articles found in journals such as:**

- American Journal of Psychiatry
- BMJ
- JAMA Psychiatry
- Schizophrenia Bulletin
- Schizophrenia Research
- Psychiatric Services
- Psychiatric Rehabilitation Journal
- Psychological Services
- World Psychiatry.

**Training curricula such as:**

- APA's *Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders* (American Psychological Association & Jansen, 2014)
- *Person-centered Care: From Theory to Practice* (Tondora, 2011)
- *Practice Guidelines for Recovery-Oriented Behavioral Health Care* (Tondora & Davidson, 2006)

**Other similar materials developed to meet specific training needs such as:**

- U.S. Department of Veterans Affairs *Behavioral Family Therapy for Severe Mental Illness Clinician Training DVD/CD Instructional Set* (Niv, Hassell, Frousakis, & Glynn, 2013).
Experiential Training

First and foremost, the experiential preparation required for effectively working with this population requires development of the empathic response capability needed to truly understand how it feels to have a serious mental illness, be shunned, isolated, be terrified by your own thoughts and experiences, be forced to take medication whose side effects can be debilitating, be rejected by family and friends, lose educational and work opportunities, live in poverty, be discriminated against by police, forensic personnel, and members of the community in which you live, and experience the self-stigma that comes from believing that those who want nothing to do with you are in fact correct because your problems and behavior are the result your own weakness, poor judgment, and inability to manage or control your symptoms. Without specialized training and exposure to people with SMI and SED and the challenges they face, most psychologists (and other mental health providers) do not develop this understanding no matter how good their training program may be.

Development of this understanding can be accomplished by working closely with individuals who are affected, talking with and listening to them, their family members, other individuals who are close to them and who support them, and doing so from the perspective of attempting to understand what they are experiencing. This is a different perspective than the clinical one that psychologists will traditionally adopt as clinicians and is a necessary pre-cursor to the specialized clinical training also required. Additional experiences such as accompanying people with SMI/SED on visits to seek community housing, employment, voter registration, etc., and doing so not as an advocate but as a bystander to observe the functional limitations of individuals and the reaction of those spoken to can also help to develop the empathic understanding needed to help people with these conditions.

Once a true understanding of the unique challenges faced by those with SMI and SED is reached, psychologists must then become accomplished at delivering the assessments and treatments specifically developed, tested, and found efficacious for this population.

Assessments and Interventions Specific to SMI/SED

Assessment – General:

- Selection, administration, scoring and interpretation of psychological tests for SMI/SED persons
- Integrating data and preparing written reports specific to SMI/SED population
- Dissemination of psychological test findings to individual and relevant stakeholders

Assessment – Specific:

Please Note: For an excellent overview, see the chapter by Glynn and Mueser (in press) which presents a comprehensive review of the many instruments available for use in assessing persons with SMI/SED and presents information about their psychometric properties. We list again here some selected assessments that post-doctoral residents would learn (also listed in Criterion V). Following the listing, detailed information about culturally informed, strengths based and functional assessments, also an integral part of the didactic and experiential training, is provided. For the sake of brevity, we do not present detailed information about the more well-known assessment instruments.

- **Culturally informed assessment**

  The DSM 5 Cultural Formulation Interview
- **Symptom assessment/diagnostic assessment**
  - Structured Clinical Interview for DSM-5 (SCID-5)
  - The Brief Psychiatric Rating Scale (BPRS)
  - Scale for the Assessment of Negative Symptoms and Positive Symptoms (SANS-SAPS)
  - The Positive and Negative Syndrome Scale (PANSS)
  - The Revised Behavior and Symptom Identification Scale (BASIS-R)
  - Mini International Neuropsychiatric Interview (MINI)
  - Clinician Administered PTSD Scale (Schizophrenia) (CAPS-S)
  - Clinical Assessment Interview for Negative Symptoms (CAINS)
  - Brief Negative Symptoms Scale (BNSS)

- **Cognitive screening/evaluations**
  - Mini–Mental State Examination (MMSE)
  - Montreal Cognitive Assessment (MoCA)
  - Brief Neurocognitive Assessment (BNA)
  - Cognitive Assessment Inventory (CAI)
  - The MATRICS Consensus Cognitive Battery (MCCB)
  - Standard neuropsychological measures

- **Decision making capability/capacity**
  - Aid to Capacity Evaluation (ACE)
  - MacArthur Competency Assessment Tool for Treatment (MacCAT-T)

- **Strength based assessment**
  - The Self-reported Quality of Life Measure for People with Schizophrenia
  - The Client's Assessment of Strength, Interests, and Goals (CASIG)
  - The Psychosocial Rehabilitation Services Toolkit

- **Readiness assessments**
  - Psychiatric Rehabilitation Training Technology - Readiness Assessment

- **Functional assessment**
  - The University of California San Diego Performance-based Skills Assessment (UPSA-B)
  - Specific Levels of Functioning (SLOF)
  - The Multidimensional Scale of Independent Functioning (MSIF)
  - The Maryland Assessment of Social Competence (MASC)
  - Camberwell Assessment of Need (CAN)
The importance of strengths-based and culturally relevant assessment

In the following, we present detailed information about specialized assessments for which psychologists typically do not receive training. These culturally-informed, strength-based, and functional capability assessments are distinct from assessments that assess symptomatology, pathology, and enable diagnosis. Specialized culturally-informed, strength-based, and functional capability assessments should be part of the repertoire of psychologists who work with persons with SMI/SED.

Assessments for use with people with SMI and SED are those that measure strengths, functional capabilities, and resource needs and availability. Traditional clinical assessments on the other hand, to a large degree, focus on a person’s deficits: psychiatric diagnosis, problematic symptoms and behaviors, failures in social, educational and vocational pursuits, and difficulties experienced in living. Traditional clinical assessments rarely include questions about the circumstances of the person’s life such as his or her living situation, family dynamics, socio-cultural environment, and the context in which all of these occur. A traditional clinical assessment also rarely asks questions about the positive aspects of the individual or the person’s life and generally do not emphasize the strengths, resilience, and accomplishments of the person. The focus of a traditional clinical assessment is on the person’s illness and the ways this has negatively impacted the individual’s life. This negative focus colors personal interactions and future service plans, focuses interventions solely on the individual, his or her deficits, and reinforces an illness mentality (Slade, 2010).

Strengths-based and functional assessments provide psychologists with information most useful for helping a person recover from the oftentimes devastating effects of SMI/SED and achieve a satisfying life. Such information is comprised of the individual’s strengths, goals, skills and challenges, available resources, environmental context, experience of daily life, and the sociocultural factors that provide the context for his or her experiences (Davidson, Rowe, Tondora, O’Connell, & Lawless, 2008; Pratt & Mueser, 2011).

Understanding a person’s lived experience is crucial to assisting the person with the recovery process. In order to do this, many psychologists and other mental health practitioners now acknowledge that a more comprehensive and positive approach that looks beyond the individual and his or her symptoms and diagnosis is important for helping the person think about the future, decide what his or her goals are, what kind of life the person wants to have, and determine the best ways to achieve those goals (Davidson, et al., 2008; Farkas, Sullivan Soydan & Gagne, 2000; Pratt & Mueser, 2011). This is after all, the way that most people approach the process of planning future goals: people use their strengths and
successes to develop future aspirations and goals, and build on those strengths and successes to accomplish new goals.

A strengths-based assessment approach recognizes that every individual has capabilities, accomplishments and potential, and considers positive factors in the person’s surrounding environment such as his or her natural support network including family strengths, community supports, and social service system network. These characteristics mean that each person has the potential for future accomplishments that will facilitate continuing to attain the life he or she wishes to achieve (Davidson, et al., 2008; Farkas, et al., 2000).

In addition to gathering information about the individual’s strengths, accomplishments, functional capabilities, and resiliencies, information is sought regarding resources within the individual’s family, his or her support network, and community at large. Assessment is conceptualized broadly to include one’s skills and talents, community and environmental resources, cultural knowledge and lore, knowledge gained from struggling with adversity, as well as knowledge gained from educational or occupational endeavors. Information from each assessment is shared openly with the individual and his or her family, when the person has given consent for information sharing with the family and or others (Tondora, 2011). A strengths-based approach recognizes that every individual, no matter how severe the person’s illness might be, has the capacity to continue to learn and develop (Davidson, et al., 2008). Competency-building and promoting mental wellness are complementary approaches that should be used in conjunction with treatment interventions (Miles, Espiritu, Horen, Sebian & Waetzig, 2010).

Determining an individual’s strengths and capabilities is important for children and young people as well. The Outcomes Roundtable for Children and Families (a consortium of researchers, youth, family members, providers, and policymakers) identified important outcomes that all families want for their children, and noted that families seeking services for children with mental health concerns want services that promote the development of competencies, and functional lifetime outcomes. This focus transcends symptom reduction, and goes beyond reduction of deficits (Bellonci, Jordan, Massey, Lieberman, Zubritsky & Edwall, 2012). For psychologists, learning to conduct comprehensive ecological, functional, strengths-based assessments requires a paradigm shift that is fundamental to the concept of recovery, i.e., the notion that people with SMI/SED have considerable resilience and strengths that can be used to build successive accomplishments and that psychologists and other mental health practitioners are partners in helping to enhance the skills and resources already inherent in each person.

This is a new way of thinking about and working with people who have SMI/SED and may be challenging for psychologists who have been trained to view people with such illnesses as individuals who have few residual strengths and little potential for leading a satisfying life. This shift in thinking also requires a different set of tools and techniques from those typically learned by psychologists. Specialized training is needed to accept and use these new methods.

A strengths-based approach to assessment that encompasses the person’s environmental context is sometimes referred to as an ecological assessment. In addition to looking at an individual’s strengths, resiliencies, and capabilities, the environmental factors that affect the person’s everyday living situation are taken into account (Rapp & Goscha, 2011). The continual process of seeking information would include obtaining information about environmental factors in the person’s life that may affect progress toward goals, skills and resources needed to accomplish goals, and eventually, the potential need to modify original goals and objectives. The more open and real a psychologist is, the more likely the sessions are to be successful, thereby requiring fewer changes later and assisting the person to be more open and honest with and about him or herself.
From an ecological perspective, to fully know and understand a person it is important to look at the individual’s personal characteristics, information about his or her environment, and the pattern of interactions the person has within his or her environment (Wilson, 2004).

Information for this broader assessment should be gathered about several life domains including living situation, educational and vocational accomplishments and aspirations, socialization and leisure, health status, financial and legal situation, and everyday circumstances in such realms as independent living, transportation, money management, etc. Similar to other components of the recovery oriented treatment process, the assessment should be one of two equal partners gathering information for future work together rather than one person (the psychologist) delving into the life of another person (the person with an illness) (Elder, Evans & Nizette, 2009).

Taking a broader ecological perspective allows the psychologist to gain an understanding of the “fit” between the person and his or her environment so that they can work together to mobilize strengths and resources, and develop the skills and resources needed to facilitate recovery. When combined with a traditional clinical assessment, the broader focus on strengths, abilities, and environmental factors that influence the person’s life allows a focus on understanding how advances can be made in the context of the person’s life situation. Instead of focusing on problems and deficits, the focus shifts toward an exploration of clients’ abilities, talents, and resources that are available to facilitate recovery (Gray, 2011; Saleeby, 2008).

Conducting a strengths-based assessment is very different from conducting a clinical assessment. Psychologists are typically well taught in the ways of clinical assessment; assessing an individual from a strengths perspective requires a very different approach and this is especially important when the person has a cultural background that is different from the majority.

The impact of a person’s cultural background can have profound effects on many areas of a person’s life. Cultural factors, including religion, beliefs about mental illness, its etiology, and its acceptability may influence the assessment process. The beliefs and values that a person is taught and grows up with may have considerable influence on the ways behavior is viewed, acceptability of seeking mental health services, and ability of women and children to speak for themselves, establish goals, determine skills they wish to develop, etc. Language barriers can have a profound effect on ability to communicate the many important facets of a person’s life and background that impact on the assessment and planning process. In some cultures, it could be very difficult for an individual to participate actively in the planning process and take part in determining the future direction for his or her life. Research and reviews from several countries have also highlighted the importance of culturally relevant assessment and use of appropriate assessment instruments with persons in the forensic and criminal justice systems where many individuals with SMI/SED are confined (Johnson, Beckenbach, & Kilbourne, 2013; Shepherd, Adams, McEntyre, & Walker, 2014; Shepherd, & Lewis-Fernandez, 2016).

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is not a recovery oriented manual but the DSM IV’s Outline for Cultural Formulation and the DSM 5’s Cultural Formulation Interview offer some questions that can be used as a guide for helping to understand the person and his or her contextual life and experiences. The questions should not necessarily be asked verbatim but can be used as a guide to topics that may be relevant and the questions should be phrased to reflect sensitivity to the person’s background and culture. Not all of the questions will be relevant to every person or in every situation. The examples below may be the impetus for additional discussion about the person’s background and cultural experiences and can spark additional discussion as opportunities arise:

I. Cultural identity of the individual:

- What is your ethnic background?
- In what ways do you identify with your cultural group in your daily life? For example, in types of food you eat, clothing you wear, rituals you follow during the week and on holidays?
• In what ways did your family of origin identify with your cultural group in your daily life growing up?
• In what ways do you identify with mainstream American culture in your daily life?
• What languages do you speak? Which did you speak growing up? Which do you prefer to use now, and in what situations?
• For immigrants: What kind of job did you have in your country of origin? What kind of job do you have now? What was the impact of immigration on your and your family’s financial situation and professional status?
• What were your (or your family’s) reasons for immigrating? What were the circumstances of the immigration? (note any dangers involved)

II. Cultural explanations of the individual’s illness:

• What has been your past experience with mental health professionals?
• What other kinds of help have you sought?
• What words do you and your family use to describe symptoms ("idioms for distress")?
• What is the meaning of the symptoms in relation to norms of your cultural reference group?
• How does your family explain your symptoms?

III. Cultural factors related to psychosocial environment and levels of functioning:

• What kind of stressors have you been experiencing?
• What kinds of social support are available?
• What religious or other support systems are available?

The questions below can be used to enhance the psychologist’s understanding of how culture and background influence the perception of the mental health problem:

• What do you call your problem? What caused it? Note: the answer has everything to do with the cultural filters of the person and can provide you with rich information and possible avenues for discussion of support networks.
• Whom do you include as family? Whom do you trust? Note: these are the people who may form the person’s support network.
• Have you ever been a member of a faith community? Note: this is important because many people believe that God has turned a blind eye when they become ill or develop chemical dependency problems and they cease involvement with church, synagogue, mosque or other religious communities.
• Are you a member of a faith community now? If so, would you like the Rabbi, Priest, Pastor, Imam, etc. to be part of and involved in your support network? If not, why not? Note: it is a rare clergy member who will not participate as best he/she can when called.
• Are you now going, or have you ever gone, to an Indigenous Healer for help with your problem? Would you like that person involved as part of your recovery support network? Note: this question is especially relevant for Native people, Latinos and people of African origin.
• With whom do you have intimate relations and relationships? Note: this way of asking about sexual orientation is a bit more sensitive than asking a person’s sexual orientation outright.
• Have you ever experienced racism, police brutality, discrimination and/or other forms of oppression? Note: expect a wealth of clinical information from this question, if not initially, information will be likely to be forthcoming as a trusting relationship develops.

• How do you identify culturally/racially/ethnically? Note: mental health practitioners tend to make assumptions about people based on their outward appearances and often, those assumptions are incorrect.

• What do you know about your culture? What holidays do you observe? Are they related to your culture?

• Has your family always lived in this area? Note: this question can elicit histories of emigration and immigration, as well as issues such as sharecropping in families of African origin, migrant workers, etc.

• What were the messages about your culture that you received while growing up? What were the messages you received about the cultures of others? Note: issues such as self-hate, ethnic privilege and discrimination, reverse and internalized racism, etc. surface with this question (Ali, 2011).

A strengths-based assessment will explore the whole of peoples’ lives while ensuring emphasis is given to the individual’s expressed and pressing priorities. For example, people experiencing problems with mental illness or addiction often place less emphasis on symptom reduction and abstinence than on desired improvements in other areas of life such as work, financial security, safe housing, child care, and relationships. It is essential to explore each person’s needs, desires, and available resources, in detail, in all areas to be sure that that the person’s true priorities are ascertained (Davidson, 2008; Farkas, et al., 2000; Pratt & Mueser, 2011; Rapp, 2001).

Despite psychologists’ excellent training as clinicians which typically encourages use of clinical language, it is best to record the individual’s responses as he or she gives them rather than translating the information into professional or clinical language. By keeping the responses authentic, they remain a true record of the person’s thoughts and feelings. Additionally, there will always be a record of the person’s actual responses which can become very useful when questions come up later about why something was said or done.

In addition to gathering information about the things considered most important to an individual, it is important to gather information about the person’s functional capabilities. As part of a functional assessment, questions are asked about the person’s current skills and capabilities and also about the skills needed to achieve the life goals he or she wishes to achieve. An assessment of available resources is also needed to determine the supports available to help in achieving the person’s goals (Farkas, et al., 2000).

**Examples of topical areas that can be covered and questions that can be asked of the person and of his or her family/support network include the following:**

• Personal strengths: e.g., What are you most proud of in your life? What is one thing you would not change about yourself? What are your best qualities? What are some of the traits people mention when they talk about you? What are one or two things that you see as making you different and unique from others? What makes you smile?

• Interests and activities: e.g., If you could plan the “perfect day,” what would it look like? What do you care about? What matters to you? Name three things that you occasionally look forward to? What dissatisfies you about your life? What do you wish you could change?
• Living environment: e.g., What are the most important things to you when deciding where to live?

• Employment: e.g., What would be your ideal job and why? What skills do you have, for example, artistic or athletic talents, technological expertise, leadership, capacity for work? Think back to before you first began to struggle with the illness, what did you dream of being when you grew up – tell me about it?

• Learning: e.g., What kinds of things have you liked learning about in the past?

• Trauma: e.g., In relationships with other previous or current therapist(s), doctor(s), friends, family, other consumers, teachers, or anyone else, have you ever been treated inappropriately or in ways that were harmful to you (e.g., poor boundaries, sexual inappropriateness, physical abuse, taunting, bullying, etc.)?

• Safety and legal issues: e.g., Do you have any legal issues that are causing you problems?

• Financial: e.g., Would you like to be more independent with managing your finances? If so, how do you think you could do that?

• Lifestyle and health: e.g., Do you have any concerns about your overall health? What are those concerns? Tell me a bit about your mental health: What does a good day look like? A bad day?

• Choice-Making: e.g., What are the some of the choices that you currently make in your life? Are there choices in your life that are made for you?

• Transportation: e.g., How do you currently get around from place to place? What would help?

• Faith and spirituality: e.g., What type of spiritual or faith activities do you participate in? How do you find meaning in your life? Where and when do you feel most at peace?

• Relationships and important people: e.g., Who is the person in your life that believes in you? In what ways does this person convey this belief in you? To what degree is your family, spouse, or significant other available to provide support for you?

• Hopes and dreams: e.g., Tell me a bit about your hopes or dreams for the future? What you are seeking? What are your goals for yourself?

• Resilience: e.g., What would you say are indicators of your resilience; for example, the attributes of intelligence, sense of humor, optimism, creativity? What helps you get through the day? What are your greatest strengths? What has helped you in the past?

• Mental health treatment: e.g., What can the staff do to help? What can you do to help? Who else can help? What services do you want? What, if any, do you want to avoid? What do you hope to accomplish from mental health treatment?

*Topics that can be discussed with the person’s family/support network (with the person’s permission):*

• What type of support, resources, or assistance are you or other members of the person’s support network (current family, spouse, or significant other) able to provide for the person? What would you say about the people in his or her support network in terms of their ability to be helpful, supportive, and communicative? Are there any concerns or limitations that come to mind?
Would you say the family is resilient, for example, have affirming belief systems, facilitative organizational patterns, and positive communication processes? (Gray, 2011; Tondora, 2011).

**Published assessment instruments to assess strengths and functional capacity**

Over the course of the past twenty years or so, several instruments designed to measure strengths and functioning have been developed. These instruments measure a range of different concepts of functions and do so in different ways, leaving open questions about their reliability, usability and perspective (Bellack, 2007). However, they are applicable for use with people with SMI/SED because they attempt to measure a person's strengths, goals, and functional capability, (i.e., ability to achieve the goals an individual has for him or herself) rather than focusing on symptomatology.

Psychologists who will be conducting assessments for people with SMI/SED can review the instruments in this section and combine aspects or the entire instrument with the questions listed above to form a comprehensive assessment package.

**Examples of some of these measures (with some descriptions) in chronological order are:**

5. *The DSM-IV Social and Occupational Functioning Assessment Scale* (SOFAS) (Morosini, Magliano, Brambilla, Uglioni, & Pioli, 2000) - See above for examples of questions from this instrument

The ILSI is designed to measure a person's ability to perform skills needed for successful community living. The ILSI rates items on two dimensions: one, the degree to which the skill can be performed, and secondly, the degree of assistance required to perform the skill. According to Silverstein (2000) “This scoring method is useful in planning a rehabilitation program because it distinguishes between skills deficits and performance deficits, each requiring different forms of intervention.”

5. *The DSM-IV Social and Occupational Functioning Assessment Scale* (SOFAS) (Morosini, Magliano, Brambilla, Uglioni, & Pioli, 2000) - See above for examples of questions from this instrument


The CASIG is a structured interview that the authors describe as follows: the “CASIG makes consumers active directors/collaborators in planning their own treatment, and the inclusion of their perspectives and those of the informants via parallel versions of the test increases communication among stakeholders” (Wallace, et al., 2001). The CASIG asks the individual about his or her goals in five areas of community living: housing, money/work, interpersonal relationships, health, and spiritual activities. The person is also asked to identify the services he or she thinks would be needed to achieve those goals. Other questions ask about current and past community functioning, medication compliance and side effects, quality of life, quality of treatment, symptoms, and performance of intolerable community behaviors. A review of assessment instruments by Silverstein (2000) indicated that the CASIG includes: “(a) numerous areas essential to community living, (b) its results are directly relevant for treatment planning, (c) it can be repeatedly administered to assess progress, and (d) it focuses on goals and skills as well as symptoms and behavioral or cognitive difficulties.”
There are now two additional versions of the CASIG, a self-report version, the CASIG-SR and an informant version, the CASIG-I (Lecomte, Wallace, Caron, Perreault, & Lecomte, 2004).

8. The International Association of Psychosocial Rehabilitation Services Toolkit (IAPSRS) (Arns, Rogers, Cook, & Mowbray, 2001)

The IAPSRS Toolkit is designed to monitor progress toward recovery across multiple dimensions, including employment, education, financial status, residential status, legal system involvement, hospitalization, perceived quality of life, empowerment, and client satisfaction.

9. The University of California, San Diego Performance-Based Skills Assessment (UPSA) (Patterson, Moscona, McKibbin, Hughes, & Jeste, 2001)

According to Bellack (2007):

The UPSA examines a person’s ability to perform IADLs in 5 areas as follows: (1) general organization, (2) finance, (3) social communication, (4) transportation, and (5) household chores. The UPSA involves role-play tasks similar in complexity to situations that a community dwelling person is likely to encounter, including planning a trip to the beach, using a bus schedule, and balancing a checkbook. The UPSA yields both domain-specific scores and an overall score (p. 813).


12. The Maryland Assessment of Social Competence (Bellack, Brown, & Thomas-Lohrman, 2006)

From the review by Bellack et al., (2007):

The Maryland Assessment of Social Competence measures the person’s ability to solve common problems in an interpersonal context (e.g., interacting with a health care worker). It requires the person to engage in a series (usually 3–4) of 3-min conversations with a confederate. It was empirically developed and has proven to be reliable in several studies, to have good discriminant validity, and to be relatively independent of changes in symptomatology. Each scenario is coded on 3 dimensions that reflect different aspects of social skill: Verbal Skill (a content measure), Nonverbal Skill (a measure of paralinguistic style, eye contact, and gestures), and Overall Effectiveness (ability to maintain focus and achieve the goal of the scenario) (p. 813).


A functional assessment is designed to gather information about a person’s skills and capabilities in relation to the person’s goals. The authors state:

Functional assessment is developing an understanding of a person’s functioning in the critical skills needed to be successful and satisfied in a particular environment. The functional assessment evaluates individuals’ spontaneous use, prompted use, and performance of critical skills in relation to their needed use. This technology teaches practitioners how to help define and evaluate the skills needed for consumers to be successful and satisfied in particular residential, educational, vocational, or social environments. Practitioners learn how to list critical skills,
describe skill use, evaluate skill functioning, and coach individuals through the assessment process. An evaluation of the individual's present ability to use these skills is then completed (Cohen, et al., 2007).

Interventions

In addition to training in strengths-based assessment, psychologists preparing to work with individuals with SMI and SED must become proficient in the evidence-based and promising practices designed and tested specifically for this population. While research continues to identify the best interventions to help individuals reach their full potential and achieve a satisfying life, results of the 2009 Schizophrenia Patient Outcomes Research Team (PORT) study remain the most rigorous and undisputed summary of efficacious interventions to date. The PORT study identified 8 evidence-based practices (EBPs) and 4 promising practices. The 8 EBPs are: assertive community treatment, supported employment, cognitive behavioral therapy, family-based services, token economy, skills training, psychosocial interventions for alcohol and substance use disorders, and psychosocial interventions for weight management. The 4 promising practices are: medication/illness management, cognitive remediation, psychosocial treatments for recent onset schizophrenia, and peer support and peer-delivered services (Kreyenbuhl, et al., 2010).

Psychologists serve as front-line clinicians in hospital settings, community agency settings, and or in private practice/clinic settings, but those preparing to work with individuals with SMI/SED are also likely to become researchers, program managers, and administrators in both small and large organizations that are increasingly serving this population. While not all of the interventions discussed below will be delivered directly by psychologists, those working in these settings must know about them, be knowledgeable about the research that underpins them, and be aware of how to implement them. Thus, all of the interventions presented below are crucial for psychologists in training for work with this population whether they will be in clinical practice or serve as organizational administrators.

Studies over the past several decades have shown that many adults with SMI can and do recover when they are provided with supports and services that assist them to gain the skills needed to live a satisfying and productive life. Users of mental health services have consistently said that they want the same things for themselves that every citizen wants: a family, a safe place to live, meaningful activities, adequate income, job satisfaction, and an enjoyable social life. Where children and youth are concerned, the same is true: families seeking services for children with mental health concerns want services that promote the development of competencies, and functional lifetime outcomes (Bellonci, et al., 2012).

For people with SMI/SED, attainment of life goals often requires substantial assistance in the form of specially designed psychosocial rehabilitation (PSR) services. While some people with SMI/SED may recover without assistance, many are unable to recover sufficiently to achieve the quality of life that they desire without these specialized services (Silverstein, 2000). Several of these specialized services have been shown in multiple randomized clinical trials to be highly effective and are considered to be evidence-based practices (EBPs) for this population. Yet, despite these advances, EBPs and other specialized services are not routinely available in most mental health treatment settings (Power, 2005; President's New Freedom Commission on Mental Health, 2003; Stirman, et al., 2010) and psychologists (and other mental health providers) remain ill prepared to offer them (Chu, et al., 2012; Corrigan, Steiner, McCracken, Blaser, & Barr, 2001).

None of the interventions are suggested as a “cure” for SMI/SED. Rather these interventions are a means to inform individuals and their families about the illness and to help individuals achieve the life goals they have for themselves. It is also important to know that all interventions must be provided within a recovery oriented framework and perspective that is person centered, draws on the strengths and capabilities of the individual, and is oriented to the goals of the person served (Davidson, 2010; Mueser, 2012). The evidence base supporting use of clinically oriented psychosocial rehabilitation (PSR) services for people with serious mental health disorders has developed considerably over the past two decades.
and is now quite robust. Provision of EBPs, promising practices have been shown to improve the functional capability of individuals with SMI/SED and improve outcomes across a broad spectrum of domains when compared with standard care (Patterson & Leeuwenkamp, 2008). This sentiment was echoed by the authors of the PORT study:

Consistent with the paradigm shift in schizophrenia treatment from a focus on long term disability to one focused on optimism and recovery, the ultimate goal of the Schizophrenia PORT has been to increase the use of evidence based treatments in order to optimize outcomes by reducing illness symptoms and the disability and burden associated with the illness (Kreyenbuhl, et al., 2010, p. 100).

Next, we briefly discuss each of the EBPs and promising practices. Some of the practices lend themselves more to settings where psychologists provide clinical services individually or to groups; other practices are those that are offered in settings such as community agencies or institutions. Psychologists who work with SMI/SED populations may work in either or both kinds of settings (clinical practice and agency/institutional settings) and must know how to implement services in both kinds of venue. Thus, the discussion below includes the full complement of EBPs and promising practices, organized to follow the order of the PORT study. Other well researched practices for this population that psychologists must be knowledgeable about are also described following the descriptions of EBPs and promising practices.

Evidence-based Practices

**Assertive community treatment**

The most well-known and researched EBP is assertive community treatment (ACT). Originally developed and researched in the late 1970s (Stein & Test, 1980), ACT has become the cornerstone around which community mental health treatment for those with the most SMI is provided (Dixon, 2000).

Those who receive services from an ACT program are typically those that have not benefited from traditional approaches to providing treatment, although recently the model has been implemented with those experiencing a first episode of psychosis (FEP). Provision of the ACT model with individuals with FEP resulted in the formation of greater social networks which may lead to improved clinical outcomes as a result of establishing or maintaining relationships with family and friends (Tempier, Balbuena, Garety & Craig, 2012).

ACT is designed to help people overcome the challenges they face including difficulties with basic, everyday activities such as developing and maintaining relationships, caring for their basic physical needs, maintaining safe and adequate housing, unemployment, substance abuse, homelessness, and involvement in the criminal justice system. Services are provided by a multidisciplinary team that should have enough staff so that there is a comprehensive mixture of expertise and sufficient coverage for the hours of operation. At the same time, to operate as a team, the team must be small enough to communicate easily and allow all members to be familiar enough with each consumer's status so that they can step in to provide care at any time. A team of 10 to 12 members with a total caseload of 100 persons is suggested, although teams serving a large number of individuals with acute needs may find that a smaller caseload is needed until the individuals stabilize. The types of services that are provided and how long those services are provided depend on people's needs. The team meets each day to discuss how each person is doing and services are adjusted quickly when necessary. When people need more support, team members meet with them more frequently. Staff respond to people in the community 24 hours a day, 7 days a week. As people improve, the team decreases their interactions with them, but team members remain available to provide additional support any time it is needed.

The model has been tested in countries all over the world and the results have been sustained (Marshall & Lockwood, 1998). ACT is now considered the standard for case management services for those with the most serious mental illnesses (Bond, Drake, Mueser & Latimer, 2001; Burns, Fioritti,
Holloway, & Malm, 2001; Burns & Santos, 1995; Phillips, Burns, Edgar, Mueser, et al., 2001), and after 30 years, the principles of this model remain the same. Recently, supported housing using a model known as Housing First has been shown to enhance the effects of ACT by demonstrating improved functioning, perceived quality of life, and housing stability (Adair, et al., 2016; Aubry, Nelson, & Tsemberis, 2015; Aubry, et al., 2016). ACT teams have not always included psychologists and the reason for this is not clear. Psychologists have much to contribute to interdisciplinary efforts such as ACT teams where varied psychological expertise can make substantial contributions to this highly effective intervention. A toolkit for implementing ACT can be found at http://store.samhsa.gov/facet/Professional-Research-Topics/term/Evidence-Based-Practices.

**Supported employment**

Along with assertive community treatment, supported employment (SE) is one of the most researched and validated interventions available. The most widely implemented version of SE is known as individual placement and support (IPS) and this term has become practically synonymous with SE, although the EBP is called supported employment.

Strong outcome data exist to support the efficacy of this EBP for persons with SMI/SED (Becker, Whitley, Bailey & Drake, 2007; Bond, Drake, Mueser, et al., 1997) and long term follow up studies have shown that the effects are sustained over time (Cook, Burke-Miller, & Roesssel, 2016; Hoffmann, Jäckel, Glauser, Mueser, & Kupper, 2014; Marshall, et al., 2014). SE is a place-and-train model which uses the principle of on the job training as its cornerstone. This means that individuals with mental health disorders learn how to find and keep regular, real world jobs in the community and are provided with continuous support to assist them to achieve success. Outcomes for SE have been shown to be much better than for traditional approaches and this finding has been replicated in several countries (Burns, et al., 2007; Catty, et al., 2008; Corbiere, et al., 2010; Harry, van Busschbach, Stant, van Vugt, Weeghel & Kroon, 2014; Heffernan & Pilkinson, 2011; Hoffmann, Jäckel, Glauser & Kupper, 2012; Mueser, Drake, & Bond, 2016; van Erp, et al., 2007; Wong, Chiu, Tang, Mak, et al., 2008).

One of the most comprehensive reviews of the research was a Cochrane review completed in 2001. This review of eighteen randomized controlled trials found that SE was superior to programs that offered pre-vocational training (Crowther, Marshall, Bond & Huxley, 2001). A more recent review of twelve systematic reviews and seventeen randomized controlled trials of the individual placement and support model of SE also found consistently positive results (Marshall, et al., 2014). As a result, the model is now recommended as the intervention of choice for those who want to work.

Programs that have followed the fidelity instructions and implemented evidence-based SE find that fewer crises occur because individuals are focused on using their strengths, developing their lives in the community, and managing their illness more independently, which leads to enhanced self-esteem and sense of self-worth. The comprehensive and coordinated planning that occurs with SE leads to fewer crises, less chaos, and more structure, and the on-going support of the employment specialist, whose caseload is generally no more than 25 individuals, provides the help often needed to sustain employment (Bond, et al., 2001; Burns, et. al., 2009).

Additionally, research has found that when SE is combined with other mental health services in a highly integrated model of service delivery, employment rates for those with SMI/SED can be more than double that of those who receive SE without additional services and individuals achieve significantly higher earnings and remain employed for longer periods (Cook, et al., 2005a; Cook, et al., 2005b). Cognitive remediation has been paired with SE in several studies and found to enhance the effects of SE (Bell, Choi, Dyer & Wexler, 2014; Chan, Hirai, Tsoi, 2015; Khare, Mueser, & McGurk, 2016; Lindenmayer, et al., 2008; McGurk, Mueser & Pascaris, 2005).
The essential principles of supported employment are:

- Focus on competitive employment
- Rapid job searches
- Jobs tailored to individuals
- Time-unlimited follow-along supports
- Integration of supported employment and mental health services
- Zero exclusion criteria (that is, no one is screened out because they are not thought to be ready).

A toolkit for implementing SE can be found at http://store.samhsa.gov/facet/Professional-Research-Topics/term/Evidence-Based-Practices.

One issue that remains to be resolved for any work program is the effect that added income can have on disability payments. Although SE can assist an individual to become successful in the work environment, the individual may choose to not work or to work for a limited number of hours in order to avoid risking loss of disability and other benefits which can be extremely difficult to re-gain if needed.

**Cognitive behavioral therapy**

Cognitive behavioral therapy (CBT) is a form of psychotherapy that uses education and behavioral shaping techniques to help individuals learn to think more rationally, and learn to act differently based on this more rational thinking. It is a combination of cognitive therapy which teaches rational thinking skills, and behavioral therapy which teaches behavioral skills. There can be a range of therapeutic approaches that are included under the rubric of CBT. CBT is not aimed specifically at eliminating symptomatology, i.e., changing either positive or negative symptoms, although the severity of these may be reduced. Rather it is aimed at helping those with SMI/SED learn to manage their illness better by learning to challenge their irrational thoughts and act differently. Thus, rather than “making the demons go away”, it can be thought of as learning to “manage the demons”. Medication may provide a useful assist in the management of symptomatology.

CBT is considered to be an integral component of most mental health treatment systems and is present in many mental health treatment systems around the world. Much research has supported its efficacy (Butler, Chapman, Forman & Beck, 2006; Cather, et al., 2005; Dickerson, 2000; Dickerson & Lehman, 2006; Garety, Fowler & Kuipers, 2000; Gould, Mueser, Bolton, et al., 2001; Granholm, Loh, Link & Jeste, 2010; Haddock, et al., 2003; Kavanagh & Mueser, 2001; Pfammatter, Junghan & Brenner, 2006; Scott, 2001; Wykes, Steel, Everitt & Tarrier, 2008).

**Specialized CBT for psychosis**

Specialized applications of CBT for psychosis (CBTp) have also been developed and tested, with positive results (Lecomte, et al., 2008; Morrison & Barrett, 2010; Rector & Beck, 2001; Wykes, et al., 2008; Zimmerman, Favrod, Trieu & Pomin, 2005). Research is currently underway to determine the effect of CBTp for individuals experiencing first episode psychosis and those considered in the prodromal phase or at ultra high-risk of developing psychosis.

CBTp treatment is aimed at psychotic symptoms but treatment also targets anxiety, low mood, self-esteem, etc. There is strong emphasis on development of the therapeutic alliance focused on understanding the client’s experience of psychosis in order to normalize this experience and facilitate willingness to discuss symptoms, experiences, and impact of the experience on functioning. Treatment can be provided individually or in a group setting (Mueser, Deavers, Penn & Cassisi, 2013). Client engagement, recognition of possible cognitive deficits, acceptance of suspiciousness that might arise and willingness to be flexible are key (Morrison & Barrett, 2010; Mueser, et al., 2013).
A recent meta-analysis reinforced the previously found positive outcomes for CBTp, finding that CBTp was more effective for reducing positive symptoms, while social skills training was more effective for reducing negative symptoms (Turner, van der Gaag, Karyotaki & Cuijpers, 2014). And, very recently, a small preliminary study found long term improvements in perceived distress and affective disturbance, without changes to psychotic symptomatology, following CBTp (Mason, Peters, Williams, & Kumari, 2017). Despite these findings, CBTp is not widely recognized or taught in psychiatry or psychology training programs in the US. (Kimhy, et al., 2013).

**Family based services (also known as family psychoeducation)**

Along with assertive community treatment and supported employment, family psychoeducation is one of the most researched and validated interventions. Family based services or family psychoeducation, is the process of providing education and coping skills for people with lived experience of SMI/SED and their families. Family psychoeducation is generally provided in multi-family groups but can also be offered in single family formats. Multi-family formats have the added benefit of allowing for the development of social support systems. Consent of the individual with the illness is always required. Information about the person’s illness is provided along with information for both consumer and family about recognizing the onset of symptoms, coping with behavioral changes, effects of medication, and communication skills. Family psychoeducation is a treatment modality that utilizes the consumer and family as partners in the provision of the service, not as objects of the treatment modality and whose primary focus is on the needs and desires of the consumer (Miklowitz, George, Richards, Simoneau, & Suddath, 2003).

The effectiveness of family psychoeducation has consistently been documented. Studies undertaken in several countries over the past two decades have shown remarkable success in reducing rates of relapse (Dixon, et al., 2001; Fristad, Goldberg-Arnold & Gavazzi, 2002; Glynn, Cohen, Dixon & Niv, 2006; Miklowitz, et al., 2003; Miklowitz & Goldstein, 1997; Miklowitz, et al., 2000; Mueser & Glynn, 2000; Pfammatter, et al., 2006; Sikich, 2005).

A review of over thirty randomized controlled trials of psychoeducation for individuals with SMI and over one hundred randomized controlled trials of family psychoeducation provides a high level of evidence for the effectiveness of the model. The authors state:

Reviews of consumer psychoeducation found that experimental groups had reduced nonadherence (primarily with medication regimens), fewer relapses, and reduced hospitalization rates compared with control groups. Some studies found significant improvements in social and global functioning, consumer satisfaction, and quality of life. Multifamily psychoeducation groups (the focus of numerous studies) were associated with significantly improved problem-solving ability and a reduced burden on families, compared with control groups, among other strong outcome effects. … Psychoeducation should be included in covered services. Group and family interventions are especially powerful (Lyman, et al., 2014, p. 416).

And from the same publication:

Compared with control conditions, family psychoeducation for adult consumers with schizophrenia or other psychotic disorders demonstrates consistent evidence for the following outcomes:

- Decreased relapse and rehospitalization rates
- Reduced burden on families
- Greater knowledge of the disorder and the mental health care system
- Improved ability to solve problems
• Better self-care
• Improved quality of life

Research is less extensive for families of adults with other disorders. (p. 426).

On average, rates of re-hospitalization have been consistently shown to be reduced by an average of 50 percent, with the range between 40 and 70 percent (Dixon, Adams & Lucksted, 2001; Pitschel-Walz, Leucht, Bauml, Kissling, et al., 2001). Rates of employment are also significantly higher among those who have participated in family psychoeducation. Other findings include improved family member well-being, decreases in negative symptoms, and decreased costs of general medical care (Campbell, 2004).

*Essential elements of family psychoeducation programs include:*

• Developing the relationship
• Educational workshops
• Skills building for community re-entry
• Social and vocational skills development.

The most effective family psychoeducation programs are six to nine months in duration and the best effects are shown for programs that continue for longer durations (Pitschel-Walz, Leucht, Bauml, Kissling & Engel, 2001). This is also the case for family interventions designed for clients and families where concurrent substance abuse is present (Mueser, et al., 2013). Due to the difficulty of maintaining families in programs of long duration, current research is focusing on determining the efficacy of shorter duration programs and some have begun to demonstrate success in helping families feel empowered and better able to cope, and have lessened anxiety and depression (Dixon, et al., 2011). Recently, brief interventions consisting of fewer sessions for individuals and for family members have led to marked increases in family participation, reduced symptomatology and better outcomes at follow up (Dixon, et al., 2014). A toolkit for implementing traditional Family Psychoeducation can be found at http://store.samhsa.gov/facet/Professional-Research-Topics/term/Evidence-Based-Practices.

*Token economy interventions*

Token economies are interventions that are appropriate for long term care or residential settings where individuals with the most severe illnesses live and where improvements in behaviors related to daily living skills are needed. In many cases individuals who would otherwise have remained hospitalized, have been enabled to live in the community as a result of the token economy intervention. Token economy interventions are long term interventions and commitment to long term, high intensity staff training and to providing the intervention over a long period of time are required.

A token economy intervention is based on social learning principles where intermediate positive reinforcement, such as a token that can be redeemed later, is provided contingent on performance of an identified behavior. Punishment is never part of a token economy system and to avoid the mis-use of token economy interventions, absolute fidelity to the model is necessary. Fidelity to the EBP includes a substantial investment in staff training prior to initiation of the program and careful and sustained supervision of all staff throughout the full duration of the intervention (Silverstein, Hatashita-Wong, Wilkniss, et al., 2006).

Token economies are based on the seminal work of Paul and Lentz (1977) whose work provided the cornerstone of empirical support for social learning programs. Token economies, or social learning programs are the only interventions among the eight designated EBPs specifically recommended for long-term inpatient or residential care to improve personal hygiene, social interactions, and other adaptive behaviors.
Token economies have been used successfully in institutional settings for several decades and there are many studies that support the efficacy of this highly effective intervention (Ayllon & Azrin, 1965; Beck, Menditto, Baldwin, Angelone & Maddox, 1991; Dickerson, Tenhula & Green-Paden, 2005; Glynn, 1990; Hall, Baker & Hutchinson, 1977; Silverstein, Hatashita-Wong, Wilkniss, et al., 2006).

**Skills training**

Skills training encompasses a broad range of training in skills needed for functioning in everyday life including basic communication, assertiveness training, training in skills associated with a variety of social and vocational settings, and skills needed for personal care, independent living and community integration. Skills training, often named social skills training, is applicable not only to social skills, but to any area of life where concentrated practice of a new skill can assist functioning in areas such as obtaining further education or learning to be successful in a work setting. Skills training is not aimed at reducing symptoms but rather at helping people live with their illness and its symptoms in a more functionally adaptive way and has been shown to be highly effective for helping individuals learn specific skills or skill sets (Bellack, 2004; Bustillo, Lauriello, Horan & Keith, 2001; Kopelwicz, Liberman & Zarate, 2007; Kurtz & Mueser, 2008; Penn & Mueser, 1996).

Skills training derives from the behavioral literature and consists of instructional teaching techniques and behavior shaping techniques. Instructional teaching techniques involve didactic instruction, modeling, and experiential practice with feedback until the skill is understood and in the control of the individual. Behavior shaping involves systematic practice and reinforcement of the desired behavior until the criteria are met. The intervention is often essential for success in community living and can encompass training in skills such as negotiating a place to live, making friends, using public transportation, and other everyday situations. Skills training can be especially helpful for situations where interaction with others is either necessary or beneficial.

An important consideration is that the skills learned have not always generalized to everyday living situations and have not always been sustained. Interventions designed to reinforce the learned achievements and to provide support for maintenance have shown enhanced levels of interpersonal problem-solving skills, significantly greater social adjustment and better quality of life. Results have been shown to be sustained for several months to more than two years (Glynn, et al., 2002; Liberman, Glynn, Blair, Ross, & Marder, 2002; Pfammatter, et al., 2006; Tauber, Wallace & Lecomte, 2000). Thus, support for maintenance of learned behaviors and skills should be built into service delivery systems to ensure sustainability.

Increasingly there is recognition of the need for long term follow-up of tailored skills training. One such program, designed for older adults with SMI is the Helping Older People Experience Success (HOPES) intervention (Pratt, Bartels, Mueser, & Forester, 2008). Investigators tested the HOPES program with older adults with SMI and found improved community living skills, decreased psychiatric symptomatology, greater receipt of preventive health screening and greater completion of advanced directives at 3 year follow-up (Bartels et al., 2014).

Like CBT, virtually all mental health systems utilize skills training to assist individuals with a wide range of disorders to learn skills that will help them function more successfully in a broad array of situations. While additional investigations are needed to identify the best methods for achieving sustainable results, skills training is considered an EBP for persons with SMI/SED, including those with first episode psychosis.
Psychosocial interventions for alcohol and substance use disorders (also known as concurrent disorders treatment or integrated dual diagnosis treatment)

Given the high prevalence of co-occurring substance use disorders with SMI and SED, integrated treatment for both disorders is increasingly recognized as an important component of a treatment program for persons with SMI/SED due to the fact that use of psychoactive substances exacerbates the symptoms of mental illness and can impede treatment. In order to ensure that the individual receives a consistent explanation of his or her illness and associated problems and a coherent treatment plan rather than a contradictory set of messages from different providers, treatment for those with concurrent disorders is most effective when the treatment for both disorders is integrated and offered by one provider or one team with knowledge of both disorders.

It is generally agreed that the key elements of integrated dual diagnosis treatment are:

- Assertive outreach
- Integrated case management
- An individualized treatment plan that addresses both the substance use disorder and the person’s mental illness
- Integrated services provided by the same clinician or clinical team
- Availability of multiple therapeutic approaches
- Comprehensive approach
- Knowledge about the effects of alcohol and drugs and their interactions with mental illness and the medications that are used to treat mental illnesses
- Reduction of negative consequences
- Cognitive behavioral therapy
- Stage-wise treatment provided as individuals progress over time through different stages of recovery
- Relapse prevention
- Motivational interviewing to help the individual develop awareness, hopefulness, and motivation

Lack of attention to any of the elements can jeopardize the effectiveness of the treatment program. Shared decision making which includes the client and his or her family, is at the core of integrated treatment and is critical to success (Mueser, et al., 2003).

Researchers also found enhanced outcomes when family interventions including communication and problem solving training, were combined with treatment for the substance use disorder. This research identified that persons with SMI/SED receiving the combined intervention had improved functioning and significantly less severe overall psychotic symptoms and their family members also had improved mental health functioning and greater knowledge of co-occurring disorders (Mueser, et al., 2013). A toolkit for implementing treatment for concurrent disorders can be found at http://store.samhsa.gov/facet/Professional-Research-Topics/term/Evidence-Based-Practices.

Psychosocial interventions for weight management

Interest in designing and researching interventions aimed at helping individuals manage their weight is relatively recent. Much of this interest can be attributed to the fact that most of the second generation anti-psychotic medications cause substantial weight gain for many individuals, which can lead to other serious health problems; the combination of these health problems is known as the metabolic syndrome. Metabolic syndrome is much more prevalent in people using anti-psychotic medications and
can lead to diabetes and an increased risk of cardiovascular events such as heart attack and stroke. A recent meta-analysis of the literature found that the prevalence of metabolic syndrome in people with schizophrenia and related disorders is consistent across treatment setting (inpatient vs outpatient), country of origin, and gender. Older individuals were at greater risk and those who had been ill the longest had the highest risk of developing the syndrome. When individual studies were evaluated, waist size was most useful in predicting metabolic syndrome and use of antipsychotic medication, especially clozapine, conveyed the highest risk. Those who did not use anti-psychotic medications were at lowest risk of this life threatening syndrome (Mitchell, et al., 2013).

Several randomized clinical trials of PSR interventions designed to help individuals lose weight have demonstrated substantial improvement for the PSR intervention compared to control or non-PSR conditions (Brar, et al., 2005; Jean-Baptiste, et al., 2007; Kwon, et al., 2006; Weber & Wyne, 2006; Wu, Wang, Bai, Huang & Lee, 2007; Wu, et al., 2008). Additionally, there have been several studies of individuals who had just begun to take anti-psychotic medications and these have also shown significant differences in the amount of weight gained by people beginning treatment (Álvarez-Jiménez, Hetrick, Gonzalez-Branch, et al., 2008; Evans, Newton & Higgins, 2005; Littrell, Hilligoss, Kirshner, Petty & Johnson, 2003). The effects can be difficult to maintain; booster sessions and or continuation of the weight management intervention may be needed (Álvarez-Jiménez, et al., 2010). Because of the weight inducing effects of anti-psychotic medications, losing weight once it has been gained can be very difficult for individuals taking these medications; it is thus important to begin weight management intervention at the earliest possible time.

Researchers have identified that pharmacologic interventions may be helpful in preventing or reducing weight gain associated with anti-psychotic medications (Jarskog, et al., 2013; Mahmoud, Booker, Huang & Coleman, 2013). Because of the serious health implications associated with obesity, and the great difficulty that people with SMI/SED who are using antipsychotic medications have in controlling their weight, individuals should be monitored very closely for early signs of respiratory and cardiovascular disorders, for cancers of all kinds, and provided with the newest and best pharmacologic interventions available. Due to the potentially life-saving benefits of managing one’s weight, interventions for weight management should be an essential component of the PSR continuum of services offered.

**Promising Practices**

*Medication/illness management*

Medication is used by many individuals with SMI/SED to help decrease symptoms of the illness. Management of the dosage and side effects is a critically important aspect of a person’s decision to continue to use prescribed medications. Medication is a potentially important and yet often difficult component of most treatment regimens. Taking medications, for a variety of reasons (side effects, weight gain, health concerns, etc.) can be difficult and for some individuals, non-adherence to prescribed medications may result in relapse. As a result, identifying ways to assist those prescribed medication to adhere to the treatment can be important. However, to date, there are not sufficient data to support any of the interventions designed to maintain adherence. Approaches tailored to the needs of the individual and that involve the person, his or her family, and clinicians, offer the best success to date. The consumer’s concerns and preferences must be an integral part of the overall process. Use of medication should be driven by the evidence base for psychotropic medications, taking into account knowledge from the most recent research literature (Buchanan, et al., 2010) and the emerging literature showing initial results related to long term use of these medications (Harrow & Jobe, 2007; Harrow & Jobe, 2013; Harrow, Jobe & Faull, 2012; McGorry, Alvarez-Jimenez & Killackey, 2013; Wunderlink, Nieboer, Wiersma, Sytema & Nienhuis, 2013).

A widely used approach consists of teaching illness management skills and usually involves a series of sessions where mental health providers help individuals with SMI/SED learn a broad range of coping strategies for living with their illness. Illness Management and Recovery (IMR) (Gingerich &
Mueser, 2011) consists of combining a set of specific EBPs for teaching people how to manage their disorder in collaboration with professional staff and family members in order to achieve their own recovery goals. The coping strategies taught in most illness management programs are a subset of those utilized in other EBPs and are designed to help individuals build healthy, wellness oriented lifestyles. Programs usually run for three to six months and consist of educational and skills building sessions. Programs are designed so that family members can also attend, with permission of the individual.

Several programs have been developed to help individuals learn the skills they need to take charge of their illness including its symptoms and its management. In addition to IMR, a peer led approach is the Wellness Recovery Action Plan (WRAP) (Copeland, 2002). WRAP and other programs that teach illness management and wellness skills have been found to help individuals feel more empowered to take charge of their illness, feel more hopeful and experience enhanced quality of life (Cook, et al., 2012). WRAP has also been found to reduce individuals’ perceived need for, and use of, mental health services (Cook, et al., 2013), confirming the importance of peer led illness management groups in combination with other EBPs.

Research on illness management programs indicates that provision of several key components, especially when utilizing a peer co-facilitator, can help those with SMI/SED reduce the severity of symptoms and cope better with the symptoms they have (Merinder, 2000; Mueser, Bond & Drake, 2001; Mueser, et al., 2002).

These components include:

- Psychoeducation
- Behavioral skills to learn how to take medication as prescribed and follow the medication regimen
- Cognitive behavioral strategies to assist with symptom management.

Topics covered in an illness management program include:

- Recovery strategies
- Practical facts about mental illness
- The stress-vulnerability model and coping strategies
- Building social support
- Reducing relapses
- Using medication effectively
- Coping with stress
- Coping with problems and symptoms
- Getting one’s needs met in the mental health system (Mueser, et al., 2013).

Because of the breadth of the topics covered, and the short duration of most programs (3 - 6 months), in-depth training in any one of them, is not possible. As a result, most individuals will also benefit from other EBPs that provide greater coverage of given topics.

Cognitive enhancement: cognitive remediation and social cognition training

As we have indicated previously, neuropsychological functioning is often negatively affected in people with SMI/SED, resulting in executive function impairments that impact on learning, memory, attention, concentration and those functions that control and regulate adaptive abilities and behaviors, such as initiating, monitoring and changing behavior as needed (David, et al., 2008; Green, Kern, Braff, & Mintz, 2000). In addition to these executive function deficits, aspects of cognition that are critical for social functioning and interpersonal relationships are also typically affected (Galletly & Rigby, 2013;
Harvey & Penn, 2010). Deficits in both executive functioning and in social cognition present unique and serious obstacles to individuals who are struggling to recover from the effects of their illness and regain functional capability for education, work, and everyday social/community functioning (McGurk, et al., 2015).

Cognitive remediation has been shown to improve neuropsychological functioning and life skills outcomes in social, educational, and employment settings by improving cognitive functioning, especially those processes involved in executive functioning, especially those processes involved in executive functioning. Several investigators have concluded that cognitive remediation holds the greatest promise when delivered in conjunction with other PSR interventions designed to improve community functioning such as SE (Chan, et al., 2015; Ikebuchi, et al., 2017; McGurk, et al., 2015; Mueser, et al., 2013; Wykes, Huddy, Cellard, McGurk, & Czobor, 2011). Importantly, in order to impact on aspects of social cognition (also important in a variety of settings such as work, education, social interactions, etc.), cognitive remediation has been found especially effective when combined with social cognition training which includes emotional processing skills and affect recognition, illness management skills, attributional bias and mentalizing exercises (Horan, et al., 2011; Kurtz & Richardson, 2012; Lindenmayer, et al., 2013; Roder, Mueller & Schmidt, 2011).

Cognitive remediation programs generally provide computer assisted training exercises designed to help clients re-learn cognitive skills aimed at improving learning, memory, attention, concentration, and executive functions that control and regulate adaptive abilities and behaviors, such as initiating, monitoring and changing behavior as needed. Researchers have found increased cognitive functioning after remediation efforts (Anaya, et al., 2012; Fisher, Holland, Subramaniam & Vinogradov, 2009; Grynszpan, et al., 2010; McGurk, Twamley, Sitzer, McHugo, & Mueser, 2007; Pfammatter, et al., 2006; Wykes, et al., 2007) and some have found enhanced employment outcomes when cognitive remediation is paired with SE (Lindenmayer, et al., 2008; McGurk, Mueser & Pascaris, 2005), although one investigator found these effects mainly for those with lower community functioning capability (Bell, Choi, Dyer & Wexler, 2014). Evidence has begun to accumulate which indicates that emotional distress and negative symptoms may also be positively impacted (Sanchez, et al., 2014). Other investigators have found only small effects of cognitive remediation efforts on neuropsychological or functional outcomes (Dickinson, et al., 2010) but research combining training in executive functioning with training in social cognition has shown favorable results (Lindenmayer, et al., 2013).

Because of the importance of the range of neuropsychological processes for attainment of one’s life goals, this is an important area where more research is needed to identify the conditions under which maximum benefit can be obtained from these interventions. There are increasing calls for integrated treatment to include cognitive enhancement approaches as a fundamental component (Pfammatter, Brenner, Junghan & Tschacher, 2011; Roder, et al., 2011) and some have stated that including cognitive remediation “may result in a magnitude of change that exceeds that which can be achieved by targeted treatments alone” (Pinkham & Harvey, 2013, p. 499).

Lastly, a recent meta-analysis of interventions using aerobic exercise supervised by physical activity professionals combined with psychotropic medication was conducted and results indicate substantial improvement in cognitive functioning (social cognition, working memory, and attention) for individuals with SMI; these effects were even larger with greater intensity levels of aerobic exercise (Firth, et al., 2016). Given the importance of reducing obesity and its consequences, aerobic exercise may have multiple benefits for this population. As with other psychosocial interventions for this population, it may be that combining multiple interventions such as aerobic exercise with targeted cognitive improvement interventions such as cognitive remediation, social cognition training, and supported employment will prove to be the best approach for enhancing overall cognitive functioning and improving the outlook for cardiovascular health, and attainment of educational, vocational, and social goals.
Psychosocial treatments for recent onset schizophrenia

Note: At the time the PORT study was completed, early intervention programs showed considerable promise but the research base was not robust enough for the study authors to list early intervention as an EBP; rather these were listed as a promising practice. Since that time however, a large scale, multi-site NIMH funded project known as the RAISE initiative (Kane, et al., 2016) has confirmed that a comprehensive treatment package is effective in helping those with early onset psychosis achieve community stabilization. Most believe the RAISE project provides the necessary evidence to consider this as an EBP. However, since this section of the specialty petition is organized according to the PORT study, for simplicity, the discussion of early interventions remains under the category of promising practices.

Although the onset of SMI/SED can occur in the prime of one’s life, these illnesses mostly strike young people. The median age at which symptoms first appear is 14 with diagnosis typically occurring between the ages of 15 and 26 (National Health Policy Forum, 2009).

Often, people with SMI/SED and substance use disorders become ill early in their lives when the skills needed for success in life are just developing. When this happens, thinking ability is often severely compromised because of the negative effects these disorders have on cognitive processing capabilities. Education and work are disrupted, and often stopped completely along with the ability to form meaningful relationships with family and friends.

Frequently, there is a period of symptomatology that occurs before full blown psychosis develops. This period has been called the “prodromal period”, and those in this state have been said to be at “ultra high-risk”, or to be experiencing an “attenuated psychosis syndrome” (Yung, et al., 2012); the rate of onset of a psychotic disorder has been shown to be thirty six percent within three years (Fusar-Poli, et al., 2012). Clinical staging models have been applied to those with mental health disorders in an effort to help clinicians identify the best course of action for those who may not have progressed to full blown psychosis and to help prevent progression (Cross, et al., Hickie, et al., 2013). Previous models focused on symptoms usually seen in early stages of illness such as anxiety and depression but these do not account for the symptoms that may indicate signs of more serious illness. Innovatively, the model described by the authors above incorporates a range of symptoms and syndromes within a single staging model, thus allowing for attention to potential developing psychosis for those at ultra high risk (UHR). Additionally, specially designed CBT (CBTuhr) has been shown in a long term trial (4 year follow-up) to prevent development of psychosis for significantly more participants than treatment as usual. Those in the treatment as usual group also evidenced more severe psychopathology and poorer social functioning than those in the CBTuhr group, indicating a promising development for improving the trajectory of those at very high risk of psychosis (Ising et al., 2016).

Although there are many factors that influence functional outcomes, there is growing evidence that early intervention with pharmacologic and psychosocial interventions during the first episode of psychosis may lead to improved outcomes (Baksheev, Allott, Jackson, McGorry & Killacky, 2012; Bertelsen, et al., 2008; Bird, et al., 2010; Ehmann, Yager & Hanson, 2008; Kane, et al., 2016; Marshall & Rathbone, 2011; Tandon, Keshavan & Nasrallah, 2008) and may prevent or delay relapse (Álvarez-Jiménez, Parker, Hetrick, McGorry, & Gleeson, 2011). These results are strengthened when there is sufficient funding to support the interventions fully and with fidelity to the researched model (Csillag, et al., 2016). First episode intervention programs (such as the RAISE initiative) generally include the provision of multimodal psychosocial interventions (CBT, family based psychoeducation, illness management, educational and vocational interventions), pharmacotherapy, and some form of case management with lower case-loads and an assertive approach to treatment, all within the context of intervening as early as possible. Another unrelated, but interesting line of research has shown that omega-3 fatty acids (fish oil) prevented development of psychosis for the duration of the initial study period (12 months) (Amminger, et al., 2010) and confirmed by a longer term (median 6.7 years) follow up
A study (Amminger, Schafer, Schlogelhofer, Klier, & McGorry, 2015), making this a potentially promising intervention to help individuals who are averse to taking psychotropic medications.

Despite the promising results of early intervention research, the evidence also suggests that the effects may not be sustained beyond the intervention period and continued intervention may be needed (Bertelsen, et al., 2008; Bird, et al., 2010; Bosanac, Patton & Castle, 2010; Gleeson, et al., 2013; McGorry, Nelson, Goldstone & Yung, 2010; Norman, et al., 2011; Pretia & Cella, 2010), especially during what is considered the five year critical period from onset of psychotic symptoms (Addington, Leriger & Addington, 2003; Birchwood, Todd & Jackson, 1998; Harrison, et al., 2001; McGlashan, 2006; McGorry, 2002; Perkins, Gu, Boteva, & Lieberman, 2005; Wyatt & Hunter, 2001). The NIMH RAISE initiative is continuing research designed to determine the sustainability of early intervention results (Kane et al., 2016).

Emerging research is indicating that use of pharmacologic interventions following remission from first episode psychosis (FEP) may need to be used at much lesser doses and potentially discontinued altogether. In one of the first studies in this area, Harrow and Jobe (2007) identified individuals with schizophrenia who achieved greater symptom and functional recovery at all follow up periods over a fifteen year period. These results were confirmed following additional follow up at twenty years post initial hospitalization. The authors also measured individuals pre-morbid characteristics and identified greater levels of resiliency, better pre-morbid developmental achievements, less vulnerability to anxiety, better neurocognitive skills, and less vulnerability to psychosis as factors that contributed to individuals’ better outcomes (Harrow, et al., 2012; Harrow & Jobe, 2013).

In another study, Wunderlink and colleagues showed that following remission from FEP, discontinuing psychotropic medications over an 18 month period resulted in initially greater rates of relapse at three years post relapse, but at seven years, the rate of functional recovery was twice that for the discontinuation group compared to the maintenance therapy group with relapse rates at the seven year follow up similar in both groups (Wunderlink, et al., 2013). Clearly, initially increased relapse rates are not desirable but may be an acceptable price to pay for significantly greater functional capability over the long term (McGorry, et al., 2013).

Somewhat distinct from the issue of long term medication use is a related but slightly different aspect of medication use, i.e., duration of untreated psychosis (DUP). Evidence suggests that the longer an individual remains without treatment after evidencing psychosis, the poorer the ultimate outcome (Marshall, et al., 2005). There is also evidence that reducing DUP leads to better long term outcomes (Kane, et al., 2016; McGlashan, et al., 2011). This is also an important and emerging area of intense research interest that needs to be followed carefully.

Early intervention is an area that many see as one of the most important, and considerable research is underway in this area. This is because the real tragedy of SMI/SED is the loss of life’s potential that happens when proven rehabilitative treatments are not provided. Engaging individuals who are experiencing a first episode of psychosis, especially those who are youth is especially important and may be facilitated by developmentally appropriate interventions (Green, Wisdon, Wolfe & Firemark, 2012) as demonstrated by the RAISE trial and other research efforts that help individuals establish and maintain family and social networks along with involvement in education and employment endeavors (Tempier, et al., 2012).

**Peer support and peer delivered services**

Participation of consumers in the design and delivery of mental health services is one of the hallmarks of a mental health system that truly supports the principles of recovery. People with lived experience of mental illness consistently report that having the support of others who have gone through what they are going through is one of the most important and helpful services; several studies have confirmed these perceptions (Dumont & Jones, 2002; Naslund, Grande, Aschbrenner, & Elwyn, 2014;
Nelson, Ochocka, Janzen & Trainor, 2006; Piat, et al., 2009). There are many models of consumer involvement in the delivery of services and peer support is the most widely known of these.

Peer support programs are provided by individuals who have experienced SMI/SED themselves and who have recovered sufficiently to be helpful to others who have similar problems. Peers listen, share their own experiences, and offer support, hope, encouragement, education, and practical suggestions. Peer leaders are trained to engage in active and supportive listening, and are trained to lead groups themselves or to work individually with current consumers. Training in basic communication skills may be needed to ensure that the peer support worker is skilled enough to offer a helpful intervention. Many believe that peer support programs help to normalize the experience of having an SMI/SED while traditional treatment tends to medicalize and stigmatize it.

In addition to peer support services, other types of peer delivered services are currently being delivered and researched. These can include peers serving as regular members of the mental health clinical team and peers organizing and running independent services. Naturally occurring peer support via social media has been shown to help minimize feelings of isolation and provide a sense of hope, enhance feelings of support via peer exchange and reciprocity, allow for sharing strategies for coping with day-to-day challenges of SMI/SED, and allow for learning from shared experiences of medication use and mental health care seeking (Naslund, et al., 2014).

Controlled studies of peer support are beginning to emerge with increasingly effective outcomes demonstrated (Chinman, et al., 2014; van Gestel-Timmermans, 2012). Peer support is currently the focus of considerable research interest to determine if there is enough empirical evidence to include it as an EBP. There is no question that those receiving services value it greatly (Smith, et al., 2017). Because of the importance of peer support services to those with SMI/SED and the wide acceptance of the model in community mental health services worldwide, psychologists will increasingly work alongside individuals who are peer supporters. Psychologists who serve as managers and administrators will also function as supervisors and program developers of this new and important service. There are many issues that can arise because of the need to balance the role of service recipient and service provider; a more comprehensive discussion of these issues can be found in module 13 of the APA Curriculum which is devoted to peer delivered services (American Psychological Association & Jansen, 2014).

Additional interventions to address critically important problems experienced by people with SMI/SED

Stigma and self-stigma

Changing long-standing attitudes and behaviors is very difficult. Psychologists have been at the forefront of highlighting the important and devastating consequences of societal stigma for people with SMI/SED and have also led efforts to develop and test interventions to help individuals overcome the internalized stigma they have as a result of their experiences (Corrigan & Rao, 2012). In fact, an entire special issue of an APA journal was recently devoted to the topic of self-stigma (Psychiatric Rehabilitation Journal, 2015, volume 38, number 2) and included several articles on interventions designed to help individuals counter their internalized stigma (Conner, McKinnon, Ward, Reynolds, & Brown, 2015; Harris, et al., 2015; Mackay, Bradstreet, McArthur, & Dunion, 2015; Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2015).

Interventions to change attitudes and decrease discriminatory behaviors among health providers and the public at large have also been developed. Corrigan, Mueser, Bond, Drake and Solomon, (2008) identified the most promising of these as education and contact, with contact being the stronger of the two (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). Peer delivered services can serve as a stepping stone as peers are individuals with a serious mental health disorder who have recovered sufficiently to be of assistance to individuals not yet recovered and many peers work in mental health service settings; contact with peer specialists can change provider attitudes (Nemec, Swarbrick, &
Legere, 2015). To date, despite the plethora of psychological research identifying the effects of stigma, no single intervention or combination of interventions has been proven definitively to change attitudes and behavior.

With respect to enhancing opportunities for community inclusion, creating opportunities for people with and without SMI/SED to meet and interact has been shown to break down stereotypes and reduce stigma (Vaughan & Hansen, 2004). This has been found to be especially true with respect to reducing stigma due to perceived dangerousness, fear and social distance (Couture & Penn, 2003). When communities do not focus on increasing positive components and decreasing negative ones, individuals with SMI/SED often exclude themselves for fear of further stigmatization, rejection, behavioral flare-ups, and instead seek out situations where others with similar conditions are present and where they will be more readily accepted (Bromley, et al., 2013).

By helping people develop skills that will help them achieve their goals, assisting with attainment of good housing, social activities, and employment opportunities, while at the same time refusing to accept or sanction (even by silence or inaction) discrimination, stigmatization, marginalization, or policies and practices that are, or have the potential to lead to exclusion, and by working to change environments that are dehumanizing and emotionally toxic, psychologists can actively promote social inclusion and an environment conducive to recovery from SMI/SED.

Promoting community inclusion involves interventions designed to build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion. Psychologists can assist individuals by using behavioral shaping methods to teach skills for accessing and using community facilities, teaching social and communication skills to ensure individuals feel confident about their abilities to participate and helping people to become connected to support and peer groups. CBT and other psychological treatments to improve cognition, self-esteem and confidence can be of great help to those struggling to deal with the devastating effects of internalized and external stigmatization (Thornicroft, Brohan, Kassam & Lewis-Holmes, 2008). Simply feeling that one matters to others, i.e., is valued by others, recognized by others, and that others are concerned about the person’s well being, has been shown to help mediate the effects of social support and reduce self stigma, potentially leading to sustained involvement of persons in supportive social engagements (Pernice, Biegel, Kim, & Conrad-Garrisi, 2017). Additionally, implementing social enterprise projects to promote inclusion of individuals with SMI/SED in community development activities can help to develop a supportive community through business and civic infrastructure (Mandiberg, 2012), leading to opportunities for social inclusion, reduced isolation, increased self-esteem and confidence, economic opportunities, and ultimately less stigmatization.

Indeed, psychologists and other mental health providers have a responsibility to work to ensure full integration as part of the treatment and rehabilitation services provided rather than assuming that these will be taken care of by someone else after the person leaves the service system (Farkas & Anthony, 2010; Tondora, 2011). Ideally, psychologists would take an active role in promoting full inclusion of people with SMI/SED. The American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct (2002) encourages psychologists to advocate for the rights of all individuals, especially those who are most vulnerable (Preamble, p. 3 and Principle E, p. 4).

**Trauma interventions**

We have stressed that many if not most of those with SMI/SED have experienced severe and often repeated abuse leading to serious trauma reactions. Treatment must be specifically geared toward helping people with SMI/SED work through the devastating effects of the traumatic experiences they have had (Rosenberg et al., 2001). Yet, psychologists receive only cursory information about the seriousness of trauma for people with SMI/SED and receive little training in how to effectively help people with SMI/SED deal with the consequences of trauma (Cook & Newman, 2014). In 2015, APA released its Guidelines on Trauma Competencies for Education and Training (American Psychological Association,
This document outlines a comprehensive set of general guidelines and competencies for practice with persons who have experienced trauma. Despite noting that competence requires recognition of characteristics of various sub-populations, even this comprehensive document does not address the unique experiences and outcomes that trauma often has had in the lives of people with SMI/SED. Competently intervening to help people with SMI/SED who have experienced severe trauma requires highly specialized training and treatment, often referred to as trauma specific care.

A review of interventions for people with SMI/SED and severe trauma found that both cognitive behavioral treatment (combined with psycho-education about PTSD, breathing retraining, and cognitive restructuring) (Mueser, et al., 2008) and exposure therapy (combined with group therapy focused on education, relaxation training and social skills building) (Frueh, Grubaugh, Cusack, Kimble, Elhai & Knapp, 2009) were effective, with the cognitive behavioral treatment program evaluated in the largest clinical trial conducted to date. This comprehensive review notes that continued research is needed to address the extremely important but often overlooked issue of trauma experienced by people with SMI/SED (Grubaugh, et al., 2011). Results for the effectiveness of cognitive restructuring have recently been confirmed in subsequent research (Mueser et al., 2015).

Due to the high prevalence of male perpetrated violence against women, the treatment needs of women may be very different from those of men (Bently, 2005). Women that have been abused by men will likely be unable to work through those issues in a mixed group – a mixed trauma group can actually exacerbate their trauma. Services offered in women only groups may be essential for women who have been abused both to help them recover and to avoid exacerbating their trauma (Salina, Lesondak, Razzano, & Weilbaecher, 2007; Saxena, et al., 2014; Wright, et al., 2012). A PTSD group for women in these circumstances is essential. Some trauma services (Najavits, 2006) have been designed or modified specifically for women been but their availability is typically limited.

With respect to psychological treatments for children and adolescents with PTSD, a recent review found that all psychological treatments studied were effective at helping those in this age group recover, likely due to their age and the resilience of most youth. CBT was found to be particularly effective (Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2012).

While not specific to trauma experienced by those with SMI/SED, The latest version of the VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress indicates the following:

The evidence-based psychotherapeutic interventions for PTSD that are most strongly supported by RCTs can be considered broadly within in the trauma-focused psychotherapy category or stress inoculation training. Trauma-focused psychotherapies for PTSD refer to a broad range of psychological interventions based on learning theory, cognitive theory, emotional processing theory, fear-conditioning models, and other theories. They include a variety of techniques most commonly involving exposure and/or cognitive restructuring (e.g. Prolonged Exposure, Cognitive Processing Therapy and Eye movement Desensitization and Reprocessing). They are often combined with anxiety management/stress reduction skills focused specifically on alleviating the symptoms of PTSD. Psychoeducation is another important component of all interventions. Other CBT interventions that are not trauma-focused are less effective. (U.S. Department of Veterans Affairs and U.S. Department of Defense, 2010, p. 115).

Along with exposure, CBT for trauma includes:

- Learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts (cognitive restructuring)
- Managing anger
- Preparing for stress reactions (stress inoculation)
- Handling future trauma symptoms
• Addressing urges to use alcohol or drugs when trauma symptoms occur (relapse prevention), and
• Communicating and relating effectively with people (social skills or marital therapy).

Alcohol and drug abuse commonly occur with trauma related disorders because of the numbing effect of the drugs and their ability to help the person escape from the high levels of anxiety experienced. It is important to treat the substance use disorder along with the trauma disorder (Dass-Brailsford & Myrick, 2010; Finkelstein, et al., 2004; Harris & Fallot, 2001). Given the high co-morbidity of substance use disorders among those with SMI/SED and the prevalence of exposure to violence, abuse, and other traumatic experiences, concurrent treatment for these conditions can be critical. A manualized program not developed for people with SMI/SED but developed specifically for co-occurring substance abuse disorders and PTSD is called Seeking Safety. Seeking Safety is a CBT based program that has been found to be effective for a range of individuals with PTSD (Najavits, 2006; Najavits & Hien, 2013); a version of this program adapted for women who have experienced severe trauma is also available. A comprehensive toolkit for understanding the effects of trauma and providing trauma specific services to address the effects of trauma and the co-morbidities often present such as substance use disorders, homelessness, etc., has been developed and is freely available for download (Manitoba Trauma Information and Education Centre, 2013).

Finally, in addition to trauma specific psychotherapy, pharmacotherapy is an important component of treatment to reduce the anxiety, depression, and insomnia that often accompany trauma reactions and PTSD, making it possible for individuals to participate in psychotherapy treatment.

**Suicide prevention interventions**

We have stressed the importance of engaging people in treatment as soon as symptoms are observed. Other than outreach and close follow up, few preventive measures have been identified to reduce suicide attempts, although high levels of support have been shown to reduce the risk that an attempt will be made (Sinclair, et al., 2004). Receiving timely medical treatment has also consistently been found to reduce the risk that an individual will commit a homicide or suicide (Coid, 1983; Fazel & Grann, 2004; Meehan, Flynn, Hunt, et al., 2006; Niellsen, Westmore, Large & Hayes, 2007; Wallace, et al., 1998). A 2005 worldwide review of available evidence of interventions for the public at large indicated that educating physicians to recognize and treat depression and limiting access to lethal methods of suicide were the only methods with evidence of efficacy (Mann, et al., 2005). Hogan and Grumet (2016) discussed the need for greater attention to developing effective interventions, but research in this area has been limited. Recently, ketamine, an anesthetic drug, has been found to rapidly lift depression and reduce suicidal ideation (Grunebaum, et al, 2017). This research is still in early stages, thus no recommendation can be made at this point. While the research to date has focused on persons with major depression and not specifically on those with SMI/SED, this may prove helpful for this population if determined in future research to be safe and effective.

For people with SMI/SED, greater awareness of their condition and feelings of hopelessness are associated with higher risk of suicide; thus individuals need to be carefully assessed for suicidal ideation especially if they are markedly depressed, and/or there is considerable improvement in their awareness of their condition (Pompili, et al., 2007). Treatment for affective symptoms, especially depression, improving adherence to treatment and very close follow up may be effective in preventing suicide (Hawton, et al., 2005). Outreach and close follow up are among the few non-pharmacologic preventive measures that have been definitively identified as effective in preventing suicide with this population, although high levels of support have been shown to reduce risk (Sinclair, et al., 2004).

Additionally, the second generation anti-psychotic medication Clozapine has been shown to be effective (Alphs, et al., 2004; Hennen & Baldessarine, 2004; Modestin, Dal Pian, & Agarwalla, 2005). A
recent meta-analysis of attempts to categorize suicide risk found that there has been little progress and that such categorization efforts remain elusive (Large, et al., 2016).

**Violence prevention interventions**

As with suicide prevention, engaging people in treatment as soon as symptoms are observed is highly important and as mentioned above, receiving timely medical treatment has consistently been found to reduce the risk that an individual will commit a homicide or commit suicide (Coid, 1983; Fazel & Grann, 2004; Meehan, et al., 2006; Nielsens, et al., 2007; Wallace, et al., 1998). It has further been shown that the second-generation antipsychotics Clozapine, Risperidone, and Olanzapine significantly decreased violent behavior, while conventional antipsychotics did not have the same effect (Swanson, Swartz & Elbogen, 2004). Unfortunately, there are often delays in accessing treatment for people experiencing their first episode of psychosis, putting them and others at risk.

For both suicide and violence prevention, in addition to psychotropic medication, a recovery oriented, person-centered approach to engaging people to recognize their illness and take part in psychosocial rehabilitation interventions such as CBT, skills training, illness management, and family psychoeducation, are important for helping individuals with SMI/SED to gain control of their illness and their lives, identify the goals they wish to accomplish, and work toward achieving a satisfying life.

**Interventions to decrease homelessness**

Most individuals who are homeless have experienced trauma and being homeless is an added traumatic experience in and of itself (Hopper, et al., 2010) and leaves many open to victimization and even greater trauma (Grubaugh, et al., 2011). Given that many individuals with SMI/SED have experienced severe trauma, the addition of yet another trauma inducing event such as homelessness can be seen as devastating (Substance Abuse and Mental Health Services Administration, 2007) and many have stressed the need for trauma informed care and trauma specific services in homeless service settings (Cocozza, Jackson, & Hennigan, 2005; Gillis, Dickerson, & Hanson, 2010; Hopper, et al., 2010; Jennings, 2008; McHugo, et al., 2004). Most people prefer to live independently and many people with SMI do live independently. Others need varying levels of support and there are a range of options for helping people with SMI/SED live in the community. Trauma, homelessness, substance abuse, and victimization intersect requiring integrated trauma informed care, trauma specific services, and homeless services (Cocozza, et al., 2005; Gillis, et al., 2010; Hopper, et al., 2010; Jennings, 2008; McHugo, et al., 2004).

Many studies have found decreased use of alcohol and drugs, reduced costs for police services, emergency room treatment, increased housing stability, and decreased psychiatric hospitalization when people have a stable place to live (Culhane, Metraux & Hadley, 2002; Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Leff, et al., 2009; Lipton, Siegel, Hannigan, Samuels, & Baker, 2000; Pearson, Montgomery & Locke, 2009). Additionally, outcome studies have generally concluded that functioning can improve, social integration can be facilitated, and residents are generally more satisfied in supported housing compared with conventional hospital care (Best, et al., 2006; Clarke, Febbrara, Hatzipantelis & Nelson, 2005; Fakhoury, Murray, Shepherd & Priebe, 2002; Forchuk, Ward-Griffin, Csiernik & Turner, 2006; Parkinson, Nelson & Horgan, 1999; Rog, 2004). Some programs provide treatment for co-occurring substance use disorders with support embedded with the housing program and these have shown reduced service system costs (Gilmer, Stefancic, Ettern, Manning, & Tsemberis, 2010; Mares & Rosenheck, 2009).

Supported housing is an intervention designed to assist people with SMI find and maintain stable residences with the ongoing support of mental health professionals (Chilvers, Macdonald & Hayes, 2010). Models range from providing support for people living independently with casual support through to housing where staff persons are on site twenty four hours per day. Often individuals with SMI/SED who are homeless or at risk of becoming homeless need information and skills training to help them learn how
to manage their home and frequently need treatment for co-occurring substance use disorders. Although information and skills development related to obtaining and maintaining appropriate housing are sometimes integrated into other clinical interventions, these can be provided as a separate service. Recent reviews have found that the best outcomes were achieved when housing was provided together with support utilizing an integrated services model such as a comprehensive assertive community treatment model (Adair, et al., 2016; Aubry, Nelson, Tsemberis, 2015; Aubry, et al., 2016; Coldwell & Bender, 2007; McHugo, et al., 2004; Nelson, Aubry & Lafrance, 2010; Rogers, Kash & Olschewski, 2009); integrated services that adopt a trauma informed care approach, and trauma specific services are needed.

Authors of a comprehensive synthesis of the research literature found the following:

Overall, our synthesis suggests that supported housing can improve the living situation of individuals who are psychiatrically disabled, homeless and with substance abuse problems. Results show that supported housing can help people stay in apartments or homes up to about 80% of the time over an extended period.... Housing services appear to be cost effective and to reduce the costs of other social and clinical services. In order to be most effective, intensive case management services (rather than traditional case management) are needed and will generally lead to better housing outcomes. Having access to affordable housing and having a service system that is well-integrated is also important.... Supported housing can improve clients' quality of life and satisfaction with their living situation.... In addition, rapid entry into housing, with the provision of choices is critical (Rogers, et al., 2009, p. 1).

To date, the most solid evidence for the benefits of assisting people to achieve stable housing indicates that permanent, supportive housing appears to achieve the best results. Models of permanent, supportive housing are rated more positively by individuals and led to reduced homelessness, increased housing tenure, and decreased emergency room visits and hospitalization (Rog, et al., 2014). Additional research is needed to identify the best housing solutions for people with SMI, many of whom have co-occurring substance use disorders. As mentioned, current results indicate that provision of safe and affordable supportive housing can help homeless individuals with SMI remain in stable housing, use adjunct social services less and achieve stability. Providing stable housing and decreasing homelessness are desirable goals irrespective of other benefits.

**Smoking cessation**

Smoking cessation for people with SMI/SED is a priority because of the life threatening implications of the habit and because of the difficulty individuals with SMI/SED have in quitting. In addition to pharmacologic treatments, behavioral interventions have been consistently recommended and, although remaining smoke free is very difficult, these have been shown to be effective (Schroeder & Morris, 2010; Siu, for the U.S. Preventive Services Task Force, 2015). Behavioral interventions include quit lines, motivational interviewing, physician advice to quit, peer advice to quit, and skills training to increase coping with smoking urges, nutritional eating, etc. Because psychotropic medications can cause those with SMI and SED to smoke more heavily, interventions tailored to meet the specific needs of each individual are recommended, along with careful monitoring for depression (Schroeder & Morris, 2010). As with obesity, the serious health implications of smoking and the great difficulty that people with SMI/SED have in changing both eating and smoking behaviors, individuals should receive close monitoring; unfortunately, this is not often the case.

**Interventions for people with SMI/SED in the criminal justice/forensic systems**

As we mentioned in the section on Social Problems, the terms forensic system and criminal justice system are frequently used interchangeably, making a separate discussion of these systems difficult. As in the previous section, we do not make a distinction between these systems in our discussion of interventions for the population of people with SMI/SED in these settings.
While the these deplorable conditions of jails and prisons may make forensic psychiatric hospitals appear to be stellar institutions, and despite the fact that some forensic psychiatric institutions are at the forefront of providing the latest services and opportunities for this population, for the majority of U.S. jails, prisons, and forensic psychiatric hospitals, there are not adequate or appropriate services for people with serious mental illnesses in any setting. In many ways, forensic/criminal justice settings are antithetical to the concept of recovery for people with SMI/SED. Individuals who are incarcerated or are in these settings have little free choice and often have serious threats to their own safety. Thus, in most of these settings, there is little ability to provide services consistent with the recovery paradigm and to offer services designed to help people learn the skills they need to achieve their life goals.

Forensic patients (referring particularly to those found unfit to stand trial, not criminally responsible, or with forensic hospital as the final disposition after criminal offending) have unique rehabilitative needs. Their recovery tasks encompass all of the usual elements including recovery from acute symptoms, finding medication that is effective and gaining insight into their illness and the need for treatment. They must try and define a ‘life worth living’ for themselves, overcome problems of functional impairment, find vocational support and foster healthy relationships with family and friends....The offender–patient, however, is likely to have additional tasks to do, over and above these ‘typical’ recovery tasks. The extra work would be related to the origins and effects of their offending, and the legal oversight and accountabilities now imposed upon them. Furthermore, these variables coalesce in the context of a secure hospital where the person is often isolated from community contacts and living within a structure of compulsory care that curtails liberty and several key elements of autonomous decision-making, such as consent to treatment or management of finances. (Simpson & Penney, 2011, p. 301-302).

Despite this, some interventions have been developed to help people avoid re-incarceration and achieve a stable and satisfying life in the community. Information about these is presented below. Due to the complexity of the issues involved, release planning and intervention efforts must be included and we also present information about these critical components.

Most mental health professionals who work in forensic/criminal justice settings do not understand the adaptive behaviors that must be learned if one is to blend in, avoid abuse, and survive in an environment where coercion can come at the hand of other inmates and or at the hands of guards and officials – this is particularly true in jails and prisons. Mental health professionals need to understand the complex dynamics of forensics/criminal justice settings and assist the people they work with to learn healthy behaviors that will help them adapt in the community and avoid re-incarceration (Rotter, et al., 2005). The increasing census of correctional systems and the decreasing budgets allocated to these systems, make implementing recovery oriented best practices a desirable but elusive goal for most. Despite this, one forensic hospital stands above the rest because of the commitment of the psychologists who work there and the trainees who have learned from them. Fulton State Hospital in Missouri has been at the forefront of implementing recovery oriented psychosocial rehabilitation interventions for over twenty years (Newbill, Paul, Menditto, Springer & Mehta, 2011), and there are other forensic facilities where individual mental health professionals are desirous of doing the same (Tapp, Warren, Fife-Schaw, Perkins & Moore, 2013).

However, research on clinical interventions for people with SMI/SED in criminal justice/forensic settings has been limited, with much of that research aimed principally at reducing re-arrest, although some attention has been given to symptom improvement. In the forensic/criminal justice arena, there are several reasons for the limited research and the emphasis on reducing re-arrest, chief among them is the fact that those who have committed a crime have not been viewed as candidates for clinical services, largely due to the emphasis on risk management in these settings. This approach has been questioned more frequently in recent years due to the high cost of maintaining increasing numbers of individuals in expensive institutional settings, and because of the social implications of failing to help mentally ill offenders achieve a satisfying and productive life in the community. Research is also resource intensive.
and it can be difficult if not impossible for forensic systems that are continually facing budget cuts to choose between continuing to house people versus conducting research on the best ways to achieve long term solutions even though such long term solutions will ultimately benefit the systems and the people in them. Researchers recently showed that receipt of outpatient treatment following release including having a 90 day supply of medication reduced the likelihood of arrest (Van Dorn, Desmarais, Petrila, Haynes, & Singh, 2017). Some have suggested a more collaborative approach, which includes asking the affected individuals what would best help them (Tapp, et al., 2013); this collaborative approach is not normative in the forensic/criminal justice system.

Among the more prominent endeavors has been research aimed at improving adaptive behavior deficits to help individuals learn more pro-social behaviors in order to integrate more successfully into the community. Social learning programs based on the seminal work of Paul and Lentz (1977) are the basis for these efforts which have achieved success in multiple residential settings, including forensic psychiatric hospitals (Beck, Menditto, Baldwin, Angelone & Maddox, 1991; Lyskowski, Menditto & Csernansky, 2009; Newbill, et al., 2011; Silverstein, et al., 2009). Social learning programs aim to teach skill development, including communication and other social skills, increase an individual’s capacity for self-care, and improve cognitive skills such as attentional capacity, problem-solving skills, etc., and help people learn more appropriate leisure skills (Newbill, et al., 2011). While not common in forensic psychiatric hospitals, where provided, these programs have achieved success.

Like research, providing complex planning and intervention strategies is resource intensive. Unfortunately the forensic/criminal justice systems are significantly under resourced and becoming ever more challenged by the growing census of people who have mental health disorders, including SMI, are homeless, have co-occurring substance abuse disorders, are physically ill, and have been severely abused and traumatized. Thus, it is important to recognize that simply providing one or more interventions will not solve the multitude of problems faced by individuals within this population. Rather, a set of services designed for and with, the individual and tailored to his or her complex needs must be provided if we are to help people break the cycle of incarceration, release, symptom exacerbation, and re-incarceration (Epperson, et al., 2011; Epperson, et al., 2014; Frank & McGuire, 2011; Skeem, et al, 2011). It is also important to note that pharmacotherapy with the right medication has been shown to play an important part in breaking this cycle (Chang, Lichtenstein, Langstrom, Larsson, & Fazel, 2016) and should be considered in combination with the psychosocial interventions discussed below.

Driven often by initiatives of the U.S. Department of Justice, but also by the independent recognition of a need to improve the quality of services provided, many state-run forensic psychiatric hospitals are further along in incorporation of recovery approaches and inclusion of a range of services than are prisons and jails. The kinds of treatments that can be found in modern, well-run forensic psychiatric hospitals (such as Fulton State Hospital in Missouri) include a range of treatments. Recently forensic and criminal justice mental health professionals have begun to think about using interventions already shown to be effective with non-forensic populations to help those in forensic and criminal justice settings. A few of the evidence based practices (EBPs) we discussed above have been adapted and tested for this population. Initial results indicate some success with some individuals. Results are not clear cut however, as there are several different settings within the overall forensic/criminal justice system, and because of the diversity of the population which ranges from people who have committed petty crimes to those who have committed capital offenses and also ranges from people with less serious mental health disorders to those with very severe mental illnesses. It can also be difficult to recruit subjects who are willing to participate in research studies and there is a high drop-out rate from such studies and from treatment. All of these factors make drawing consistent conclusions about the effectiveness of an intervention with varied populations difficult.
Notwithstanding the above, two overarching findings that have emerged consistently across settings and populations are the following:

1. Combining mental health interventions with forensic supervision is necessary to achieve success; often multiple interventions are needed.

2. The intensity of both the clinical intervention and the forensic supervision must be matched to the level of risk or recidivism of the individual with greater intensity afforded to those at higher risk. In the forensic/criminal justice literature, this is called the Risk-Needs-Responsivity principle (Andrews, Zinger, Hoge, Bonta, Gendreau & Cullen, 1990; Blackburn, 2004; Prins & Draper, 2009).

The Risk-Needs-Responsivity principle is widely accepted as the premier model for guiding assessment and treatment in forensic settings. A recent adaptation is the Good Lives Model which places greater emphasis on a strengths based approach (Barnao, 2013), but which does not differ substantially in content from the Risk-Needs-Responsivity principle according to reviews of the literature (Andrews, Bonta & Wormith, 2011). However, from the perspective of providing services that are oriented toward helping people recover and achieve a satisfying and productive life in the community, some have called into question the ethics of following these models because of their reliance on controlling risk as the basis for providing services instead of focusing on establishing a true therapeutic partnership and providing the best services available (Gannon & Ward, 2014). Given the current emphasis on controlling real or perceived risk, the debate about what is most appropriate is likely to continue.

A model combining clinical interventions with interventions to reduce criminal behavior and risk factors has been proposed (Epperson, et al., 2014). The model includes interventions aimed at medication adherence, criminogenic risks such as inability to control anger, impulsivity, criminal thinking, etc., addiction risks, trauma risks, stress risks, and social and environmental disadvantage risks. The model is depicted by the figure below:

Person-place framework of factors contributing to criminal justice involvement (Epperson, et al., 2014)

Within this model, a comprehensive array of interventions to address each risk factor is proposed. While most agree that such an approach is needed, continued funding cuts combined with the stigma associated with SMI/SED and criminality make implementation of comprehensive services difficult, albeit extremely important.
Although intervention research related to forensic/criminal justice settings is limited, three clinical EBPs (assertive community treatment, cognitive behavioral therapy, concurrent disorders treatment (also known as integrated dual diagnosis treatment) and some promising practices (trauma informed care, trauma specific services and supported housing) have been studied in forensic/criminal justice settings. Related interventions, most often based on cognitive behavioral approaches, are often offered in various justice related settings and some of these have begun to show positive results (Haddock, et al., 2009; Tew, Dixon, Harkins & Benett, 2012). Systematic reviews of published studies have also begun to provide evidence that interventions to help people with SMI/SED in forensic systems can be beneficial (Duncan, Nicol, Ager & Dalgleish, 2006; Mancini, Linhorst, Menditto & Coleman, 2013; Martin, Dorken, Wamboldt & Wootten, 2012).

For the most part, research on these efforts is in early stages. Consequently, the following discussion is limited to what is currently known about using the existing evidence-based and promising practices along with mental health courts.

**Forensic assertive community treatment (FACT)**

FACT is a version of the EBP Assertive Community Treatment (ACT), modified for use in the forensic system. FACT combines mental health and criminal justice involvement through collaboration between the two systems and is described as follows:

Forensic Assertive Community Treatment (FACT) is distinguished from ACT in four ways: participants have criminal justice histories, preventing arrest and incarceration are explicit outcome goals, the majority of referrals come from criminal justice agencies, and supervised residential treatment is incorporated into the program (Prins & Draper, 2009, p. 27).

People with SMI/SED in the varied parts of the criminal justice/forensic system are very diverse. Because of this, FACT and other interventions are typically provided in a wide array of settings. In addition to use in community settings for individuals with SMI/SED released from the criminal justice system, FACT has been used in jail diversion programs and in prison re-entry programs. Investigators have found the characteristics of individuals in these settings to be very different however. Prison re-entry individuals are more likely to be older, male, have schizophrenia, and be in assisted living, while jail diversion persons are more likely to be female, have mood and substance use disorders, be living independently, and have been physically and sexually abused. Given these differences, FACT and other intervention programs need to be tailored to meet the needs of the group they are to be serving. Services for older and more ill individuals should focus on providing help with independent living skills while services for younger, less severely ill persons need to be aimed at helping people achieve successful and stable transition to more normalized community life (Cuddeback, Wright & Bisig, 2013).

Outcome studies for FACT in a variety of settings have yielded mixed results but several have shown decreased recidivism, improved psychiatric stability and community treatment engagement, and reductions in overall spending (Cusack, et al., 2010; Lambert, Deem, Weisman & LaDuke, 2011; Prins & Draper, 2009; Smith, Jennings, & Cimino, 2010). FACT is currently considered to be a promising practice for helping people with SMI/SED in the criminal justice/forensic system avoid re-incarceration and remain in the community. The services and the intensity of those services need continued study to determine which combination works best for those with varying needs and in different settings.

**Cognitive behavioral therapy (CBT) in the criminal justice/forensic systems**

The research literature is replete with recommendations for use of interventions based on CBT with incarcerated individuals with mental illness and particularly for those with conduct disorders and antisocial personality disorder, principally aimed at controlling anger and reducing aggression (Novaco, 2013; Wilson, 2013). Investigators have also shown that CBT holds promise for helping individuals with schizophrenia achieve better interpersonal functioning (Williams, Ferrito & Tapp, 2014), and for helping
individuals reduce the impact of substance misuse (Morris & Moore, 2009). Additionally, medication and psychoeducation combined with CBT have been found to be beneficial (Tapp, et al., 2013). A meta-analysis of the effectiveness of CBT for corrections populations concluded that its use can substantially decrease recidivism (Lipsey, Landenberger & Wilson, 2007). This review found that several factors were related to increased success including adequate training for the clinician providing the intervention, skills training targeted at specific problem behaviors, the risk level of the participants, the quality of the treatment implementation, and the presence of anger management strategies and interpersonal problem solving components.

One CBT program that was designed specifically for forensic populations has been extensively evaluated, the Reasoning and Rehabilitation CBT intervention program (Fabiano, Porporino & Robinson, 1990; Porporino & Fabiano, 2000). The program has been implemented in several countries including the US, Canada, England, Wales, Scotland, each of the Scandinavian countries, Spain, the Canary Islands, Germany, Australia and New Zealand. The program has consistently demonstrated good results (Tong & Farrington, 2006; Young, Chick & Gudjonsson, 2010). Cognitive-behavioral programs for this population typically address attributes most related to criminal behavior and that may be most amenable to change. These include such factors as impulsivity, inability to control anger, violent behavior, maladaptive patterns of thinking, antisocial behaviors and attitudes, associations with pro-drug and antisocial peers, poor social skills, and drug use.

Concurrent disorders treatment (integrated dual diagnosis treatment) in the criminal justice/forensic systems

The rate of co-occurring substance abuse and mental health disorders among forensic/criminal justice populations is extremely high, estimated to be 72% of both males and females in the corrections system (Abram & Teplin, 1991; Abram, Teplin, & McClelland, 2003; Skeem, et al., 2011). It is widely acknowledged that integrated treatment must be a cornerstone of efforts to assist persons to remain out of prison and achieve success in the community (Osher & Steadman, 2007; Prins & Draper, 2009). Unfortunately, needed treatments are not readily available; this is also widely acknowledged.

The components of a concurrent treatment approach include psychotropic medication, Motivational Interviewing, and CBT interventions. In 2012, the U.S. National Institute on Drug Abuse (NIDA) issued a revised report based on the latest research entitled Principles of Drug Abuse Treatment for Criminal Justice Populations. Due to the very high rates of co-morbid mental health and substance abuse disorder in forensic psychiatric populations, these principles could guide the provision of services for this population.

The principles articulated by NIDA include:

1. Drug addiction is a brain disease that affects behavior.
2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
3. Treatment must last long enough to produce stable behavioral changes.
4. Assessment is the first step in treatment.
5. Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.
6. Drug use during treatment should be carefully monitored.
7. Treatment should target factors that are associated with criminal behavior.
8. Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.
9. Continuity of care is essential for drug abusers in re-entering the community.

10. A balance of rewards and sanctions encourages prosocial behavior and treatment participation.

11. Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.

12. Medications are an important part of treatment for many drug abusing offenders.

13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis (U.S. Department of Health and Human Services, 2012).

The SAMHSA GAINS Center’s publication entitled Treatment of People with Co-occurring Disorders in the Justice System (undated) is an excellent document that succinctly outlines what providers need to do to help people with co-occurring disorders. These are:

- Engage the person and encourage commitment
- Take steps to ensure continuity of care from one setting to another
- Provide comprehensive services
- Provide on-going assessment and services tailored to the needs of each individual.

The document also outlines the key strategies needed:

- Provide integrated treatment for both the mental health disorder and the substance abuse disorder; both should be considered primary disorders and treated as such
- Design individual psychosocial and skills building interventions that are tailored to the needs and goals of each person
- Review all medications and ensure that appropriate ones are used. Inform each person about the complications that can be caused by use of alcohol and other drugs
- Ensure community connections that follow through with release planning for continuity
- Integrate therapy with self-help groups and support (p. 3).

Trauma informed care/trauma specific services in the criminal justice/forensic systems

Exposure to trauma is considered to be the norm due to its high prevalence for those in the criminal justice system (Osher & Steadman, 2007). For both men and women who are under probation supervision, 39 percent of those with mental illnesses, compared with 12 percent of people without mental illnesses, reported being abused before their arrest (Prins & Draper, 2009). This figure does not include individuals in jails, prisons, or forensic psychiatric hospitals. If all those in the forensic system were included, the figures would likely be much higher. As described by Jennings (2008, p. 2):

Many of the individuals … have developed extreme coping strategies, in childhood, adolescence and as adults, to manage the impacts of overwhelming traumatic stress, including suicidality, substance abuse and addictions, self-harming behaviors such as cutting and burning, hallucinations, emotional numbing and dissociation, hypervigilance, somatization, aggression and rage, re-enactments such as abusive relationships, and serious health risk behaviors (Saakvitne et al., 2000; Dube et al., 2001; Felitti et al., 2002; Felitti, 1998; Hammersley, 2004; Sareen, 2005; CDC, 2005)...For the most part these individuals have never received screening, assessment or treatment for trauma. (Cusack, Frueh & Brady, 2004; Frueh et al., 2002; Mueser et al., 1998). The situation is similar for children in the mental health service system. Although many have histories
of severe interpersonal violence and multiple adverse childhood experiences, recognition of the trauma underlying their behaviors and diagnoses typically does not occur (Hodas, 2006; Perrin et al, 2000).

We provided this quote earlier; we believe it is worth repeating here:

The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants. Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992, p. 22).

Though interventions designed to assist people who have experienced trauma are not yet an officially recognized EBP, there has been research to support the efficacy of some specially developed interventions in the justice system (Prins & Draper, 2009; Substance Abuse and Mental Health Services Administration GAINS Center for Behavioral Health and Justice Transformation, 2011).

Most of what has been written about trauma interventions for those with SMI/SED addresses the serious issue of women in these settings because virtually every woman with SMI/SED in the forensic or criminal justice system has experienced severe abuse and trauma. Thus, we devote a section below to interventions for women in the forensic or criminal justice system.

**Trauma informed care/trauma specific services for women in the criminal justice/forensic systems**

Several studies have reported the extremely high rates of abuse for women in the forensic/criminal justice system; most who study this issue consider this to be the norm for women in the justice system (Osher & Steadman, 2007; Parsons & Sandwick, 2012). The traumatic experiences of women put them at heightened risk for PTSD and other anxiety disorders with 34 percent meeting criteria for PTSD (Alvorado, 2002). The extraordinarily high rate of trauma evidenced by women in the justice system has also put them at risk for substance abuse and dependence (Salisbury & Van Voorhis, 2009) and three-quarters of the women who had a mental health problem also met criteria for substance abuse or dependence (Abram, et al., 2003; James & Glaze, 2006). The U.S. Bureau of Justice Statistics found that 73% of the women in state prisons and 75% of women in local jails have symptoms of mental disorders, compared to 12% of women in the general population.

Additionally, incarcerated women have greater chronic medical and mental health disorders and drug dependence than men; this is true even for those conditions more prevalent in men (Binswanger, et al., 2010), indicating increased need for treatment of these conditions for women. Women with mental health problems who do not receive appropriate mental health treatment while in the forensic/criminal justice system are highly vulnerable and at high risk for homelessness, violence, further abuse and trauma, and repeated involvement in the criminal justice system when they are released (Smith, Simonian & Yarussi, 2006).

**Racial and cultural factors in the criminal justice/forensic systems**

There are clear differences in the way that people of color are perceived and treated by criminal justice authorities and the forensic system in the US. These differences are confounded with social determinants of health, education, employment, housing, socio-economic status, and other aspects of life in the US. (Primm, et al., 2010; Thompson, 2011). In addition to these attitudinal issues, some factors that should be considered when mental health providers encounter individuals from diverse racial and cultural backgrounds in these settings include those discussed below. We presented these in the section on Social Problems but they apply equally to forensic and criminal justice settings and are worth
summarizing here as it is vitally important for psychologists to understand them as services are provided in criminal justice and forensic settings:

- Some cultures consider behavior to be under the control of spirits to be healed or controlled by indigenous healers; thus mental illness does not exist in this context (Constantine, Myers, Kindaichi & Moore, 2004; Malarney, 2002).
- Stigma may be so great in some cultures that accepting mental health services is not acceptable. Women may not be allowed to express opinions or make decisions in some cultures (Said-Foqahaa, 2011), making it very difficult for women in forensic and correctional settings to discuss aspects of their life.
- Most families do not discuss trauma resulting from family perpetrated physical or sexual abuse. Some cultures consider women and children to be property to be used as desired (Chaudhuri, 2005; Said-Foqahaa, 2011), and in these cultures, abuse can be overlooked or even unofficially sanctioned. These situations lead to tremendous trauma for the victim and potentially for the perpetrator as well.
- Language barriers can make it exceedingly difficult to communicate the important aspects of one’s life that may have an impact on mental health. Some languages do not have words or expressions to describe mental illness; this adds to the stigma of behavioral problems.
- Sensitivity to individuals from different backgrounds is essential if steps toward engaging an individual and his or her family are to be successful in the criminal justice/forensic system. Personnel who can speak multiple languages should be available and the cultural perspective of the person should always be respected.

_Supported housing for those released from the criminal justice/forensic systems_

Providing supported housing is thought by many to be the key to helping people with SMI/SED remain out of jail and in the community but this often proves difficult due to the double stigma of SMI/SED and criminality and lack of resources for housing stock and personnel from the many disciplines needed for success. Draine, Salzer, Culhane, & Hadley, (2002) have argued that providing people with SMI/SED a greater safety net via social insurance and work advantage programs could change their trajectory by averting the usually devastating consequences of homelessness, incarceration, poverty and destitution, often faced by these individuals.

Many of those with SMI/SED have no place to live when they are discharged. These individuals, most of whom have also experienced trauma and may have been re-traumatized by the criminal justice experience, find themselves living on the streets and at risk of being re-traumatized, continued abuse of alcohol and other drugs, and re-incarceration. Supported housing, which is typically offered in conjunction with FACT, has been suggested as an approach that may be beneficial for helping these individuals to become connected with the treatment system and remain out of the forensic/criminal justice system.

Some studies have found that supported housing can improve outcomes for this population by helping people connect with treatment services that can lead to reduced incarceration rates (Culhane, et al., 2002; Osher & Steadman, 2007; Prins & Draper, 2009). Clearly, individuals need stable housing and having a safe and secure place to live coupled with help to remain connected with treatment services makes sense. All too often, resources to provide supported housing, FACT and other needed services are limited, making it difficult for people with SMI/SED who have been in the forensic/criminal justice system to achieve stability and a satisfying life in the community (Prins & Osher, 2009).
**Mental health courts**

Mental health courts have been introduced in several jurisdictions throughout the US and Canada. Mental health courts are specialized court dockets that deal exclusively with people with mental health disorders in the criminal justice system. These courts combine community treatment services for people with SMI/SED with criminal justice supervision and have the following goals:

...to improve public safety by reducing criminal recidivism; to improve the quality of life of people with mental illnesses and increase their participation in effective treatment; and to reduce court- and corrections-related costs through administrative efficiencies and often by providing an alternative to incarceration (Almquist & Dodd, 2009, p. v).

Mental health courts are used for individuals who can be adjudicated to community supervision. The combination of criminal justice supervision with community treatment holds promise of helping individuals with serious mental illnesses avoid incarceration, increase community tenure and achieve stability. Almquist & Dodd, 2009, offered the following related to mental health courts:

Research has found that participants in some mental health courts have lower rates of recidivism than individuals with mental illnesses processed through the traditional criminal court system. Some research findings indicate that this trend continues after individuals are no longer under court supervision. Mental health courts have also been found to connect participants with mental health treatment services more effectively than do the traditional court system and jails. In addition, mental health courts have the potential to save money through reduced recidivism and associated savings in jail and court costs. Also, treatment costs are reduced by avoiding expensive inpatient care (p. vi).

Although chiefly a criminal justice intervention for individuals who are not incarcerated, the principle of coordinated care that mental health courts embody is one that the mental health service delivery system has been advocating for years. Some studies have concluded that mental health courts improve access to mental health treatment and reduce recidivism (Kennedy-Hendricks, Huskamp, & Barry, 2016). Combined with a range of interventions provided at the intensity needed by this population, and when implemented with competent and knowledgeable court outreach personnel who assist individuals to access needed health mental health, and legal services, it may be that mental health courts hold promise of helping individuals remain out of the forensic/criminal justice system and achieve a stable and satisfying life in the community (Sylvestre, Aubry, Smith & Bridger, 2010).

We note however, that factors such as community isolation, social disadvantage, poverty and stigmatization will impede the success of interventions aimed at helping individuals achieve successful re-integration into the community. A wide range of interventions aimed at ensuring proper housing, successful employment if the person is able to work, help with medical and mental health follow up, and community integration that diminishes stigmatization are all necessary to help individuals in this population succeed (Barrenger & Draine, 2013; Epperson, et al., 2014).

**Transition planning and follow-up in the criminal justice/forensic systems**

For people who are being discharged from forensic and criminal justice settings, providing adequate and appropriate transition planning and follow up are crucial (Cuddeback, et al., 2013). Failure to provide the needed planning and follow up is a major reason for the revolving door of release, illness, substance use, homelessness, trauma, and re-incarceration that afflicts this population.

Almost all jail inmates with co-occurring mental illness and substance use disorders will leave correctional settings and return to the community. Inadequate transition planning puts people with co-occurring disorders who enter jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public
safety, an increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness, and re-arrest (Osher, Steadman & Barr, 2002, p. 1). Inadequate transition planning puts people with co-occurring disorders who entered the jail in a state of crisis back on the streets in the middle of the same crisis (p. 3).

A comprehensive model to address the problem and provide guidance for how to ensure that coordinated and integrated planning and follow up services are delivered has been developed and is called the APIC model (Osher, Steadman & Barr, 2002).

The model consists of the following components:

- Assessment of the person’s clinical and social needs, and public safety risks
- Planning for the treatment and services required to address the person’s needs
- Identifying required community and correctional programs responsible for post-release services
- Coordinating the transition plan to ensure implementation and avoid gaps in care with community-based services.

The authors stress that planning must take the following into account:

- The period immediately after release is critical – the first hour, day or week can determine success or failure and high intensity interventions that support the person during this time are essential;
- The person him or herself must be engaged and asked what helped or hindered success following previous incarcerations – this is considered the most important part of the assessment and planning process;
- Seeking input from family members;
- Addressing housing and the other multiple needs of the person;
- Naming specific community referrals that are appropriate for the person’s medical, mental health, social and economic needs and forwarding a copy of the person’s discharge summary to the community provider;
- Connecting the person with appropriate medical resources and making needed appointments;
- Ensuring that the person has an adequate supply of appropriate medication that will last until the first follow up appointment;
- Initiating applications for needed benefits (Medicaid, SSDI/SSI, veterans benefits, food stamps, Temporary Assistance for Needy Families (TANF), etc.

Ensuring that the person has:

- Adequate clothing
- Resources to obtain adequate nutrition
- Transportation from jail to place of residence and from residence to appointments
- A plan for childcare if needed that will allow him or her to keep appointments (Osher, et al., 2002, p. 8–9).

To ensure the person has as much support as needed to follow through with services, it is crucial to explicitly inform the person him or herself, the family, those in the releasing facility and the treatment providers in the community of the names and contact information for the person(s) responsible for following up between the time of release and the first follow-up appointment. On-going support is
essential, as is a mechanism to stay in touch with the individual and reach those who miss the first follow-up appointment to re-schedule and get the person back on track with the transition (Osher, et al., 2002). Connecting people with their communities and ensuring that follow-up and help with all needed aspects (housing, employment, medical and mental health services, normalized leisure and socialization to diminish stigma, etc.) is essential (Barrenger & Draine, 2013).

Transition planning must attend to the cultural, racial, gender and age related factors that are important to ensure the person is linked to services that are accepting and compatible (Hicks, 2004; Osher, et al., 2002; Rotter, et al., 2005).

**Interventions for bipolar disorder**

Psychotropic medications for individuals with bipolar disorder have been available since the 1970s but pharmacologic interventions are not sufficient to help individuals learn the skills needed to overcome the difficult challenges associated with this disorder (Geddes & Miklowitz, 2013; Salcedo, et al, 2016; Swartz, Levenson, & Frank, 2012; U.K. National Collaborating Centre for Mental Health, 2006).

As with most disorders under the SMI heading, bipolar disorder is extremely challenging and it is only recently that research has identified psychosocial interventions for this population; thus far several have been tested and found to be helpful. Since virtually every publication on this topic recommends a similar combination of psychological interventions (with pharmacotherapy) for the treatment of this disorder (Geddes & Miklowitz, 2013; Salcedo, et al, 2016; Swartz, et al., 2012; U.K. National Collaborating Centre for Mental Health, 2006) and since we discussed all but one of these above, the previously discussed recommended interventions are simply listed below. (We provide information about the additional intervention (IPSRT) following the list). They are:

- Psychoeducation for the person and family about the illness
- Family focused therapy
- Promoting medication adherence
- Social support
- Reducing drug and alcohol misuse
- Interpersonal and social rhythm therapy (IPSRT)

Interpersonal and social rhythm therapy (IPSRT) is a multi-component approach that focuses on working collaboratively to identify key triggers for interpersonal conflicts and stressors such as role transitions, grief arising from substantial loss, and other problem that may predispose to relapse and helping the individual learn skills to cope with or resolve these interpersonal problem areas, and at the same time, learn to improve the regularity of everyday routines (particularly sleep and waking) in order to minimize relapse.

In addition to the interventions listed above, two others have been suggested as important; there may be considerable overlap between these and the interventions listed above. These additional interventions are:

- Dialectical behavior therapy (DBT) (Salcedo, et al., 2016; Van Dijk, Jeffrey, & Katz, 2013)
- Mindfulness-based cognitive therapy (Salcedo, et al., 2016).

Like IPSRT, we have not mentioned dialectical behavior therapy (DBT) in this petition so a very short synopsis of it is presented here. Dialectical behavior therapy (DBT) is a form of cognitive behavioral therapy that was originally developed to treat highly suicidal individuals with borderline personality disorder (Linehan, 1993). DBT is designed to help people change patterns of behavior that are not
helpful, such as self-harm, suicidal ideation, and substance abuse. Like IPSRT, DBT helps individuals increase their emotional and cognitive regulation by learning about the triggers that lead them to react in undesirable ways and to develop coping skills to avoid undesired reactions. DBT combines mindfulness with therapy designed to help individuals learn to tolerate distress, regulate their emotional reactions, and become more capable of handling interpersonal situations (Psych Central, 2016).

Given the recency of research and the challenges faced by those with bipolar disorder, it may be that a differential combination of interventions will be needed by some individuals.

**Experiential Training: Additional Topics**

Motivational interviewing has been shown, in several clinical trials, to be a highly effective intervention that assists people to make changes in their lives (Miller & Rose, 2009). The strategy is particularly important when individuals are confronting behaviors that are difficult to change, such as addictive behaviors, but has been shown to be useful for a wide variety of situations and populations, and may be helpful for those with chronic mental health disorders (Arkowitz, Westra, Miller & Rollnick, 2008; Hettema, Steele & Miller, 2005; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Rollnick, Butler, Kinnersley, Gregory, & Mash, 2010; Rubak, Sandbaek, Lauritzen & Christensen, 2005). Motivational interviewing is considered an EBP for substance abuse. The goal of motivational interviewing is to help individuals explore their ambivalence about their behavior and may be useful in helping people with SMI/SED persist in treatment seeking and adherence despite the stigma they face and the many obstacles they encounter. There have been some adaptations for use with people with SMI/SED (Carey, Leontieva, Dimmock, Maisto, & Batki, 2007; Drymalski, & Campbell, 2009) but research indicating the efficacy of the approach for this population is not conclusive (Barrowclough, et al., 2010; Chien, Mui, Cheung, & Gray, 2015) and further study is needed. We include it here because it may be useful in helping those with SMI and SED modify behaviors that are particularly harmful such as smoking, overeating, non-adherence to medication regimens, criminal behavior, etc.

Several other interventions are considered an important component of any mental health service that assists persons with SMI/SED. These include supported education (increasingly included with programs where supported employment is offered), leisure services to lessen isolation and teach social skills, and activities of daily living which are typically not learned by individuals whose illness begins in adolescence and whose illness is severe. Psychologists who are program managers, administrators, and those in policy/funding positions should know about these and recognize their importance within an overall mental health service system for people with SMI/SED.

In conclusion, research evidence has been accumulating that an integrated approach that combines multiple interventions within a recovery oriented context may be the most effective approach (Lyman, et al., 2014; Spaulding & Deogun, 2011) and scholars are increasingly calling for such an integrated, recovery oriented system (Davidson & Chan, 2014). Such an approach must be targeted to the unique needs of each individual including those in forensic and criminal justice systems (Epperson, et al., 2011; Strauss, 2014). In addition, it has become apparent that cognitive impairment is likely at the heart of the functional skill deficits so commonly experienced by people with SMI/SED (Harvey & Penn, 2010) leading to the conclusion that integrated approaches should include cognitive enhancement approaches as a fundamental component (Pfammatter, et el., 2011; Roder, Mueller & Schmidt, 2011) and underscores the importance of social cognition for improving community functioning. Indeed, some have stated that including cognitive remediation “may result in a magnitude of change that exceeds that which can be achieved by targeted treatments alone” (Pinkham & Harvey, 2013, p. 499).

However, to date, no definitive combination of approaches has been determined to be most effective, although some combination of cognitive therapies (cognitive remediation, social cognition training, cognitive behavioral therapy), supported employment, psychoeducation (client/family approaches, illness management approaches), seems to be most promising. As discussed above, early intervention in first episode psychosis is increasingly recognized as critically important and the RAISE
initiative results (Kane, et al., 2016) reinforce the efficacy of this approach which is also most likely applicable to those who have had additional episodes of psychosis. Continued research and identification of which interventions work best for whom, under which conditions, at which stage of illness, and potentially at which age of each individual, may lead to the development of personalized approaches tailored for each individual.

References


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Criterion VII. Structures and Models of Education and Training in the Specialty

The specialty has structures and models to implement the education and training sequence of the specialty. The structures are stable, sufficient in number, and geographically distributed. Specialty education and training may occur at the doctoral, postdoctoral, or both.

Commentary:

A) Sequence of Training. A petition describes a typical sequence of training, including curriculum, research, and supervision.

B) History and Geographic Distribution. A specialty has at least four identifiable psychology programs providing education and training in the specialty in more than one region of the country that are geographically distributed and which have produced an identifiable body of graduates over a period of years.

C) Psychology Faculty. Specialty programs have an identifiable psychology faculty responsible for the education and training of students and their socialization into the specialty. The faculty has expertise relevant to the education and training offered. Faculty may include individuals from other disciplines as appropriate. Specialty programs also have a designated psychologist who is clearly responsible for the integrity and quality of the program and who has administrative authority commensurate with those responsibilities. This psychologist has credentials of excellence (e.g., the diplomate from one of the specialty boards affiliated with the American Board of Professional Psychology, or status as a fellow of the American Psychological Association or the Canadian Psychological Association, or other evidence of equivalent professional recognition) and a record of scholarly productivity as well as other clear evidence of professional competence and leadership.

D) Procedures for Evaluation. Specialty programs regularly monitor the progress of trainees to ensure the relevance and adequacy of the curriculum and integration of the various training components. Attention focuses on the continuing development of the trainee’s knowledge, skills, attitudes, and values. Formal performance based feedback is provided to trainees in the program.

E) Admission to the Program. Program descriptions specify the nature and content of the program and whether they are designed to satisfy current licensing and certification requirements for psychologists as well as whether or not graduates can satisfy the education and training requirements for advanced recognition in the specialty. Postdoctoral programs have procedures that take into account the trainees’ prior academic and professional record. These programs design an education and training experience that builds upon the doctoral program and internship and the professional experiences of the postdoctoral residents as they prepare for meeting the guidelines of preparation for the specialty.

1. How are education and training programs in the specialty recognized? How many programs exist in the specialty?

Since this is a petition for initial recognition of this specialty area, there are no existing training programs that are recognized by APA as a specialty in this area. However, there are doctoral and postdoctoral programs that are APA accredited under other specialty areas (primarily clinical and counseling) as well as non-APA accredited programs that provide training in this area of specialization. These programs are not officially recognized in this specialty area because that recognition does not currently exist, but do advertise this emphasis area of their training on the APA and APPIC websites, in brochures, on their websites, and at conferences and other training venues.
As we discussed in Criterion II, NIMH and several eminent psychologists have called attention to
the need for specialized training to treat persons with SMI/SED since the 1990s and current
psychologists continue to do so (Carr, Bhagwat, Miller, & Ponce, 2014; Corrigan, Steiner, McCracken,
Mueser, Silverstein, & Farkas, 2013; Stacey, Klee, & Jansen, in press). Despite this, the number of
programs offering training in this area of specialization is relatively small but growing. We speculate
about the major reasons for the small number of existing programs below.

First, the concept of recovery from mental illness, especially severe mental illnesses such as
schizophrenia, schizoaffective disorders, bipolar disorder, and other illnesses severe enough to include
psychotic episodes in their symptomatology, was foreign to most mental health providers until the mid-
1970s. Psychologists and other providers generally believed that individuals with SMI/SED would be
chronically ill and would not be able to function in society – and many still hold these beliefs (Charles,
2013; Stuber, Rocha, Christian, & Link, 2014). The fact is that despite the long held and pervasive beliefs
about the deteriorating course of SMI/SED, several meta analyses and summaries of well conducted
studies have been published and all continue to document that many individuals with SMI/SED can, and
do recover from the effects of their illness (Warner, 2010), and indeed have the potential to achieve long-
term remission and functional recovery (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harding,
Zubin, & Strauss, 1987; President’s New Freedom Commission on Mental Health, 2003; Zipursky, Reilly
& Murray, 2012).

Secondly, until very recently, few psychologists had the specialized expertise needed to work with
people who have SMI/SED. Many psychologists do not feel prepared to treat those with SMI/SED and
are uncomfortable doing so (Buck, Romeo, Olbert, & Penn, 2014) because most do not fully understand
the underlying concepts nor do they have the skills to use the evidence-based and promising practices
needed to treat people with SMI/SED effectively (Mueser, 2012). This is because most training programs
provide training in traditional methods of working with the population – methods that were not designed
and evaluated specifically for this population and for the most part, have not been demonstrated to be
effective. Aspiring psychologists are trained by mentors, i.e., faculty members who have existing areas of
specialization and research that are often well funded and well publicized. Many of these mentors were
trained before the advent of the recovery paradigm and the development of specialized PSR
interventions and they themselves often know little about how to help people with these serious illnesses
regain their full functional capacity (Mueser, et al., 2013). These mentors and by extension, their trainees,
are reluctant to work with those with SMI/SED resulting in little exposure to the population, perhaps
because, as we mentioned above, most believe that persons with SMI/SED will be chronically ill with little
chance of recovery (Corrigan, et al., 2001). The effect is transgenerational, i.e., trainees have been
taught traditional methods and when these trainees become trainers, they teach the next generation of
trainees the same methods they were taught, often passing on the pessimism seen about the recovery
potential of persons with these disorders (Slade, 2010). Ongoing mentorship and support are also
needed but without a larger pool of mentors, this is difficult to achieve (Drake, Mueser, & Brunette, 2007).
As a result, most psychologists continue to be unprepared to provide the interventions that are most
helpful to people with these illnesses, i.e., those interventions that can help people live successful lives in
the community (Reddy, Spaulding, Jansen, Menditto, & Pickett, 2010; Roe, Yanos, & Lysaker, 2006;
Rollins & Bond, 2001).

We also know that in addition to specialized didactic and experiential training, “To achieve client
change, it is necessary for therapists to reach proficiency levels in knowledge, adherence, competence,
and skill. This perspective speaks to the importance of training therapists to criteria prior to implementing
treatments” (Beidas & Kendall, 2010, p. 20), and that ongoing mentorship and support are needed
(Beidas & Kendall, 2010; Drake, et al., 2007). Similarly to the paucity of mentors in doctoral or post-
doctoral training programs, there are few practicum, internship, and residency programs that have
supervisors who themselves have been trained and or have sufficient experience in the newer
intervention methods to provide the level of supervision needed for trainees to become skilled in the
provision of these services. Knowing how to implement the concepts and having the ability to
appropriately use the proper interventions are skills that continue to be foreign to most psychologists (Mueser, 2012).

Thirdly, many currently practicing psychologists believe that existing clinical psychology or counseling psychology training programs are teaching what is needed to work with this population. This is especially true if the program indicates that it offers training in serious mental health disorders, as some currently accredited programs do. We can see from the websites of APA accredited doctoral and post-doctoral programs that relatively few mention SMI/SED, but among those that do, most of the topics covered and the discussion of those topics center on highly traditional models of diagnosis and treatment according to traditional methods. Very few include any mention of the newer evidence-based interventions or the increasingly accepted, recovery paradigm. Most psychologists continue to be trained to arrive at a diagnosis and provide traditional mental health treatment, i.e., medications, psychotherapy, etc. (Mueser, et al., 2013). While these may be of some assistance, they are not sufficient to help those with SMI/SED learn to live successfully in the community. According to Corrigan, et al. (2001), “students in some psychological training programs learn projective testing and psychodynamic therapy techniques (Corrigan, 1995; Corrigan, Hess, & Garman, 1998), neither of which has been shown to be useful in treating disabilities among people with serious mental illness (Mueser & Berenbaum, 1990)” (Corrigan, et al., 2001, p 1599-1600). In order to work effectively with people with these conditions, psychologists must not only recognize the symptoms of the disorder and be able to correctly diagnose each person, but they must also recognize and understand the unique aspects of these illnesses and the challenges faced by those with them, including additional challenges that may co-exist or interact with the primary disorder. Factors such as co-occurring physical and or mental health conditions, gender identity/preference concerns, socioeconomic status, homelessness, and stigma can affect the behaviors and needs of an individual and can affect the way others, including health and mental health professionals, respond to them.

A 2010 survey of training directors of CUDCP clinical psychology programs found that more than half of the training directors believed the factor that most discouraged training in this area is that psychologists prefer “clients with ‘insight and motivation for treatment” (Reddy, et al, 2010, p. 259), further reinforcing the stereotypical beliefs that people with SMI/SED have no insight and are not motivated for treatment – beliefs that are inevitably passed on to trainees. This comment from training directors seems at odds with the growing interest among trainees and early career psychologists in knowing how to better assess and treat people with SMI and SED (evidenced in part by very well attended [primarily by younger attendees] APA convention sessions on topics related to SMI/SED) and may be reflective of the training directors’ thoughts rather than those of trainees. These results and the continuing dearth of training in EBPs and functional assessment methods have led to the following call to action:

Professional organizations overseeing the training and licensure of clinical psychologists in the United States, starting with American Psychological Association (APA) as the most influential such organization, should make a public commitment to increasing the competence of the workforce treating individuals with serious mental illness by mandating training for all students in APA approved clinical psychology programs. Such mandated training is a moral imperative incumbent upon our professional responsibilities to society based on the existing need of this population and the emergence of effective interventions to meet the need. In addition, such required training is economically strategic in light of trends in health care policy suggesting a potentially expanded role for psychologists, as the funding of health care moves toward demanding greater accountability for the delivery of evidence based services to persons with a serious mental illness (Mueser, et al., 2013, p. 54).

Lastly, we speculate that since the area is not yet an APA recognized specialty, programs may be reluctant to offer training in an area not officially recognized as a specialty for fear that doing so might put their accreditation in jeopardy. Although this should not happen unless training became sub-standard or outside the purview of post-doctoral training in psychology, this is a stated reason of some programs.
The number of SMI/SED training programs that currently exist is unknown. However, a search of APA accredited programs and a review of content taught revealed several at the doctoral, internship and post-doctoral levels. Additionally, two non-APA accredited post-doctoral programs were identified. The programs identified by these searches are likely not the only ones, but the few listed below indicate that there is growing recognition of the need for specialized training and growing interest in the area. In addition, as of March 2017, the APPIC website listed just 63 post-doctoral residency programs that identified themselves as having an interest in SMI/SED training. Whether or not these have the requisite focus on recovery and training in psychosocial rehabilitation assessments and interventions is unknown.

With the above in mind, several APA accredited programs at all three levels (doctoral, internship and post-doctoral), one non-APA accredited internship program, and two non-APA accredited post-doctoral programs are listed below. Please note that these are in addition to the four post-doctoral programs listed under question number 7 of this Criterion. Therefore, in addition to those listed under question 7, examples of other APA accredited programs offering specialized training in SMI/SED include:

**Additional APA accredited programs at the doctoral level:**

- Indiana University, Purdue University at Indianapolis, Indianapolis, IN
- Palo Alto University, Pacific Graduate School, Palo Alto, CA
- Long Island University, C. W. Post Campus, Brookville, NY
- Bowling Green State University, Bowling Green, OH

**Additional APA accredited programs at the internship level:**

- Fulton State Hospital, Fulton, MO
- Marin County Health and Human Services, San Rafael, CA
- Friends Hospital, Philadelphia, PA
- Adult Community Mental Health and Inpatient Services Training Program, New Haven, CT
- Western Kentucky Consortium, Hopkinsville, KY
- VA Capitol HealthCare Network Mental Illness Research, Education and Clinical Care, Baltimore, MD

**Additional APA accredited programs at the post-doctoral level:**

- Harbor UCLA Assertive Community Treatment/Corrections, Los Angeles, CA
- Central Arkansas VA Healthcare System, Little Rock, AR
- Alpert Medical School of Brown University Recovery Program, Providence, RI
- Institute of Living / Hartford Hospital Residency, Hartford, CT
- VA Long Beach Healthcare System, Long Beach, VA
- Miami VA Healthcare System, Miami FL
- Louis Stokes Cleveland VA Medical Center, Cleveland, OH
- Puget Sound VA Health Care System, Seattle, WA

**Example of non-APA-accredited program at the internship level:**

- Community Treatment Teams, Philadelphia, PA

**Examples of non-APA accredited programs at the post-doctoral level:**

- Mount Sinai St. Luke's and Mount Sinai Roosevelt, New York, NY
- San Carlos Apache Wellness Center, San Carlos, AZ
2. Describe the qualifications necessary for faculty who teach in these programs. Describe the qualifications required for the director of such programs.

Core faculty who teach in a clinical area of a post-doctoral residency program in SMI/SED must be licensed in their respective discipline (e.g., psychology, psychiatry, occupational therapy, nursing, social work, etc.), or if in the process of becoming licensed, they must be directly supervised by a licensed practitioner in their discipline. All teaching faculty should have training, experience, or exposure in the area of SMI/SED and have expertise in the specific courses or areas in which they are teaching. Faculty who are not yet fully qualified would not qualify as core faculty but they too should have some training and experience, although may be continuing their learning experiences.

Faculty who teach in the research component of the program do not have to be licensed but should also have experience in the area of SMI/SED and would typically be affiliated with an active SMI/SED research program. In model programs, research faculty would engage with individuals with SMI/SED in a clinic or other setting.

Directors of Training may oversee several training programs including those in this area of specialization. They should be experienced psychologists who have advanced academic and experiential qualifications such as an ABPP, Fellow status in APA, other recognized status in APA, ABPP, APPIC, certification from the Psychosocial Rehabilitation Association (CPRP), or similar recognition of their advanced qualifications. Where the program is university affiliated, they should have an academic appointment and be active in the university program. While they may not have direct experience or expertise in SMI/SED (if they oversee programs in addition to those in this specialty), they should have familiarity and a working knowledge of the principles and practices in the field and be able to provide oversight and guidance to faculty.

3. If programs are doctoral level, what are the requirements for admission? Provide sample evaluation forms.

NA

4. If programs are postdoctoral, what are the requirements for admission? Provide sample evaluation forms.

In accord with APA’s Standards of Accreditation for Health Service Psychology (American Psychological Association, Commission on Accreditation, 2015), (downloaded from APA website December, 2017):

i. The program has procedures for resident selection that ensure residents are appropriately prepared for the training offered.

ii. At the initiation of training, residents will have completed doctoral and internship training in programs accredited by an accrediting body recognized by the U.S. Secretary of Education or by the Canadian Psychological Association. If the program accepts residents who attended unaccredited programs, the residency must describe how the program ensures that selected residents are otherwise qualified and appropriately prepared for advanced training in the residency program. (p. 38).

Accordingly, residency programs are advised to ensure that residents have completed doctoral and internship training that meets these requirements.

Applicants for post-doctoral psychology residency programs in SMI/SED must have completed a doctoral degree and training in health service psychology or appropriate re-specialization, either of which must have included the completion of an appropriate internship. At the initiation of the residency program,
residents will have completed doctoral and internship training in programs accredited by an accrediting body recognized by the U.S. Secretary of Education or by the Canadian Psychological Association (CPA). If the program accepts residents who attended unaccredited programs, the residency must describe how the program ensures that selected residents are otherwise qualified and appropriately prepared for advanced training in this specialty.

Post-doctoral residency programs in SMI/SED require official transcripts from the doctoral or re-specialization program and from the internship program, a cover letter indicating previous clinical experience with persons with SMI/SED or in settings where persons with SMI/SED are seen, commitment to a career working with those diagnosed with SMI/SED, statement of future goals as they relate to SMI/SED, letters of recommendation, and the applicant’s CV. Programs may also have other requirements such as submission of a work sample, graduation from an APA or CPA accredited program, etc.

Please Note: Sample admission evaluation forms and guiding questions specific to SMI/SED post-doctoral residency programs are provided at the end of this criterion narrative. Please note these are samples only. Programs should ensure their forms comply with current guidance and requirements from APA.

5. Include or attach education and training guidelines, for this specialty as appropriate for doctoral training, postdoctoral training, or both. (In this context, education and training guidelines may be found in documents or websites including, but not limited to, those bearing such a title or as described in a variety of published textbooks, chapters, and/or articles focused on such contents.)

The Education and Training Guidelines for this specialty are attached as Appendix I and are also available on the Specialty Council’s website (www.psychtrainingsmi.com).

6. Provide sample curriculum expected of model programs.

A resident’s clinical training follows a progression that evolves from less to increasingly autonomous service delivery. Depending on the experience and competence of the trainee this progression may include observing supervisor modeling (in vivo service delivery with persons with SMI/SED and role plays in supervision), to delivering services to persons with SMI/SED with periodic direct observation of resident-delivered services by the supervisor and/or with supervisor and resident as co-therapists, to increasingly autonomous, albeit monitored and supervised, service delivery. Residents with prior experience in providing recovery and rehabilitation oriented services to persons with SMI/SED may need to spend less time observing supervisors, depending on their demonstrated competence level. All services should be provided within the context of the recovery orientation building on the individual’s strengths, and focused around the person’s goals and psychosocial rehabilitation services designed to meet those goals.

As with any post-doctoral residency, caseloads are lower in the beginning of the training year, and increase as the year progresses. Unlike residency training in clinical psychology (which may be an extension of what was learned during doctoral training), residency training in SMI/SED is considerably different and more complex. Due to the fact that persons with SMI/SED very often have multiple problems and deficits, specialized assessments are required and residents will need to learn how to administer and score them. Interventions are also very different and frequently more than one intervention is needed; as we have indicated, residents need to learn about these different procedures and must learn how to implement them. This often requires considerable time. Further, assessment and intervention for those diagnosed with SMI/SED are often provided in community settings, which requires additional supervision and skill development.
Similarly to other residency training, resident progress is assessed by clinical supervisors during the course of informal and formal supervision, and supervisors and residents are expected to exchange feedback routinely as a part of the supervisory process; the evaluation procedures are meant to formalize this continuous information flow. While it is the responsibility of the training director and supervisors to ensure that evaluation occurs in a timely and constructive fashion, residents are encouraged and expected to take an active role. As trainees progress and increase their confidence and levels of responsibility, they receive more complex cases, more independent clinical work, the ability to pursue their own training goals, and take on additional cases if desired. This is all determined in a collaborative nature between trainee, supervisors, and the Director of Training.

While training will build on and enhance the foundation of knowledge, skills, and proficiencies that define the practice of professional psychology, post-doctoral training in this specialty must be of sufficient depth to develop more focused competence and expertise in the specific area of SMI/SED. This is accomplished through involvement in focused didactics and clinical experiences on teams and units devoted to working with persons with SMI/SED. Residents may also take part in more general secondary placements and didactics with post-doctoral psychology residents in other specialty areas where these exist at a given academic training site, but not at the expense of the SMI/SED focus.

Each resident’s training plan should be individually created to meet the specific training needs of the resident and to develop competence in a full range of mental health and psychosocial rehabilitation skills specifically designed for individuals with SMI/SED. Training activities include attention to advancing development of core skills such as: specialized assessments for persons with SMI/SED, treatment interventions developed and researched specifically for this population, i.e., those that are unique to work with this population, consultation and interprofessional teamwork, research and scientific inquiry, supervision and teaching, ethics, program management and administration, and cross-cultural and diversity sensitivity. Residents should be prepared to leave their residency well-prepared to function successfully as an independent scientist-practitioner and work effectively with persons with SMI/SED. Another goal of the residency is to train residents to function in leadership positions working with persons with SMI/SED. As a result, the resident should also be prepared to transition to practice with an interprofessional team, promoting client-centered, recovery oriented care and interprofessional collaboration for specialized assessment and treatment of persons with SMI/SED.

A sample curricula from model programs is provided at the end of this criterion narrative. Details regarding the topics in these curricula are provided in Criterion V. The literature supporting these topics is included in Criterion VI.

A typical sequence of training, a sample training plan, and an example of a graduated levels of responsibility form are also presented at the end of this criterion narrative.

A sample suggested reading list is also offered at the end of this criterion narrative.

**Supervision, resident and program evaluation:**

At a minimum, two hours of individual supervision must be conducted weekly by doctoral-level licensed psychologists who are involved in an ongoing supervisory relationship with the resident and have professional clinical responsibility for the cases on which they provide supervision. A postdoctoral resident must have a minimum of two doctoral level licensed psychologist supervisors, at least one of whom serves as the resident’s primary supervisor.

Supervisory hours beyond the two hours of individual supervision may be provided either individually or via group supervision and must be provided by professionals who are appropriately credentialed for their role/contribution to the program. The primary doctoral-level licensed psychologist supervisor maintains overall responsibility for all supervision, including oversight and integration of supervision provided by other mental health professionals with psychological research and practice.
During each rotation, there should be a written evaluation of the residents’ progress as well as verbal feedback given to the residents by each supervisor and the Director of Training. Feedback should be provided at several times during the rotation with the exact timing dependent on the duration of the rotation. Competency evaluations would typically be behaviorally based and any deficit areas addressed with the resident. Particular attention should be paid to ensuring that residents act ethically and with understanding of and respect for the full range of diversity issues particularly as these relate to persons with SMI/SED. Additionally, rotation learning objectives would be reviewed mid and end of rotation to determine appropriateness and status.

Residents should be evaluated on their knowledge, skills, and abilities in relation to: understanding and applying didactic and seminar information, participating in supervision, supervising others, providing consultation, teaching and/or providing training, working in interprofessional and discipline-specific teams, and conducting research/evaluation activities. An evaluation instrument, the Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED), is attached as Appendix III. This instrument is a modification (modified and used with permission) of the excellent Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel, et al., 2012).

At the end of each rotation, residents should complete an evaluation of supervisors and rotations, and at the end of the residency, evaluations of the residency overall, research opportunities, didactics, seminars and other components. This feedback will be used to modify, improve, and/or enhance the quality of residency training.

A sample evaluation form and an example of a professional identity and confidence evaluation are provided at the end of this criterion narrative.

7. Select four exemplary doctoral and/or postdoctoral level geographically distributed, and publicly identified programs in psychology in this specialty and provide the requested contact information. If no example programs that are APA accredited are available, please complete the appropriate Attachment (A or B) for the level of the program. If the specialty education and training occurs at both the doctoral and postdoctoral levels, provide examples of both and not from the same institution.

Program One

<table>
<thead>
<tr>
<th>Program One</th>
<th>Doctoral</th>
<th>XX Postdoctoral</th>
<th>Both</th>
</tr>
</thead>
</table>

Name of University, School, or Institution offering program: Minneapolis VA Healthcare System

Name of Program: Postdoctoral Fellowship in Clinical Psychology, Serious Mental Illness

Address: One Veterans Drive

City/State/Zip: Minneapolis, MN 55417-2300

Contact Person: Wayne Siegel, Ph.D., ABPP, Director of Training   Telephone: (612) 467-4024, E-mail address: Wayne.Siegel@va.gov

Contact Person: Bridget Hegeman, Ph.D., Program Director   Telephone: (612) 467-1782, E-mail address: Bridget.Hegeman@va.gov

Website: [http://www.minneapolis.va.gov/education/psychology/postdoc/post_setting.asp](http://www.minneapolis.va.gov/education/psychology/postdoc/post_setting.asp)

APA Accreditation: Yes.
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</thead>
<tbody>
<tr>
<td>Name of University, School, or Institution offering program: University of Michigan Health System / VA Ann Arbor Healthcare System</td>
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<td></td>
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<tr>
<td>Name of Program: Clinical Psychology Postdoctoral Residency Program</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Address: 2215 Fuller Road</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/State/Zip: Ann Arbor, MI 48105</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Person: Kenneth Adams, Ph.D., ABPP, Director of Training, Telephone No. 734-845-3602, E-mail address: <a href="mailto:kmadams@med.umich.edu">kmadams@med.umich.edu</a></td>
<td></td>
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</tr>
<tr>
<td>Contact Person: Clayton Nelson, Ph.D., Program Director, Telephone No. 734-845-7332, E-mail address: <a href="mailto:claytonn@med.umich.edu">claytonn@med.umich.edu</a></td>
<td></td>
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<tr>
<td>Website: <a href="http://www.psych.med.umich.edu/education/psychology/clinical-adult/">http://www.psych.med.umich.edu/education/psychology/clinical-adult/</a></td>
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</thead>
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<td></td>
<td></td>
</tr>
<tr>
<td>Name of Program: Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery Oriented Services</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Address: 8989 Rio San Diego Drive Suite 360</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/State/Zip: San Diego, CA 92108</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Person: Dimitri Perivoliotis, Ph.D., Director of Training, Interprofessional Fellowship Program, Telephone No. (619) 228-8028, E-mail address: <a href="mailto:dperivol@ucsd.edu">dperivol@ucsd.edu</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Person: Brian Buzzella, Ph.D., ABPP, Director of Training of parent post-doctoral residency program, Telephone No. (858) 552-8585, ext. 2187, E-mail address: <a href="mailto:babuzzella@ucsd.edu">babuzzella@ucsd.edu</a></td>
<td></td>
<td></td>
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<tr>
<td>Website: <a href="http://www.sandiego.va.gov/careers/psychology_training.asp">http://www.sandiego.va.gov/careers/psychology_training.asp</a></td>
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<td>Name of University, School, or Institution offering program: VA Connecticut Healthcare System / Yale University School of Medicine</td>
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<tr>
<td>Name of Program: Post-doctoral Residency in Clinical Psychology, with an emphasis in Psychosocial Rehabilitation</td>
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<tr>
<td>Address: Errera Community Care Center, 114-52 Boston Post Road</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>City/State/Zip: West Haven, CT 06516</td>
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<td></td>
</tr>
</tbody>
</table>
Contact Person: Anne Klee, Ph.D., CPRP, Director of Interprofessional Fellowship (APA CoR, Past President, APA Division 18), Telephone No. (203) 932-5711 x 2231; E-mail address: anne.klee@yale.edu

Contact Person: Meaghan Stacy, Ph.D., Director of Psychology Training (Division 18 Chair-elect, Section on SMI/SED), Telephone No. (203) 932-5711 x 2916, E-mail address: Meaghan.stacy@yale.edu


APA Accreditation: Yes.
List of Forms Included at the End of This Criterion VII

Sample PSR/SMI/SED Fellow Applicant Rating Form
Sample Admission Evaluation Form
Sample Suggested Criteria for Evaluating PSR Fellowship Candidates
Example of Typical SMI/SED Recovery and Psychosocial Rehabilitation Interprofessional Fellowship Curriculum for Post-Doctoral Specialty
SMI/SED PSR Competencies
Broad, General Descriptive Narrative of the SMI/SED PSR Competencies
Sample Sequence of Training for Post-Doctoral Psychology Residents in SMI/SED Specialty
Sample Training Plan
Sample Graduated Levels of Responsibility for Post-Doctoral Psychology Residents in SMI/SED Specialty
Sample Recommended Readings for Post-Doctoral Specialty in SMI/SED
Sample PSR Fellow/Resident Competency Assessment Form
Sample Professional Identity and Confidence Evaluation for Post-Doctoral Psychology Residents in SMI/SED Specialty

List of Appendices for Criterion VII

Appendix I: Education and Training Guidelines for Post-Doctoral Psychology Residencies in SMI/SED
Appendix III: Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)

References


university directors of clinical psychology (CUDCP) clinical psychology training and doctoral education. Training and Education in Professional Psychology, 4, 4, 254-263.


Warner, R. (2010). Does the scientific evidence support the recovery model? The Psychiatrist Online, 34, 3-5.

## Sample PSR/SMI/SED Fellow Applicant Rating Form

**Applicant Name:**

**Graduate Program:**

**Internship Program:**

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<thead>
<tr>
<th>Domain</th>
<th>Score</th>
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<tr>
<td>Intervention (recovery-focused? EBPs for SMI?)</td>
<td>Very strong</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neither</td>
<td></td>
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<tr>
<td></td>
<td>Deficient</td>
<td></td>
</tr>
<tr>
<td>Assessment (experience with assessing psychosis?)</td>
<td>Very strong</td>
<td></td>
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<td></td>
<td>Neither</td>
<td></td>
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<tr>
<td></td>
<td>Deficient</td>
<td></td>
</tr>
<tr>
<td>Scholarly Potential (specific to SMI? Integrate recovery focus?)</td>
<td>Very strong</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neither</td>
<td></td>
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<tr>
<td></td>
<td>Deficient</td>
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</tr>
<tr>
<td></td>
<td>Research Interests</td>
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</tr>
<tr>
<td></td>
<td>Research Mentor</td>
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<tr>
<td>Letters of Recommendation</td>
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<tr>
<td>Sensitivity to Diversity</td>
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<tr>
<td>Section</td>
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<td>Notes</td>
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<tr>
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<td>-----------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Cover Letter (recovery orientation? Career plans with SMI? Previous work with persons with SMI?)</td>
<td>Very strong</td>
<td></td>
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<tr>
<td></td>
<td>Neither</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deficient</td>
<td></td>
</tr>
<tr>
<td>Work Sample (SMI population? Measures consistent with what we use? Strengths-based approach?)</td>
<td>Very strong</td>
<td></td>
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<td></td>
<td>Neither</td>
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<tr>
<td>Match with SMI Residency</td>
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<td>Career goals</td>
</tr>
<tr>
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<td>Clinical mentor</td>
</tr>
<tr>
<td></td>
<td>Deficient</td>
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</tbody>
</table>

Total Very Strong: _____  Total Neither: _____  Total Deficient: _____

Overall: 1) Interview  2) Marginal  3) Cut
Sample Admission Evaluation Form

Note: This form is specific to an SMI/SED post-doctoral residency application evaluation form and can be used in addition to a more general, overall post-doctoral residency admission evaluation form.

PSR Residency Interview (Revised January 2017)

Applicant: ________________________  Date of Interview: __________

Panel/Rater: _____________________________________________________________

Today we will be asking you several complex questions. Given that we have approximately sixty minutes for the interview, we ask that you limit your initial response to each question to five minutes.

1. What is your understanding of the Recovery Model / PSR model for working with people with serious mental illness? Please describe the key elements of the model and provide an example of the way you have utilized these concepts while working with clients. How do you differentiate Recovery from Psychosocial Rehabilitation?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) ____

2. Much of the work we do here involves clinical case management and support with life skills, including going into the community to meet with clients in their homes, taking them to medical appointments, or helping them with basic needs such as grocery shopping, banking, etc.

   • What experiences have you had with this type of work and what benefit can you see of this kind of work?

   • What positives and negatives would you anticipate working as a clinical staff member in community settings?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) ____
3. When working with a client in the community, the client will be interacting with you in more ways than in a traditional office setting and may see sides of you that are not always apparent in an office.

   - How would you handle personal questions that might come up?
   - How might your boundaries differ in the community versus in the office?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) ____

4. Tell us about a time when a team member or a supervisor challenged your decision-making and how you went about resolving the issue (and what was the resolution?).

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) ____

5. Fellows have overlapping deadlines, tasks in different locations throughout the day, and oftentimes interruptions by other clinicians or Veteran issues will disturb your work. How do you typically prioritize work, manage multi-tasking and shifting from one task to another? Can you provide an example of how you have done this on internship?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) ____

6. How would you handle the following situation? You are meeting a client, Mr. Smith, at his home, but he is not there when you arrive. You call Mr. Smith who says he is on his way, but stuck in traffic. He asks you to wait for him. Mr. Smith arrives at 2:30pm. You have a twenty-five minute drive back to the hospital/agency for your 3pm seminar. What factors would help you determine how much time (if any at all) to spend with Mr. Smith, and how would you proceed?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) ____


7. Please describe interventions that have been shown by research to be effective when working with people with SMI particularly with schizophrenia, and your experiences with these approaches.

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) ____

-----------------

8. How does this fellowship fit in with your short term and long term career plans?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) ____
Sample Suggested Criteria for Evaluating PSR Fellowship Candidates

PSR Fellowship Purpose:

To develop future mental health leaders with vision, knowledge, and commitment to transform mental health care systems in the 21st century by emphasizing functional capability, rehabilitation, and recovery.

1. **Psychosis Experience/Commitment.** Experience with, and commitment to, working with people with psychosis. Have they done this before? Do they know what this is like and its unique challenges? Moreover, do they have a passion for working with this population so that they can become future leaders?

2. **Clinical/EBP Experience.** Do they have at least intermediate knowledge and experience with the concept of recovery from serious mental illness and with evidence-based interventions (both individual and group) in general? Do they have a recovery orientation that they can articulate and are they familiar with and committed to providing recovery-oriented care? Do they have unique expertise or interests that would contribute to a SMI/SED team—e.g., ideas for new groups, expertise in trauma, SUD, ACT, personality disorders, community integration ideas/enthusiasm?

3. **Leadership Potential:** Do they have potential to become future leaders in the area of psychosocial rehabilitation for people with SMI (as this is the PSR Fellowship’s mission)? For example, have they been involved in leadership activities? Do they have big exciting ideas for the future? Do they have a promising research trajectory that could have impact on the field?

4. **Professionalism and Interpersonal Effectiveness.** Are they kind, respectful, professional? Can you envision them fitting well with the PSR team? Can you imagine getting along with them easily and collaborating with them? Do you like them as a person? Would they work effectively with clients, including those who might be guarded, paranoid, or otherwise challenging (i.e., can they show empathy, be engaging, communicate succinctly, etc.)? Do they demonstrate professional skills necessary to do well (e.g., time management, initiative, ethics)?
### Example of Typical SMI/SED Recovery and Psychosocial Rehabilitation Interprofessional Fellowship Curriculum for Post-Doctoral Specialty

This table outlines in chart form typical post-doctoral residents’ duties, e.g., one example of a typical curriculum.

<table>
<thead>
<tr>
<th>Location</th>
<th>Duty</th>
<th>Explanation</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Recovery and PSR Unit</td>
<td>Serve as Recovery Psychologist</td>
<td>Assist individuals in developing and following Recovery Plans on outpatient PSR unit</td>
<td>All Residents</td>
</tr>
</tbody>
</table>
| Outpatient Recovery and PSR Unit| Provide individual/family assessment and psychosocial rehabilitation services | Services may vary and may include:  
- Assessments (e.g., biopsychosocial diagnostic intake assessments, vocational assessments)  
- Psychotherapy  
- Family therapy  
- Supported Employment (SE)  
- Crisis intervention (e.g., suicide assessment and safety planning)  
- Case management | Supported Employment (SE): Different discipline trainees carry varying number of cases; Psychology Residents carry at least 1 case |
| Outpatient Recovery and PSR Unit| Provide group-based psychosocial rehabilitation services | Services may vary and may include:  
- Psychoeducational groups  
- Psychotherapy & skills training classes  
- Community integration groups  
- Wellness groups  
- Support groups | All Residents |
| Inpatient Psychiatry Unit       | Complete rotation on inpatient psychiatry unit |  
- Facilitate weekly transition/bridging group  
- Conduct intakes on unit when needed  
- Conduct other assessments or short term psychotherapy, as needed and if possible during the rotation time  
- Occasionally attend staff meetings to conduct outreach/provide consultation about recovery-oriented care for individuals when transitioned to outpatient | All Residents |
<p>| Outpatient Recovery and PSR Unit| Conduct outreach activities                | Educational trainings in the principles and strategies of psychosocial rehabilitation and recovery-oriented services for other staff and/or trainees | At least 1 per Resident |</p>
<table>
<thead>
<tr>
<th><strong>Outpatient Recovery and PSR Unit</strong></th>
<th><strong>Design and implement a research/dissemination project</strong></th>
<th><strong>Spend 8 hours per week on a research/dissemination project and (at minimum) present as poster at annual conference</strong></th>
<th><strong>1 independent project per Resident</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Recovery and PSR Unit</strong></td>
<td><strong>Assist in clinic administration</strong></td>
<td><strong>Select a clinic administration task and provide assistance to director and staff in this area</strong></td>
<td><strong>All Residents select 1 role</strong></td>
</tr>
<tr>
<td><strong>Outpatient Recovery and PSR Unit</strong></td>
<td><strong>Provide supervision</strong></td>
<td><strong>Provide supervision to a junior trainee or peer support specialist</strong></td>
<td><strong>Psychology Residents only</strong></td>
</tr>
<tr>
<td><strong>Outpatient Recovery and PSR Unit</strong></td>
<td><strong>Attend supervision and didactics</strong></td>
<td><strong>Attend individual supervision (with 2 supervisors), group supervision (including team meeting) and attend required didactics</strong></td>
<td><strong>All Residents (didactic requirements vary by discipline)</strong></td>
</tr>
</tbody>
</table>
SMI/SED PSR Competencies

The specialized training needed to develop competence to treat persons with SMI/SED includes: very different assessment methods that assess functional capability rather than symptomatology, EBPs and promising practices designed specifically for this population, interventions modified and found to be effective with people in this population in the forensic mental health system, research methods adapted for populations such as this, and systems transformation methods specific to large mental health systems that serve this population, to name but a few – these are the major areas of specialized training needed by psychologists to work with individuals with SMI/SED. With funding from a Board of Educational Affairs grant and from Division 18, a meeting was convened following the 2016 APA convention to identify the specific competencies that are needed to meet the training needs of psychologists. While it is recognized that not every post-doctoral specialty program could include all of these, the following competencies are those that would ideally be included or available to trainees (a broad, general descriptive narrative follows the listing):

Assessment

• Comprehensive knowledge of strengths based and functional capability assessments and ability to use these
• Ability to utilize standardized assessments in ways that may require modification in light of the fact that these assessments were not developed or normed using persons with SMI/SED
• Ability to competently utilize specialty assessments such as the Structured Clinical Interview (SCID for DSM), the Positive and Negative Syndrome Scale (PANSS), the Brief Psychiatric Rating Scale (BPRS), and the Brief Psychiatric Rating Scale for Children (BPRS-C) as needed and appropriate
• Ability to conduct an assessment of an individual’s readiness and desire for psychosocial interventions
• Ability to conduct an assessment of internal and external resource availability and the individual’s ability to utilize available resources
• Ability to assess perceived recovery and life satisfaction/quality of life
• Ability to assess and address positive and negative symptoms
• Ability to recognize psychosis and thought disorder and understand in depth the nuances of each condition considered within the purview of SMI/SED
• Ability to recognize and screen for potential cognitive deficits that are core areas of dysfunction for people with SMI/SED including processing speed, verbal memory, and attention
• Ability to recognize and screen for social deficits that often accompany these disorders
• Ability to recognize the limitations posed by cognitive impairments and the potential for lessened insight and, as needed, ability to conduct behavioral observational assessments that accurately account for these
• Ability to assess for the potential risk for suicide and violence to self or others
• Ability to recognize and understand etiology of comorbid trauma and substance use disorders in SMI/SED disorders and be competent in differential diagnosis of similarly presenting diagnoses such as PTSD and personality disorders
• Knowledge of medication side effects especially those specific to psychotropic medications and ability to assess for medication adherence and barriers to adherence
• Ability to integrate theintersection of diversity related to age, cultural, spiritual/religious beliefs, etc. specifically related to the presentation of symptoms unique to SMI/SED
• Ability to recognize the level of capacity and competence of an individual with SMI/SED in order to make appropriate recommendations regarding interventions or to refer to appropriate specialty services including those provided by other disciplines

**Interventions**
Comprehensive knowledge of psychosocial rehabilitation interventions designed to foster recovery and meet the needs identified by each person:

• Schizophrenia PORT evidence based and promising practices (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010):

• Assertive Community Treatment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others

• Supported Employment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others

• Cognitive Behavioral Therapy (CBT) and CBT for psychosis (CBTp) – knowledge of differences between CBT and CBTp and ability to competently practice and supervise others in both interventions

• Family intervention/psychoeducation – knowledge of fidelity criteria and ability to implement intervention and supervise others

• Social learning program (Token Economy) – knowledge of intervention, its appropriate use, ability to implement and train and supervise others

• Integrated dual diagnosis treatment/Co-occurring disorders treatment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others

• Weight management approaches and Smoking cessation approaches – ability to competently implement appropriate interventions and supervise others

• Illness self-management including Wellness Recovery Action Planning (WRAP), behavioral tailoring for medication – knowledge of interventions, how to implement and supervise others

• Cognitive Remediation and Social Cognition Training – knowledge of interventions, ability to competently practice and supervise others

• Psychosocial interventions for first episode psychosis – knowledge of recent research indicating the effectiveness of a set of interventions (RAISE) and ability to implement interventions, participate on teams, and supervise others

• Peer support/peer delivered services – knowledge of interventions and ability to implement and supervise peers and other professionals

Additional interventions to address critically important problems for people with SMI/SED including:

• Stigma/Self-stigma interventions – knowledge of, and ability to implement interventions to change attitudes and decrease discriminatory behaviors among health providers and the public at large

• Trauma interventions (trauma informed and trauma specific care) – ability to competently implement trauma interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care

• Suicide prevention – ability to recognize when individuals may be at risk and provide high levels of support, refer for medical intervention and provide treatment for depression in order to reduce hopelessness
• Violence prevention – ability to recognize when individuals may be at risk and refer for medical intervention while providing high levels of support

• Interventions to decrease homelessness – ability to provide a comprehensive array of services designed to facilitate supported housing, e.g., trauma informed care, relapse prevention for substance abuse, and other supports to maintain housing

• Motivational interviewing for those with SMI/SED – ability to competently implement motivational interviewing as appropriate and to supervise others in practice

Specialized interventions for forensic/criminal justice populations with SMI/SED including:

• Knowledge of the factors that impact the success of interventions for forensic and criminal justice populations with SMI/SED

• Forensic Assertive Community Treatment (FACT) – ability to ability to implement intervention, participate on team, and supervise others

• CBT for those in criminal justice/forensic settings – ability to competently provide specialized CBT services and to supervise others in practice

• IDDT/Co-occurring disorders treatment for those in criminal justice/forensic settings – knowledge of the specialized needs of people with SMI/SED in these settings, ability to provide integrated mental health and substance use services targeted to the population, and supervise others in practice

• Trauma interventions for those in criminal justice/forensic settings (trauma informed and trauma specific care) – recognition of trauma as the norm for those with SMI/SED in the forensic and criminal justice system, ability to competently provide trauma specific interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care, including services for those at highest risk and to supervise others in provision of services

• Supported housing interventions for those in criminal justice/forensic settings – ability to implement comprehensive services to assure supported housing is available for individuals being released into the community

• Transition planning and follow-up for criminal justice/forensic settings – ability to implement adequate and appropriate transition planning and follow up for individuals being released into the community

Specialized interventions for people with bipolar disorder - in addition to demonstrating competence with the above interventions for people with SMI/SED (several of which are also recommended specifically for this population):

• Demonstrate an ability to competently provide interpersonal and social rhythm therapy (IPSRT) and Family Focused Treatment (FFT) for bipolar disorder and to supervise others in practice

• Understand the potential of Dialectical behavior therapy (DBT) which may also be helpful for individuals with bipolar disorder and personality disorders

Consultation

• Ability to effectively present information and develop treatment recommendations that are understandable to the person, his or her support team, and in accord with his or her goals

• Ability to competently work with an interprofessional team and present information about persons with SMI/SED so that team members can understand and learn from the presentation

• Ability to apply specialty knowledge and expertise concerning SMI/SED symptomatology and diagnosis to problems that arise in professional settings
• Comprehensive knowledge of psychosocial functioning and recovery and ability to describe this to team members, other colleagues, and members of the public
• Ability to provide education and training for mental health staff on all aspects of the recovery paradigm and psychosocial rehabilitation assessments and interventions
• Ability to integrate all information into a case formulation that presents an opportunity for use of psychosocial interventions designed to promote recovery and attainment of the goals articulated by each person
• Ability to assist supervisees and team members in the management of difficult behaviors that may be exhibited by persons with SMI/SED
• Ability to integrate the knowledge, values, and attitudes critical for successful work with people with SMI/SED into interprofessional team settings to facilitate shared decision making
• Ability to work with staff in specialized facilities such as supported housing, etc. to help them recognize and respond appropriately to symptoms and problem behaviors to help individuals with SMI/SED thrive in the community
• Ability to educate, train and supervise staff at all levels of training from front line behavioral health staff through to highly trained staff and managers/administrators, in the best ways to help people with SMI/SED manage symptoms, set and achieve goals for themselves, and use resources available to them. Some examples of potential issues and difficult behaviors include limit setting, stigma, empathy, delusions/hallucinations, crisis intervention
• Ability to consult with families about their family member’s illness and the role of family in treatment
• Knowledge of resources to help with access to care (e.g., family members trying to get members into care and navigate a complex healthcare system)
• Ability to educate and train staff in facilities and on specialized units for youth, young adults, and older persons where knowledge and expertise is lacking about behavioral health particularly SMI/SED

Research and Evaluation
• Recognition of the importance of incorporating persons with lived experience of SMI/SED into all aspects of research and evaluation from conception to completion and publication. This includes formulation of hypotheses, study questions and design, determination of statistical methods, participants to be recruited, etc.
• Knowledge of and ability to use mixed methods research designs
• Familiarity with and ability to use single case designs (disorders may be persistent over time and multiple baselines provides a clearer picture of the impact of different treatment components and their helpfulness to individuals)
• Recognition of ability to incorporate family members and first degree relatives into designs (research provides insight into how the illness manifests in individuals vs. family members looking at the phenotypes in individual and family)
• Recognition of importance of involvement of caregivers and other stakeholders in research and willingness to incorporate them into designs
• Ability to collaborate with other disciplines (e.g., psychiatry, rehabilitation services, nursing, etc.)
• Up to date knowledge of the latest assessments and interventions for this population
• Ability to utilize research/evaluation knowledge to adapt/modify assessments and interventions that have excluded persons with SMI/SED and to do so appropriately recognizing when fidelity to the original practice is essential
• Recognition and understanding the needs of vulnerable populations vis a vis their participation in research efforts
• Recognition and understanding of the ability of persons with SMI/SED to provide informed consent
• Ability to inform and educate IRBs about the type of intervention research common with SMI/SED populations such as psychosocial interventions
• Understanding of the unique needs of persons with SMI/SED vis a vis research/evaluation and ability to apply this knowledge to prevent/minimize drop out as typically this is different for SMI/SED 1) drop outs tend to be doing worse and 2), severe economic disadvantages impact people with SMI/SED disproportionately 3), follow up studies need to include more time (>1 year) due to the nature of the illness
• Knowledge of and ability to conduct multifactorial designs of programs as these are the norm with SMI/SED populations; understanding of the importance of controls for non-specific factors
• Ability to identify appropriate outcomes for program evaluation efforts due to broad nature of quality of life, psychosocial functioning, and recovery
• Ability to undertake program evaluation which is critical so that a developed program can be improved - systems within which SMI/SED persons are seen may be more difficult to work with than structured research settings due to presence of multiple stakeholders
• Ability to obtain buy-in from multiple under-resourced clients and stakeholders

**Supervision/Teaching**

• Comprehensive knowledge of all psychosocial assessments and interventions and ability to impart knowledge about these and to supervise others in practice
• Ability to provide education and training for mental health staff on all aspects of the recovery paradigm and psychosocial rehabilitation interventions
• Ability to impart knowledge and help others develop an understanding of, and ability to convey the importance of hope, respect, positive regard, and acceptance of person’s goals, wishes, and preferences in the development of the therapeutic relationship (which is key and sometimes difficult to form) and to supervise others in their development of these factors
• Ability to impart an understanding of the pace and non-linear process for recovery and ability to develop positive expectations for the person’s progress despite the combination of social, functional, and cognitive impairments that are commonly observed
• Ability to help trainees and supervisees recognize incremental improvements and utilize the process of shaping in goal setting and recovery
• Ability to impart knowledge of the phenomenology of the disorders of SMI/SED (e.g., auditory hallucinations, negative symptoms such as diminutions of basic drives, etc.)
• Ability to supervise effective goal setting with people with SMI/SED that is often different in quality (i.e., level of difficulty) and outcome (i.e., type of goals set) than in those without SMI/SED
• Ability to promote self-examination of fear and pre-conceptualization of people with SMI/SED including stigma and self-efficacy
• Ability to teach and supervise trainees about appropriate boundaries and differences in working with this population
• Knowledge of standard tools for fidelity measures and ability to supervise trainees in their use
• Ability to use live or audiotape feedback to understand the often complex nuances of work with persons with SMI/SED
• Ability to supervise a range of other mental health providers (e.g., psychiatrists, peers, nurses, social workers, occupational therapists)

• Knowledge of the complexity of systems change issues and ability to promote resiliency as resistance is encountered

**Management/Administration**

• Knowledge of the complexity of systems change issues and ability to promote resiliency as resistance is encountered

• Knowledge of needed systems of care and the importance of integration and interprofessional cooperation

• Familiarity with reimbursement structures and with psychosocial services that are not funded or are partially funded and ability to secure funding for needed specialized services

• Knowledge of Commission on Accreditation of Rehabilitation Facilities (CARF) requirements for accreditation and ability to implement policies and procedures needed to secure and maintain accreditation

• Knowledge of Joint Commission and Centers for Medicare and Medicaid Services (CMS) standards and ability to implement policies and procedures needed to secure and maintain accreditation and ensure CMS standards are met

• Knowledge of the Americans with Disabilities Act and its amendments and application to those with SMI/SED

• Ability to lead effectively within complex interprofessional teams and settings

• Knowledge of implementation and dissemination of EBPs for those with SMI/SED and the challenges of this in multiple, complex settings

• Recognition of the importance of conducting program evaluation and/or quality improvement studies and ability to convince management and team members of this

• Ability to develop comprehensive programs across the full continuum of care that incorporates needed interventions such as supported employment and others

• Knowledge of the complexity of systems change issues and ability to implement needed changes

• Ability to assist organizations to understand the importance of providing services within a recovery orientation

• Comprehensive knowledge of all psychosocial assessments and interventions and ability to impart knowledge about these and ensure cooperation and implementation within teams and overall system

**Advocacy**

• Ability to create opportunities for people with SMI/SED to meet and interact with others with and without SMI/SED, build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion

• Knowledge of community resources and ability to reach out to these as a means of expanding access to services for people with SMI/SED

• Knowledge of community resources and ability to intervene to help with access to care (e.g., family members trying to get members into care and navigate complex system).

• Knowledge of laws that affect individuals with SMI/SED negatively and may lead to human rights violations (e.g., laws about competency restoration process, not guilty by reason of insanity, etc.).

Please Note: See Appendix III for the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances*
(SMI/SED), a tool that can be used by practitioners and supervisors to evaluate knowledge and skills in the competencies of this specialty. This instrument is a modification of the evaluation tool developed by the Council of Professional Geropsychology Training Programs known as the *Pikes Peak Geropsychology Knowledge and Skill Assessment Tool* (Karel, et al., 2012). Permission was received from the Council of Professional Geropsychology Training Programs to modify and use the Pikes Peak tool; we are grateful for the Geropsychology Council for granting their permission to modify and use this excellent instrument.

**Broad, General Descriptive Narrative of the SMI/SED PSR Competencies**

**Competence in Assessment Skills:**

Sophisticated assessment is essential to any recovery service plan. Residents should be able to appropriately assess, evaluate and then develop practical interventions for individuals with severe and persistent mental illnesses, including those with complicated mental, substance use and medical co-morbidities, often with histories of trauma. Close monitoring and supervision to ensure the ongoing development and presence of these skills is an essential part of this residency year. All residents present in weekly supervisory meetings, team meetings and case conferences.

**Competence in Psychotherapeutic Interventions - Individual, Family, and Group:**

By the completion of their training year, residents should demonstrate skill in applying and adapting evidence-based interventions with SMI/SED consumers. Residents are expected to independently assist clients with the development of realistic goals, development of tailored clinical and recovery-oriented interventions that meet the client's identified goals, develop action steps for goal achievement, modify rehabilitation plans to reflect the needs and values of the client and determine satisfaction of services provided. Residents also are expected to manage crisis situations and identify opportunities for transition of services. When working with and on behalf of individual clients, family members and/or groups, residents are expected to demonstrate the ability to effectively work with diverse populations, interprofessional providers, various program specialties, and provide appropriate interventions in response to a range of presenting psychosocial problems and treatment concerns.

**Competence in Consultation Skills:**

Within the bounds of confidentiality and privacy, residents must be able to listen, understand, communicate, and display excellent rapport with relevant stakeholders including: the person served, family members, relevant community members, other healthcare providers within and outside of the system, and partnering agencies. The resident is expected to exhibit comfort and proficiency in providing effective consultation and feedback to the person served, family members, clinical programs, interprofessional staff and community partners.

**Competence in Teaching and Supervision Skills:**

By the completion of the training year, residents should demonstrate the ability to give presentations in a formal didactic setting, develop mentoring skills for working with small groups and/or one to one to teach skills, communicate knowledge, and provide feedback to those they serve, their support networks, other professionals, trainees, para-professionals, and/or community partnering agencies. When providing supervision and teaching, residents should demonstrate sensitivity to ethical, legal, and cultural issues and demonstrate ability to teach the principles of PSR.
Competence in Scholarly Inquiry and Application of Theoretical and Scientific Knowledge to Practice:

Residents are expected to participate in scholarly inquiry, and apply theoretical and scientific knowledge to their clinical practices. They are expected to engage in their own scholarly endeavors which may include research, grant proposal writing, as well as program development, implementation, and evaluation.

Competence in Understanding Organizational and Systemic Dynamics:

By the completion of their training, residents should demonstrate an advanced level of knowledge of the various healthcare systems in which they have operated and have a broader understanding of health and mental healthcare systems both nationally and to some extent globally. They should show awareness of and sensitivity to systemic issues that impact the delivery of services. They should demonstrate a good understanding of organizational dynamics as well as systemic issues within programs, effectively functioning within various institutional contexts and appreciating how such forces impact and influence clinical care.

Competence in Professional Conduct, Ethics, and Legal Matters:

All residents are expected to know and follow strict privacy and confidentiality guidelines. This is taught in a number of settings including: seminars, workshops, supervision sessions, and other trainings. Residents should demonstrate sensitivity to ethical, legal, and cultural issues in all aspects of their work, as well as the nuances of ethics and boundaries in community settings.

Competence in Cultural and Individual Diversity:

Residents should recognize the wide range of diversity that occurs in the SMI/SED population and recognize their own level of acceptability and comfort within each. Residents are expected to learn about and demonstrate understanding of the range of diversity that is critical to understanding the individual. Residents must participate in trainings on diversity and culture. Residents are expected to use individual and group supervision to explore and develop understanding of all different aspects of culture, diversity and identity and to apply this learning to treatment.

Growth in Professional Development:

Residents should demonstrate continued growth in professional development over the post-doctoral year. Residents should assume increasing professional responsibility for clinical care, consultation and program development. They should demonstrate advanced knowledge in ethical, legal and cultural issues related to all of the above competencies, and conduct themselves in accordance with these principles and with current professional standards. Residents should participate in the larger professional community by involvement in professional and scientific organizations. They should demonstrate commitment to continued self-assessment and reflection, to self-education and life-long learning, and contribute to the larger community by making themselves available as an educational resource to other professionals.
Sample Sequence of Training for Post-Doctoral Psychology Residents in SMI/SED Specialty

**Beginning of Training Year**
1. Complete initial self-evaluation to identify training needs
2. Construct Training Plan in collaboration with supervisors to organize and guide training experience
3. Complete orientation to rotation procedures
4. Undertake introductory trainings and readings on SMI/SED-related topics (e.g., recovery planning, specialized assessments for this population, cognitive behavioral therapy for psychosis, supported employment, suicide and violence risk management, etc.)
5. Observe licensed providers conducting SMI/SED clinical practice, (e.g., strengths based, readiness, assessment intakes and screening, recovery planning, interventions), or be observed by licensed providers (depends on experience level); attend grand rounds where applicable
6. With supervisor and training committee, make preliminary decisions regarding rotations
7. Begin providing outpatient and/or inpatient psychosocial rehabilitation services independently and with other residents, under supervision
8. Participate in seminars, didactics, consultation meetings, etc.
9. Brainstorm research/dissemination projects via discussions with supervisors and clinical team
10. Complete evaluation of resident’s professional identity, confidence, and competency evaluation/assessment to identify knowledge/skills/abilities with respect to SMI/SED clinical practice in order to inform future training goals and independence

**Middle of Training Year**
11. Complete mid-year competency evaluations along with supervisors to measure progress and identify training needs
12. Continue providing outpatient and inpatient psychosocial rehabilitation services independently and with other trainees, under supervision
13. Continue participation in seminars, didactics, consultation meetings, etc.
14. May begin supervising junior-level trainees in their provision of psychosocial rehabilitation services where possible including intakes, specialized assessments, recovery planning, individual and group therapies, specialized interventions, etc.
15. Execute research/dissemination project
16. Conduct outreach to educate colleagues and community on SMI/SED and recovery-oriented care
17. Provide consultation to other staff and trainees on recovery orientation and interventions for persons with SMI/SED, as needed
18. Prepare for EPPP and other professional credentials (CPRP, etc.)
19. Complete evaluation of resident’s professional identity and confidence to inform future training goals and independence

**End of Training Year**
20. Continue providing outpatient and inpatient psychosocial rehabilitation services independently and with other trainees, under supervision
21. Continue participation in seminars, didactics, consultation meetings, etc.
22. Continue providing consultation to other staff and trainees on recovery paradigm and interventions for persons with SMI/SED, as needed
23. Submit research/dissemination project findings for presentation at 1 conference and/or present if accepted; possibly submit manuscript for publication
24. Take licensing (EPPP) and other professional examinations
25. Prepare for and take state license exam
26. Apply for and obtain licensure (where jurisdiction permits prior to residency completion)
27. Complete end of year competency evaluations along with supervisors to measure progress and outcome of training

**Throughout the Training Year**
28. Participate in supervision, consultation, self and supervisory evaluations. Fulfill training requirements specific to residency program.
**Sample Training Plan**

Training goals are established by discussing required and desired experiences. Plans are developed by residents in conjunction with supervisors and training directors. Training plans should be revised accordingly to reflect new goals and objectives. This process is highly interactive between the resident and faculty. It is also further structured and monitored by the Residency Training Committee, which meets monthly.

Resident: ___________________________    Date: _________________

<table>
<thead>
<tr>
<th>GOALS</th>
<th>CLINICAL ROTATIONS &amp; TRAINING ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Based on self-assessment of training needs to meet residency competencies</em></td>
<td><em>Where Resident will gain skills/knowledge and experiences to work toward listed goals</em></td>
</tr>
</tbody>
</table>
| 1. Conduct clinical work with individuals, groups and/or family members, work as part of interprofessional team, have exposure to community mental health experiences and receive clinical supervision. | Select primary clinical placement (20 hours per week)  
- Behavioral Health Recovery Clinic "Recovery from the Start" 4 month assessment rotation  
- Facilitating ACT groups. 4 month rotation  
- Facilitating Social Skills Training groups, 8 month rotation |
| 2. Develop understanding and skill in the principles of psychosocial rehabilitation and evidence-based and promising practices for working with individuals with severe and persistent mental illnesses. | Participate in didactics  
- PSR Principles Seminar, weekly  
- Leadership Development Seminar (monthly)  
- Diversity Seminar (meets every other month)  
- SST and ACT Consultation Meetings  
- Program Evaluation and Research Seminar (monthly)  
- Interprofessional Case Assessment & Presentation Seminar (monthly) |
| 3. Scholarly inquiry (research, program development, impact statement) | Educational Dissemination Project (EDP) – design and develop a project that can be presented at the United States Psychiatric Rehabilitation Association's Annual Conference. An EDP can include designing a new psycho-educational group or program, research, a policy initiative. |
| 4. Teaching and supervision | Teach two seminars (possibilities include: ECCC professional development colloquia, PSR Residency Seminars, Peer Specialist seminars.)  
- Provide supervision and co-supervision to trainees |
| 5. Consultation          | • Provide consultation to two community providers (examples may include providing training, technical assistance, case consultation.)  
                          | • Attend Continuum of Care meeting with other teams/units |
|--------------------------|------------------------------------------------------------------------------------------------------------------|
| 6. Professional development | Participate in  
                          | • Leadership Seminar Series  
                          | • Quarterly mentorship meetings with supervisors and leadership from community agencies  
                          | • Monthly individual meetings with each of the directors of training |
| 7. Explore issues surrounding cultural diversity (mode of learning and skill building is up to individual) | • Attend monthly Diversity Seminar  
                          | • Discuss cultural diversity issues in group and individual supervision |

(Add additional rows as needed)

Training plan to be reviewed every four months with supervisor or as needed

__________________________________________
Resident

__________________________________________
Director of Psychology Training, PSR Residency

__________________________________________
Director, Interprofessional Fellowship
Sample Graduated Levels of Responsibility for Post-Doctoral Psychology Residents in SMI/SED Specialty

Supervisee: ________________________________

Supervision Types:

**Room.** The supervising practitioner (SP) is physically present in the same room while the resident is engaged in health care services.

**Area.** The SP is in the same physical area and is immediately accessible to the resident. SP meets and interacts with patients/clients as needed. Resident and SP discuss, plan, or review evaluation or treatment. Area supervision is available only when the resident has formally been assigned a Graduated Level of Responsibility commensurate with this type of supervision.

**Available.** Services furnished by resident under SP’s guidance. SP’s presence is not required during the provision of services. SP available immediately by phone or pager and able to be physically present as needed. This type of supervision is permissible only when the resident has formally been assigned a Graduated Level of Responsibility commensurate with this type of supervision.

Only circle a Level of Supervision for activities the supervisee is performing

<table>
<thead>
<tr>
<th>Clinical Activity (supervisors are to identify the specific tasks that will be accomplished by the individual e.g., individual therapy, assessment, etc).</th>
<th>Level of Supervision (circle the level)</th>
<th>Supervisor Initials &amp; Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Room Area Available</td>
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<tr>
<td>2.</td>
<td>Room Area Available</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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<tr>
<td>6.</td>
<td>Room Area Available</td>
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</tbody>
</table>

Ultimately, the SP determines which specific activities the resident will be allowed to perform within the context of these assigned levels of responsibility.

______________________________   ________________________________
Supervising Licensed Psychologist   Supervisee Signature
Sample Recommended Readings for Post-Doctoral Specialty in SMI/SED

Please Note: The following list is a sampling only and is not meant to be exhaustive. The references in the APA curriculum (American Psychological Association & Jansen, 2014) along with the references contained in several criteria within this specialty petition may be particularly relevant. Additionally, residents should be required to remain abreast of the literature in relevant journals, for example Schizophrenia Bulletin, Psychiatric Services, Psychiatric Rehabilitation Journal, World Psychiatry, among others.


Sample PSR Fellow/Resident Competency Assessment Form

Trainee:_____________________________

Supervisor:______________________________

Training Year:___________________________

Rotation:________________________________

Date:________________________Trimester (circle one): First    Second    Third

General Framework for Competency Ratings (Half points are permitted):
1 Substantial supervision required on all cases or related work; limited to no autonomous judgment.
2 Supervision on most straightforward cases or related work; minimal autonomous judgment (Intern Entry Level).
3 Supervision on intermediate level cases or related work, or when learning a new skill area; autonomous judgment on routine cases.
4 Score represents readiness for practice at the entry level. Supervision on advanced cases or related work; autonomous judgment (Intern Exit Level/ Postdoc Entry Level).
5 Consultation only expected on advanced, unusual cases or related work
6 Readiness at the entry level for advanced specialized practice. Consultation only expected on highly atypical, advanced cases or related work that requires focused knowledge; autonomous judgment (Postdoc Exit Level).
7 Clinical Psychologist at the expert level (e.g., Diplomate/ABPP)

Exit criteria: For the last evaluation period, no competency item can be rated below a “6” for a trainee to pass the residency/fellowship. Grievance procedures will be followed if a trainee disputes any competency rating.

SUPERVISORS: At each evaluation interval, the evaluation must be based in part on direct observation of the competencies evaluated (APA Standards of Accreditation, page 39, item D.1.ii). Please indicate how direct observation was completed:

☐ Observed resident’s individual or group clinical work
☐ Co-facilitated clinical work with resident
☐ Other form of direct observation:
____________________________________________________

This evaluation is also based on the following:

☐ Discussion with team members or colleagues
☐ Case discussion in supervision
☐ Other form of evaluation:
____________________________________________________
1. Integration of Science and Practice
Trainees must demonstrate the ability to critically evaluate and disseminate research or other scholarly activities (presentations, publications, program evaluation), and demonstrate understanding of the influence of science on practice, and practice on science.

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeks out current literature to enhance clinical work or current research project. Cites references appropriately (when indicated)</td>
<td></td>
</tr>
<tr>
<td>Identifies and applies appropriate evidence-based practices</td>
<td></td>
</tr>
<tr>
<td>Engages in scholarly inquiry, such as literature review, program development, program evaluation, or research to inform clinical practice</td>
<td></td>
</tr>
<tr>
<td>Demonstrates critical thinking in scholarly activities (e.g., EDP)</td>
<td></td>
</tr>
<tr>
<td>Is able to effectively summarize relevant literature in supervision, case conferences, research presentations, or professional talks</td>
<td></td>
</tr>
<tr>
<td><strong>Total Competency Section Score (5-35)</strong></td>
<td></td>
</tr>
</tbody>
</table>

2. Individual and Cultural Diversity
Trainees must develop and demonstrate the ability to conduct all professional activities with sensitivity to issues of individual diversity as appropriate to the setting, population served, and focus/specialty area.

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
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</thead>
<tbody>
<tr>
<td>Committed to providing clinical services that are sensitive to cultural and other individual differences.</td>
<td></td>
</tr>
<tr>
<td>Possesses an understanding of how their own personal/cultural history, attitudes, and biases may affect how they understand and interact with others</td>
<td></td>
</tr>
<tr>
<td>Integrates awareness and knowledge (including current theoretical and empirical knowledge) of individual and cultural diversity across the full range of professional roles (e.g., assessment, intervention, research, communication)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Competency Section Score (3-21)</strong></td>
<td></td>
</tr>
</tbody>
</table>

3. Ethics and Legal Standards
Trainees act professionally and ethically. This includes behavior in accordance with the APA Code and relevant laws, regulations, rules, policies, standards and guidelines.

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discusses all applicable confidentiality issues openly with clients and others</td>
<td></td>
</tr>
<tr>
<td>Demonstrates the ability to think critically about ethical issues, recognizes ethical dilemmas as they arise, and applies ethical decision-making processes in order to resolve them, seeking consultation when necessary.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates good knowledge of and acts in accordance with the APA Ethical Principles of Psychologists and Code of Conduct in all professional endeavors (e.g., assessment, intervention, research, consultation, communication, teaching, supervision, etc.)</td>
<td></td>
</tr>
<tr>
<td>Knowledgeable of and acts in accordance with relevant laws, regulations, rules, and policies governing health service psychology at the organizational, local, state, regional, and federal levels</td>
<td></td>
</tr>
<tr>
<td>Appropriately manages boundaries in all professional contexts</td>
<td></td>
</tr>
<tr>
<td><strong>Total Competency Section Score (5-35)</strong></td>
<td></td>
</tr>
</tbody>
</table>
4. **Professional Values, Attitudes, and Behaviors**
Trainees demonstrate integrity, dependability, and responsibility. They also must demonstrate reflective practice and self-assessment of strengths, weaknesses, and continued efforts for improvement.

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Writes well-organized notes that accurately capture the clinical encounter, and document client’s mental status, risk assessment, goals and preferences, and psychoeducational interventions.</td>
<td></td>
</tr>
<tr>
<td>All client contacts and care tasks (including scheduled and unscheduled appointments, and phone contacts) are documented and meet agency/organization expectations for timeliness and content.</td>
<td></td>
</tr>
<tr>
<td>Seeks consultation/supervision and uses it productively by coming prepared to supervision meetings.</td>
<td></td>
</tr>
<tr>
<td>Conducts self in a professional manner. Is accountable, dependable, responsible, and shows initiative while managing workload effectively.</td>
<td></td>
</tr>
<tr>
<td>Acknowledges own competencies and limitations (i.e. has good self-appraisal skills) and recognizes how personal characteristics influence work performance.</td>
<td></td>
</tr>
<tr>
<td><strong>Total Competency Section Score (5-35)</strong></td>
<td></td>
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</tbody>
</table>

5. **Interprofessional Systems**
Trainees are aware of relevant issues and constructs when working with other disciplines and organizations. Possess an understanding of key interactions with other agencies, settings, disciplines, and professions.

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
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</thead>
<tbody>
<tr>
<td>Demonstrates a good understanding of larger organizational dynamics as well as system influences within programs and appreciating how such forces influence clinical care.</td>
<td></td>
</tr>
<tr>
<td>Collaborates effectively in interprofessional treatment planning</td>
<td></td>
</tr>
<tr>
<td>Collaborates respectfully and effectively with individuals of other disciplines, teams and programs</td>
<td></td>
</tr>
<tr>
<td><strong>Total Competency Section Score (3-21)</strong></td>
<td></td>
</tr>
</tbody>
</table>

6. **Communication and Interpersonal Skills**
Trainee demonstrates effective communication skills and the ability to form and maintain successful professional relationships

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistently achieves a good rapport with clients.</td>
<td></td>
</tr>
<tr>
<td>Achieves and maintains positive and professional working relationships with relevant stakeholders, treatment teams, peers and supervisors.</td>
<td></td>
</tr>
<tr>
<td>Writes and speaks in a clear and concise manner</td>
<td></td>
</tr>
<tr>
<td>Effectively communicates results or feedback (e.g., clients, family members, other professionals)</td>
<td></td>
</tr>
<tr>
<td>Effectively manages difficult interpersonal challenges and conflicts</td>
<td></td>
</tr>
<tr>
<td><strong>Total Competency Section Score (5-35)</strong></td>
<td></td>
</tr>
</tbody>
</table>

6. **Assessment** *Please do not leave this section blank. Please request feedback from assessment supervisors (Screening Clinic or Interprofessional Case Assessment Rotation).*

Names of assessment supervisors who assisted in completing this section
Trainees must demonstrate competence in evidence-based psychological assessment with a variety of diagnoses, problems, and needs

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomously selects appropriate tests to answer referral question.</td>
<td></td>
</tr>
<tr>
<td>Promptly and proficiently conducts interviews, assessments, and evaluations.</td>
<td></td>
</tr>
<tr>
<td>Appropriately administers, scores, and interprets test instruments</td>
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</tr>
<tr>
<td>Writes a well-organized psychological report, incorporating information from the medical record, answering the referral question clearly, and providing referral source with specific recommendations for care.</td>
<td></td>
</tr>
<tr>
<td>Plans and carries out a feedback interview. Explains the test results in terms the client and/or caregiver can understand, provides suitable recommendations and responds to issues raised by client, team, or caregiver.</td>
<td></td>
</tr>
<tr>
<td>Performs risk assessments consistent with standards of practice</td>
<td></td>
</tr>
<tr>
<td><strong>Total Competency Section Score (6-42)</strong></td>
<td></td>
</tr>
</tbody>
</table>

7. Intervention
Trainees demonstrate competence in case conceptualization, evidence-based interventions for various of diagnoses, problems, and needs across a range of therapeutic orientations, techniques, and approaches.

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
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</thead>
<tbody>
<tr>
<td>Formulates a well thought out case conceptualization that draws on theoretical and research knowledge.</td>
<td></td>
</tr>
<tr>
<td>Collaborates with client to form appropriate treatment and rehabilitation goals that addresses client needs and preferences.</td>
<td></td>
</tr>
<tr>
<td>Conducts interventions that are well timed, effective, and consistent with sound clinical practice and evidence-based practices.</td>
<td></td>
</tr>
<tr>
<td>Monitors the effectiveness of interventions and impact on outcomes.</td>
<td></td>
</tr>
<tr>
<td>Effectively evaluates, manages, and documents risk by assessing concerns such as suicidality, homicidality, and safety issues. Collaborates with clients and providers to develop short-term safety plans, intensifying treatment as needed.</td>
<td></td>
</tr>
<tr>
<td>Explains the limits of confidentiality in the context of group therapy.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates ability provide evidence-based, clinically sound group interventions</td>
<td></td>
</tr>
<tr>
<td>Arrives prepared with material and content to discuss in group and facilitates or co-facilitates group.</td>
<td></td>
</tr>
<tr>
<td>Intervenes in group skillfully, and attends to member participation and needs</td>
<td></td>
</tr>
<tr>
<td>Manages group dynamics well, and facilitates respectful communication</td>
<td></td>
</tr>
<tr>
<td>Effectively evaluates, manages and documents client risk by assessing immediate safety concerns that arise in group context.</td>
<td></td>
</tr>
<tr>
<td><strong>Total Competency Section Score (11-77)</strong></td>
<td></td>
</tr>
</tbody>
</table>

8. Consultation
Consultation and interprofessional skills are reflected in the intentional collaboration with other individuals or groups to address a problem, seek or share knowledge, or promote effectiveness in
professional activities with individuals and their families, other professionals, groups, or systems related to health and behavior.

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhibits a comfort and proficiency in providing effective consultation and feedback to clinical programs and interprofessional staff.</td>
<td></td>
</tr>
<tr>
<td>Communicates well with referral sources or relevant providers</td>
<td></td>
</tr>
<tr>
<td>Is able to perform case consultation/conceptualization in interprofessional contexts, with appreciation and integration of contributions of other professions</td>
<td></td>
</tr>
<tr>
<td>Demonstrates an ability to provide program or systems level consultation using their own understanding of their own professional role and expertise</td>
<td></td>
</tr>
</tbody>
</table>

**Total Competency Section Score (4-28)**

9. **Teaching and Supervision**

Competence in supervision and teaching is reflected in effective communication of psychological principles, procedures, and/or data. Supervisor ratings are based on direct observation, case discussions, case presentations, feedback from peers or junior trainees, and rating is of trainee’s broad abilities as a supervisor.

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates the ability to give presentations in a formal setting.</td>
<td></td>
</tr>
<tr>
<td>Mentors small groups or individuals to teach skills, communicate knowledge and provide feedback to clients, families, and other professionals</td>
<td></td>
</tr>
<tr>
<td>Demonstrates knowledge of supervision theory/strategies</td>
<td></td>
</tr>
<tr>
<td>Builds good rapport with supervisee/audience/peers and establishes a safe learning environment</td>
<td></td>
</tr>
<tr>
<td>Establishes clear goals, objectives, and agendas for supervision, teaching activities, or presentations</td>
<td></td>
</tr>
</tbody>
</table>

**Total Competency Section Score (5-35)**

10. **Advocacy**

Trainees engage in systemic advocacy to impact policy/procedure to benefit individuals at an institutional or community level. Trainees advocate for and empower individual recipients of the services provided.

<table>
<thead>
<tr>
<th>Self</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notices and champions for the change of situations in the community that discriminate against individuals or groups</td>
<td></td>
</tr>
<tr>
<td>Teaches, supports, and encourages self-advocacy, including connecting individuals to legal and advocacy resources as needed or requested</td>
<td></td>
</tr>
<tr>
<td>Combats stigma, oppression, discrimination, and prejudice in all forms</td>
<td></td>
</tr>
<tr>
<td>Advocates for improved access, inclusion and integration with public services and resources and integration to facilitate an individual’s recovery, improved quality of life, and full community integration</td>
<td></td>
</tr>
<tr>
<td>Advocates for system changes to make services responsive to the needs of individuals receiving services.</td>
<td></td>
</tr>
</tbody>
</table>

**Total Competency Section Score (5-35)**

11. **Psychosocial Rehabilitation and Recovery-Oriented Services**

Trainees must demonstrate competence in therapeutic approaches that encourage individuals with SMI to develop their fullest capacities through learning and environmental supports. Trainees must demonstrate an understanding of recovery-oriented services, and how to provide recovery-oriented, person-centered treatment.
Collaboratively assesses preferences, strengths, and needs, and promotes individual choice to help clients achieve goals, participate in treatment, or deal with crises.  

Develops linkages to natural supports in the community, and facilitates practical and meaningful activities for individuals to live, learn, work and socialize in the environments of their choice.  

Collaborates with individuals to develop effective rehabilitation plans using goals with specific, measurable, time-framed action steps.  

Instills hope via verbal and non-verbal communication regarding a client’s potential for recovery. Identifies, assesses, and plans opportunities that empower clients to transition from professional services to natural community supports.  

Facilitates and encourages skill building, self-discovery, and learning across all life domains to assist individuals in achieving their goals and develop strategies for relapse prevention for mental and physical health.  

Assists individuals in modifying their living, learning, working, and social environments to enhance recovery.  

**Total Competency Section Score (6-42)**

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**SUPERVISOR COMMENTS:**

Summary of Strengths:

Areas of additional development or remediation, including goals for next rotation:

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**OVERALL ASSESSMENT**

- Trainee has made sufficient progress toward completion of training goals specific to this rotation.
- Trainee has not made sufficient progress this rotation, as skills have not been rated at an appropriate level of competence. Will speak with DOT and/or invoke Due Process.

**Hours of weekly supervision scheduled with this supervisor:** Individual:_____ Group:_____  

Supervisor Signature____________________________   Date ___________  

Trainee Signature_______________________________   Date ___________  

**Trainee Comments** *(optional, use additional sheet if necessary)*

Acknowledgement. This document is based on examples provided by Training Directors, as well as language from APA’s Standards of Accreditation for Health Service Psychology, the American Board of Professional Psychology’s Clinic Psychology Competencies, and Psychiatric Rehabilitation Association’s Certification for Psychiatric Rehabilitation.
Sample Professional Identity and Confidence Evaluation for Post-Doctoral Psychology Residents in SMI/SED Specialty

Resident: ________________________ Date:_________________

The following questions ask you to rate your current level of comfort on a variety of issues related to professional self-confidence and identity. Each question will ask you to rate yourself twice: first with regard to your identity as a health care provider working from a Psychosocial Rehabilitation (PSR) – Recovery oriented practice model, and then with regard to your identity as a Professional Psychologist.

1. I am confident that my clinical and research skills are sufficient to allow me to perform effectively.
   a. As a Psychosocial Rehabilitation - Recovery oriented provider
      
      1   2   3   4   5
      not at all somewhat moderately very well extremely well
   b. As a Professional Psychologist
      
      1   2   3   4   5
      not at all somewhat moderately very well extremely well
   Comments:

2. I am confident that I can work collaboratively with health care professionals from other disciplines and participate effectively on interprofessional health care teams.
   a. As a Psychosocial Rehabilitation - Recovery oriented provider
      
      1   2   3   4   5
      not at all somewhat moderately very well extremely well
   b. As a Professional Psychologist
      
      1   2   3   4   5
      not at all somewhat moderately very well extremely well
   Comments:

3. I am confident in my ability to provide training to others in my discipline and to interprofessional staff.
   a. As a Psychosocial Rehabilitation - Recovery oriented provider
      
      1   2   3   4   5
      not at all somewhat moderately very well extremely well
b. As a Professional Psychologist

1  2  3  4  5
not at all somewhat moderately very well extremely well

Comments:

4. I am confident that I can stay informed about advances in my profession and in PSR through reading literature and attendance at professional conferences and other educational offerings.

a. As a Psychosocial Rehabilitation - Recovery oriented provider

1  2  3  4  5
not at all somewhat moderately very well extremely well

b. As a Professional Psychologist

1  2  3  4  5
not at all somewhat moderately very well extremely well

Comments:

5. I am confident that I can join and actively participate in professional organizations.

a. As a Psychosocial Rehabilitation - Recovery oriented provider

1  2  3  4  5
not at all somewhat moderately very well extremely well

b. As a Professional Psychologist

1  2  3  4  5
not at all somewhat moderately very well extremely well

Comments:

6. I am confident that I have the background and knowledge to prepare effectively for relevant specialty examinations.

a. As a Psychosocial Rehabilitation - Recovery oriented provider (i.e., ABPP, USPRA CPRP certification)

1  2  3  4  5
not at all somewhat moderately very well extremely well

b. As a Professional Psychologist (i.e., progressing toward licensure examination)

1  2  3  4  5
not at all somewhat moderately very well extremely well

Comments:
7. I am confident in my ability to provide culturally sensitive services.

a. As a Psychosocial Rehabilitation - Recovery oriented provider

1 not at all 2 somewhat 3 moderately 4 very well 5 extremely well

b. As a Professional Psychologist

1 not at all 2 somewhat 3 moderately 4 very well 5 extremely well

Comments:

As residents increase their confidence and levels of responsibility, they receive more complex cases, more independent clinical work, the ability to pursue own training goals, and take on additional cases if desired. This is all determined in a collaborative nature between the resident, supervisors, and the Director of Training.
Criterion VII. Continuing Professional Development and Continuing Education

A specialty provides its practitioners a broad range of regularly scheduled opportunities for continuing professional development in the specialty practice and assesses the acquisition of knowledge and skills.

**Commentary:** With rapidly developing knowledge and professional applications in psychology, it is increasingly difficult for professionals to deliver high quality services unless they update themselves regularly throughout their professional lives through continuing education mechanisms. A variety of mechanisms may be used to achieve these goals.

1. Describe the opportunities for continuing professional development and education in the specialty practice. Provide detailed examples, such as CE offerings that are available.

For more than 13 consecutive years (beginning in 2004), the APA Task Force on SMI/SED has presented symposia at the APA convention that have been offered for CE credit. These symposia have been very well attended, garnering between 100 and 200 attendees each year. Over the past several years, the APA Task Force also sponsored four full day CE workshops; these were also highly rated, receiving ratings above 4.5 each time the workshops were presented. Beginning in 2012, the SMI/SED Section of Division 18 also began sponsoring symposia; more recently, other divisions have followed suit and as a result, the number of convention offerings on SMI/SED topics has increased considerably. Feedback has consistently indicated that training is needed to help psychologists work more competently with persons with SMI/SED and these symposia and workshops have sought to meet this need.

In 2010, APA received funding from SAMHSA to develop a curriculum to train psychologists for work with individuals with SMI/SED. The curriculum was completed and published in 2014 (American Psychological Association & Jansen, 2014). Since publication of the curriculum, the leaders of the Specialty Council (the APA Task Force, Division 18, and the Division 18 Section on SMI/SED) have been instrumental in promoting its use both at the APA convention and at meetings of the various psychology training councils. The leadership members have also given presentations at non-APA meetings, sparking interest in the curriculum among other professional groups as well. Most recently, material from the APA curriculum was presented (and very well received) in a year-long series of webinars for mental health professionals from a wide range of disciplines who work in behavioral health settings across the US. Some of the many presentations that have been given have been offered for CE credit, both for psychologists and for providers in other disciplines. Work is underway for additional presentations at various regional and national psychology meetings and conferences – these would be offered for CE credit as well.

Most recently, the APA Office of Continuing Education partnered with the Office of the APA Task Force on SMI/SED to develop a webinar series on assessment and treatment for persons with SMI/SED. The webinar series is based on the content of the APA curriculum. The webinar was produced and made available on the APA CE website in 2016, and consists of a 4 part series. Each part is one hour in length and each may be taken individually or the full series may be taken. The webinars are available for a nominal fee; the series is available on the APA CE on-line portal and has been highlighted on the CE website. The series may be found under the topical headings of Clinical Psychology or Professional Resources for Practice.

The titles of these are listed below. It is hoped that this series will continue to be available for several years to come so that psychologists could benefit from it. As new findings emerge, updates to the series can also be incorporated. From the APA CE webpage (http://www.apa.org/education/ce/):

- SMI/SED Series — New Approaches: Assessment, Engagement and Ethical Considerations (Module 1); Video On-Demand | 1 credit
2. Describe the formal requirements, if any, for continuing professional development and education to maintain competence in the specialty.

Presently there are no formal requirements for continuing professional development and education to maintain competence in the specialty. These are being developed by the Council and once the specialty receives recognition by the APA CRSPPP, these will be finalized and promulgated. A petition will also be completed for the ABPP Board and requirements for continuing professional development will be incorporated into that petition.

3. Describe the minimum expectations, if any, for continuing professional development and education to maintain competence in the specialty.

Although there are no formal requirements at this time, until these are finalized, the Specialty Council expects that anyone claiming competence for work with individuals with SMI/SED will remain abreast of professional developments by completing APA approved CE courses in the area, remaining current with the research literature, remaining current with the Council website, and the APA TF and Division 18 Section on SMI/SED listservs where new developments are posted. As ABPP certification is developed, these and other requirements will be formalized and implemented, especially with regard to the ABPP Maintenance of Certification requirements that have been recently initiated.

Reference

Criterion IX. Effectiveness

Petitions demonstrate the effectiveness of the services provided by its specialist practitioners with research evidence that is consistent with the APA 2005 Policy on Evidence-based Practice.

**Commentary:** A body of evidence is be presented that demonstrates the effectiveness of the specialty in serving specific populations, addressing certain types of psychological, biological and social behaviors, or in the types of settings where the specialty is practiced.

**PLEASE NOTE:** If the same article illustrates more than one of these items, it may be referenced under each applicable category. Evidence should include the most current available published references in each area (e.g., books, chapters, articles in refereed journals, etc.) While reliance on some on classic references is acceptable, the majority of references provided should be from last five years.

1. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of clients or populations (including groups with a diverse range of characteristics and human endeavors) usually served by this specialty. Summarize and discuss the relevance of the findings of the studies, specify populations, interventions, and outcomes in relation to the specialty practice.


Epidemiological studies find that SMI/SED afflicts individuals of every ethnic and socioeconomic group throughout the world, although some specific stressors (such as immigration, poverty, and adversity in childhood) seem to increase the risk of the disorders (Tandon, Keshavan, & Nasrallah, 2008; Okkels, Trabjerg, Arendt, & Pedersen, 2017; Isvoranu, van Borkulo, Boyette, Wigman, Vinkers, Borsboom, & Group Investigators, 2017). Studies on psychological treatments evaluated in different SMI/SED ethnic and national groups were quite prevalent in earlier decades, but much of the intervention research in the past five years has focused on ascertaining whether interventions tailored to specific phases of these
illnesses through the lifespan are effective. Of particular interest is the ultimate research objective of determining whether early intervention improves the long-term trajectory of the course of SMI/SED. To this end, three phases of illness have attracted the recent interest of clinical researchers: 1) the prodromal or ultra high risk phase, 2) the initial full symptom onset phase, followed by 3) later phases reflective of more long-term course of the disorder. Exemplars of this research are presented below. These longitudinal research investigations generally involve a test of a comprehensive intervention, including both psychological and pharmacological components, compared to customary care; the psychological components typically involve cognitive-behavioral techniques, often augmented with illness education. The results usually demonstrate a benefit of the comprehensive intervention tailored to the phase of illness over customary care.

Ising, et al., (2016) enrolled 196 young people who were deemed at high risk for psychosis due to poor social functioning and either a family history of psychosis or the documentation of mild prodromal symptoms. Participants were randomized to either 6 months of cognitive behavior therapy for ultra-high risk (called CBTuhr) embedded in treatment-as-usual (TAU) or TAU only. Of the original 196 patients, 113 consented to a 4-year follow-up (57.7%; CBTuhr = 56 vs TAU = 57), and were regularly monitored with symptom and social functioning measures. Over the four year study period, psychosis incidence, remission from UHR status, and the effects of transition to psychosis were evaluated. The number of participants in the CBTuhr group transitioning to psychosis increased from 10 at 18-month follow-up to 12 at 4-year follow-up whereas it did not change in the TAU group (n = 22); this represents a clinically important (incidence rate ratio [IRR] = 12/22 = 0.55) and significant effect favoring CBTuhr. The odds ratio of CBTuhr compared to TAU was 0.44 (95% CI: 0.24–0.82) and the number needed to treat was 8. Moreover, significantly more patients remitted from their UHR status in the CBTuhr group (76.3%) compared with the TAU group (58.7%) \[t(120) = 2.08, P = .04\]. Overall, the CBTuhr group had significantly better outcomes; fewer developed psychosis and more remitted from their prodromal state. These findings support the efficacy of the tailored psychological treatment for individuals at high risk for the development of psychosis.

While efforts to reduce transition to full psychosis in ultra high risk populations are laudable, their impact will be limited unless they are embedded in a health surveillance system that can identify appropriate potential participants. There is now a concomitant international movement to provide intensive comprehensive specialty care (CSC) to young people (typically with ages from 15-35) experiencing a first episode of psychosis (FEP); that is, to individuals who have transitioned from an ultra high risk period to a frank expression of psychotic symptoms. These CSC programs focus primarily on individuals experiencing a non-affective psychosis, which is typically understood to be a likely precursor to the development of a disorder on the schizophrenia spectrum. CSC programs typically include illness education, family support, individual cognitive-behaviorally oriented psychotherapy, supported employment and education, and low-dose medication regimens. While programs tailored to the needs of individuals developing a first episode of psychosis have been available for decades in countries with a national health system (Penn, Waldheter, Perkins, Mueser, & Lieberman, 2005), the US has only recently begun to offer CSC programs on a systematic level. Several papers evaluating CSC programs in the US, have recently been published, two of which we describe here.

The first is a single site study, (Srihari, et al, 2015), comparing a CSC program called Specialized Treatment Early in Psychosis (STEP) to customary care. STEP includes comprehensive clinical evaluation and regular outcome assessment, medication management, and individual and group therapy. Treatment targets include school and/or work goals, problem-solving and communication skills, stress management, health and wellness, symptom reduction and personal goals. Symptom status, social functioning, and hospitalization data were collected every six months on 117 randomized participants through the one year follow-up. STEP care resulted in significantly fewer total hospitalizations (20 STEP versus 39 with usual treatment) and a significantly lower likelihood of hospitalization (14 of 60 STEP [23%] patients versus 25 of 57 [44%] of those in usual treatment). These data translate to a number needed to treat (NNT) of five. STEP participants were also more likely to be engaged in productive vocational activity and remain engaged in mental health treatment than those in usual treatment.
In a second CSC publication, Kane et al. (2015) reported on a 34 site cluster randomized controlled trial comparing CSC to customary care throughout the US. Four hundred four individuals were randomized to a minimum of two years of CSC or to customary care. The CSC involved tailored medication, family education and support, individual illness resiliency training, and supported employment and education. Outcome data were collected every 6 months on symptom status, employment/educational status, quality of life, retention in treatment, and rate of hospitalization. The 223 recipients of NAVIGATE remained in treatment longer, experienced greater improvement in quality of life and overall psychopathology (including depression and symptoms of schizophrenia), and participated more in work and school compared with 181 participants in community care; there were no differences in hospitalization rates, which were low for both groups.

These early intervention studies indicate that, at least for the relatively short-term, participation in CSC programs, incorporating illness education, family support, individual cognitive-behaviorally oriented psychotherapy, supported employment and education, and low-dose medication, can significantly improve outcomes. However, there remain a substantial number of individuals diagnosed with SMI/SED who did not have access to such programs when they first became ill and/or still experience symptoms of the disorder years after entering treatment. Recent research has also focused on helping these middle-aged and older individuals improve the quality of their lives. While reducing psychotic symptoms can certainly be a treatment goal in this group of consumers, many consumers have created a life that accommodates the occurrence of these symptoms, which are often not eliminated by medication. For these individuals, improving quality of life - often through improved community functioning or physical health - frequently becomes the primary therapeutic goal. We describe two representative articles from this line of research below.

In the first study, Granholm and colleagues (Granholm, Holden, Link, McQuaid, & Jeste, 2013) compared the benefits of participation in Cognitive Behavioral Social Skills Training (CBSST) to goal-focused supportive contact (GFSC) in improving functioning in 79 older consumers (over age 45) diagnosed with schizophrenia. CBSST was a 36-session, weekly group therapy that combined cognitive behavior therapy with social skills training and problem-solving training to improve functioning. GFSC was supportive group therapy focused on achieving functioning goals. Active treatment was offered for nine months. This was a randomized trial of community outpatients and the primary outcomes were functioning (primary outcome: Independent Living Skills Survey; Wallace, Liberman, Tauber, & Wallace, 2000), CBSST skill mastery, schizophrenia symptoms, depression, anxiety, defeatist attitudes, self-esteem, and life satisfaction. Through the 18 month follow-up, functioning trajectories were significantly more positive in CBSST than in GFSC, especially for participants with more severe defeatist performance attitudes. Greater improvement in defeatist attitudes was also associated with better functioning in CBSST, but not GFSC. Both treatments showed comparable significant improvements on amotivation, depression, anxiety, positive self-esteem, and life satisfaction. These results indicate that both psychological interventions had broad effects, but the specific training on social skills, cognitive-behavioral therapy and problems solving had a unique impact on improving functioning, and that this benefit may have been mediated by decreasing defeatist attitudes.

The second trial focused on improving community functioning and physical health in individuals over the age of 50 diagnosed with an SMI (Bartels, et al., 2014). This report describes 1-, 2-, and 3-year outcomes of a combined manualized psychosocial skills training and preventive healthcare intervention (Helping Older People Experience Success [HOPES]) for older persons with SMI. A randomized controlled trial compared HOPES with treatment as usual (TAU) for 183 older adults (mean age: 60.2) diagnosed with SMI. HOPES included 12 months of weekly skills training classes, twice-monthly community practice trips, and monthly nurse preventive healthcare visits, followed by a 1-year maintenance phase of monthly sessions. Blinded evaluations of functioning, symptoms, and service use were conducted at baseline and at 1-year (end of the intensive phase), 2-year (end of the maintenance phase), and 3-year (12 months after the intervention) follow-up. Participation in HOPES, as compared to TAU, was associated with improved community living skills and functioning, greater self-efficacy, lower overall psychiatric and
negative symptoms, greater acquisition of preventive healthcare (more frequent eye exams, visual acuity, hearing tests, mammograms, and Pap smears), and nearly twice the rate of completed advance directives. No differences were found for medical severity, number of medical conditions, subjective health status, or acute service use at the 3-year follow-up.

We summarize the results of these five recent trials as follows: Psychologists working with the SMI/SED population can effectively treat a broad range of consumers, from adolescents through seniors. Effective psychological interventions tend to be intensive and cognitive-behavioral and/or skills based, and outcome domains are typically broader than simple symptom improvement. Most participants are provided concurrent antipsychotic medication. Because SMI/SED diagnoses are associated with declines in functioning as well as the experience of symptoms, clinical researchers have designed interventions with the dual goals of improving community adaptation while addressing psychopathology.

2. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty’s services for dealing with the types of psychological, biological, and/or social problems usually confronted and addressed by this specialty. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results.


As mentioned in our response to Criterion VI, many individuals diagnosed with SMI/SED encounter significant life challenges. Our society is fearful and rejecting of individuals with thought disorders and unusual behavior, which can then result in the individuals diagnosed with these disorders experiencing psychological problems such as shame and self-stigma. Depression and negative symptoms from schizophrenia often result in difficulties attending to personal health; many psychiatric medications have their own iatrogenic effects on weight and metabolism as well. Coupled with the increased smoking and illicit drug use rates found in this population, it perhaps comes as no surprise that the life spans of individuals diagnosed with SMI are, on average, 20-25 years shorter than their counterparts without diagnosed SMI (Walker, McGee, & Druss, 2015). These differences are largely attributable to cardiovascular disease. Attention to health promotion is a key task for psychologists working with this group of clients. Finally, developmental lags caused by symptom progression in adolescence and early adulthood often impede educational and employment achievement in this population, leading to poverty.
and often homelessness. Thus, optimal strategies to address unemployment and homelessness, in the SMI/SED population merit attention. Psychological interventions to address the psychological, biological, and societal challenges associated with a diagnosis of SMI/SED are presented next in turn.

With regard to psychological problems experienced by the SMI/SED population, internalized or self-stigma is a significant one attracting increasing interest. (Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2015). The term refers to the process by which negative stereotypes about mental illness are accepted and incorporated into the identity of people who have been diagnosed with these disorders (Ritsher, Ottingam, & Grajales, 2003; Corrigan, Watson, & Barr, 2006). Self-stigma is considered pervasive in the SMI/SED population, and likely interferes with efforts to achieve desired goals such as employment or finding a life-partner. Lucksted et al., (in press) developed and tested the Ending Self Stigma (ESS) cognitive-behavioral and psychoeducational intervention in a community-based randomized controlled trial including 268 adults. Participants were randomly assigned to the nine-week ESS intervention or a minimally enhanced treatment-as-usual (TAU) control condition. Participants were assessed by using symptom, psychosocial functioning, and self-stigma measures at baseline, end of treatment, and six month follow-up. Compared with participants in the control condition, ESS group participants showed significant decreases on the stereotype agreement and self-concurrence subscales of the Self Stigma of Mental Illness Scale, significant improvement on the alienation and stigma resistance subscales of the Internalized Stigma Mental Illness measure, and a significant increase in recovery orientation from baseline to post-intervention as measured on the Maryland Assessment of Recovery in People With Serious Mental Illness (MARS). Unfortunately, these differential benefits were not sustained at follow-up, suggesting the need for a longer or more intensive intervention.

With regard to biological problems experienced by the SMI/SED population, McGinty, Baller, Azrin, Juliano-Bult, and Daumit (2016) published a recent comprehensive review examining the strength of the evidence supporting interventions to address major medical conditions and health-risk behaviors among persons with SMI/SED, and thus lengthen their shorted life span. The review was based on the recommendations of a National Institute of Mental Health stakeholder meeting. Peer-reviewed studies were identified using four research databases. Randomized controlled trials and observational studies testing interventions to address medical conditions and risk behaviors among persons with schizophrenia and bipolar disorder published between January 2000 and June 2014 were included. The quality of the evidence (high, medium, low) and the effectiveness of various interventions were synthesized. One hundred and eight studies were included. The majority of studies examined interventions to address overweight/obesity (n = 80), though topics such as diabetes, hyperlipidemia, smoking, cardiovascular disease, hypertension, physical activity, and HIV/AIDs were also included. Both pharmacological and psychological interventions were assessed; the psychological intervention with the strongest evidence base was behavioral interventions for weight loss. Eighteen RCTs and 10 observational studies examined the effects of behavioral weight loss interventions on body mass index (BMI), and 22 RCTs and 15 observational studies examined the effects of behavioral interventions on weight. For BMI, the overall strength of the evidence surrounding behavioral interventions was medium, with the best available studies showing mixed effects. However, for weight, the overall strength of the evidence surrounding behavioral interventions was high, with the best available evidence showing a consistently beneficial effect. The strength of the evidence was low for most other psychological interventions reviewed, suggesting that psychological interventions can play a role in health promotion in SMI/SED, but more work needs to be done.

SMI/SED populations encounter many social challenges, and psychological interventions can play a significant role in overcoming them. For example, un- and underemployment are very common in this population. However, supported employment, and particularly a manualized version known as Individual Placement and Support (IPS), has a strong evidence-base in SMI/SED, typically increasing competitive work rates two or three fold in comparison to treatment as usual in randomized trials (Drake & Bond 2011). Key principles of supported employment include (1) a focus on competitive employment, (2) eligibility based on consumer choice, (3) rapid job search, (4) integration of mental health and employment services, (5) attention to consumer preference in the job search, (6) time unlimited individualized job supports (7)
personalized benefits counseling, and (8) systematic job development. A recent review article by Modini, et al., (2016) examined IPS results in SMI/SED populations internationally. A systematic review and meta-analysis of randomized controlled trials compared IPS (conducted with high fidelity to the model) to traditional vocational services; 17 studies (both US and non-US), as well as 2 follow-up studies, published since 1993 were included. Meta-regressions were carried out to examine whether IPS effectiveness varied according to geographic location, unemployment rates or gross domestic product (GDP) growth. The investigators determined overall pooled risk ratio for competitive employment using IPS compared with traditional vocational rehabilitation was 2.40 (95% CI 1.99–2.90). Meta-regressions indicated that neither geographic area nor unemployment rates affected the overall effectiveness of IPS. These results confirm the utility of a psychosocial intervention such as IPS in reducing unemployment in individuals diagnosed with an SMI/SED.

As we have indicated in other sections of this petition, poverty and homelessness are common in individuals with SMI/SED, and thus programs to provide a stable residence are important for this population. Housing First (HF) integrates housing and support services in a client-centered model and has been shown to reduce acute health care among homeless populations. In contrast to other forms of supported housing, HF programs typically set a low bar for initial access to housing (few eligibility requirements besides need, typically based on low income and a mental health diagnosis), and then provide extensive supports to socialize previously homeless individuals into behaviors and attitudes necessary to retain the housing or to transition to independent housing. Somers, et al., (2017) recruited two samples of homeless mentally ill participants who differed in the complexity of their needs. Eligibility was based on homeless status and current mental disorder. Participants were classified as either moderate needs (MN) or high needs (HN). Those with HN were randomized to scattered housing with Assertive Community Treatment (SHF), congregate housing with support (CHF), or usual care. Participants were interviewed every 3 months for 2 years. Participants met eligibility for either MN (n = 200) or HN (n = 297) and were randomized accordingly. Both samples were primarily male and white. Compared to participants designated MN, HN participants had higher rates of hospitalization for psychiatric reasons prior to randomization, were younger at the time of recruitment, younger when first homeless, more likely to meet criteria for substance dependence, and less likely to have completed high school. Ninety percent of the HN sample had a "severe" psychiatric diagnosis. Across all study arms, between 92% and 100% of participants were followed over 24 months post-randomization. Of the 297 HN participants, most of whom who had an SMI diagnosis, 107 were randomly assigned to CHF, 90 to SHF (90), and 100 to TAU. The percentage of time in stable housing over 24 months was 26.3% in TAU (reference; 95% confidence interval (CI) = 20.5, 32.0), compared to 74.3% in CHF (95% CI = 69.3, 79.3, p<0.001) and 74.5% in SHF (95% CI = 69.2, 79.7, p<0.001). Secondary outcomes favored CHF but not SHF compared to TAU. These results suggest that HF initiatives can dramatically increase residence stability in at-risk populations.

In a subsequent analysis of the HN data from the Somers, et al. trial (2017), Russolillo, Patterson, McCandless, Moniruzzaman, and Somers (2014) investigated the use of crisis services in the participants. Their analysis was based on HN participants enrolled in the Vancouver At Home Study (n=297) randomized to one of the three intervention arms—congregate housing with support (CF), scattered housing with support (SHF), or ‘treatment as usual’ (TAU) where individuals continue to use existing services available to homeless adults with mental illness. The investigators incorporated linked data from a regional database representing six urban emergency departments. Compared to TAU, significantly lower numbers of emergency visits were observed during the post-randomization period in the SHF group (adjusted rate ratio 0.55 [0.35,0.86]). CHF was associated with marginally lower ED utilization, in comparison to TAU, but was not statistically significant (adjusted RR 0.76 [0.49, 1.17]). The results suggest that HF, particularly the SS model, produced significantly lower hospital emergency department visits among homeless adults with a mental disorder. These findings demonstrate the potential effectiveness of HF to reduce acute health care use among homeless individuals.
Across the psychological, biological, and social domains, these studies indicate that interventions informed by psychological knowledge, and often co-developed by psychologists can have a profoundly positive impact on individuals diagnosed with SMI/SED.

3. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's procedures and techniques when compared with services rendered by other specialties or practice modalities. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results and the comparisons to other specialties or modalities.


Research on psychological interventions in SMI/SED is maturing, and as such there are an increasing number of randomized controlled trials available to inform optimal treatment planning. While early trials often used designs contrasting the benefits of medication to psychotherapy (e.g., the landmark series of studies overseen by Dr. Philip May at Camarillo (CA) State Hospital on schizophrenia in the 1960s), there is now a consensus that most clients diagnosed with SMI/SED benefit from concurrent medication and psychological interventions. Thus, the newer SMI/SED trials typically compare an active psychological intervention to either treatment as usual (TAU), which typically encompasses at least medication and case management and may also include some form of counselling, or an attention placebo.

Turner, van der Gaag, Karyotaki, and Cuijpers (2014) published a recent meta-analysis on psychological interventions with psychosis, with an emphasis on outcomes of randomized trials; they identified the following comparator interventions: befriending, cognitive behavioral therapy for psychosis, cognitive remediation, psychoeducation, social skills training, and supportive therapy. Typical outcomes in these studies assess multiple domains, including symptoms (using measures such as the Brief Psychiatric Rating Scale (BPRS) (Lukoff, Nuechterlein, & Ventura, 1986) and Positive and Negative Syndrome Scale (PANSS) (Kay, Opler, & Fiszbein, 1987), objective or subjective quality of life measures (such as the Lehman Quality of Life Scale, (Lehman, Kernan, & Postrado, 1995) or the Heinrich Quality of Life Scale, (Heinrichs, Hanlon, & Carpenter, 1984), and community functioning measured on scales such as the Social Adjustment Scale (SAS) (Schooler, Hogarty, & Weissman, 1979), the Social Functioning Scale
 Prototypic published trials in this area include: Bonnin, et al. (2016) reported on a multicenter, randomized controlled trial comparing outcomes for three adult bipolar patient groups: functional remediation, psychoeducation and treatment as usual (TAU) over 1-year follow-up. The functional remediation program consisted of 21 weekly sessions, each lasting 90 minutes, which addressed neurocognitive issues such as attention, memory and executive functions, but also focused on enhancing functioning in daily routine. The psychoeducation also consisted of 21 weekly sessions of 90 minutes each, aimed at preventing recurrences of bipolar illness by improving four main issues: illness awareness, treatment adherence, early detection of prodromal symptoms of relapse and lifestyle regularity. The primary outcome was change in psychosocial functioning measured by means of the Functioning Assessment Short Test (FAST) (Rosa, et al., 2007). In the TAU group, participants received prescribed pharmacological treatment without any psychosocial therapy. The one year results established a statistically significant group by time interaction for overall psychosocial functioning, favoring patients in the functional remediation group. The investigators concluded that improvements in psychosocial functioning found at 6 months were maintained at 1-year follow-up in patients with bipolar disorder receiving functional remediation.

In another trial on bipolar illness, Goldstein, et al. (2015) conducted a pilot test of dialectical behavior therapy (DBT) in adolescents. Eligible patients were assigned to either DBT or psychosocial TAU. All patients also received medication management. DBT included 36 sessions (18 individual, 18 family skills training) over one year. TAU was an eclectic psychotherapy approach consisting of psychoeducational, supportive, and cognitive behavioral techniques. An independent evaluator, blind to treatment condition, assessed outcomes including affective symptoms, suicidal ideation and behavior, non-suicidal self-injurious behavior, and emotional dysregulation, every three months over 1 year. As compared with adolescents receiving TAU, adolescents receiving DBT demonstrated significantly less severe depressive symptoms during follow-up, and were nearly three times more likely to demonstrate improvement in suicidal ideation; there were no between-group differences in manic symptoms or emotional dysregulation. These results are promising and suggest DBT may be an appropriate treatment for bipolar illness, especially depression and suicidality, in adolescents.

We also present three trials of psychosocial treatments for psychosis that are relevant here. The RAISE trial described earlier (Kane, et al., 2015), which involved tailored treatment for first episode non-affective psychosis, entailed a 34 site cluster randomized controlled trial comparing comprehensive specialty care (CSC), including pharmacological management, family education, individual therapy, and supported employment and education, to customary care throughout the US. Four hundred four individuals were randomized to a minimum of two years of CSC or to customary care. Outcomes data were collected every 6 months on symptoms status, employment/educational status, quality of life, retention in treatment, and rate of hospitalization. The 223 recipients of NAVIGATE remained in treatment longer, experienced greater improvement in quality of life and overall psychopathology (including depression and symptoms of schizophrenia), and participated more in work and school compared with 181 participants in community care; there were no differences in hospitalization rates, which were low for both groups. These results support the benefits of comprehensive psychosocial and pharmacological care tailored to the needs of first episode psychosis, compared to customary care.

Birchwood, et al. (2014) reported on a test of a new intervention for command hallucinations. They evaluated a novel cognitive therapy to challenge the perceived power of voices to inflict harm on the voice hearer if commands were not followed, which should thus reduce the hearer’s motivation to comply. In a single blind randomized controlled trial, eligible participants who had experienced command hallucinations for at least six months leading to major episodes of harm to themselves or other people were assigned to nine months of cognitive therapy embedded in TAU versus just TAU. The primary outcome was harmful
compliance with the voices. At nine months there was no difference between the two groups, but by eighteen months, 39 (46%) of 85 participants in the TAU group still fully complied with the voices compared with 22 (28%) of 79 in the cognitive therapy for command hallucinations + TAU group (p=0.021). Interestingly, however, there was no group related effect on hallucinations overall.

Finally, Schaub, Mueser, von Werder, Engel, Möller, and Falkai (2016) reported on the long-term benefits of participation in a group-based coping-oriented program (COP) that combined the elements of illness management with cognitive behavioral-therapy for psychosis to an equally intensive supportive therapy (SUP) program during inpatient treatment following a symptom exacerbation. One hundred ninety-six inpatients with DSM-IV schizophrenia were randomized to COP or SUP, each lasting 12 sessions provided over 6–8 weeks. Outcome measures were collected in the hospital at baseline and post-assessment, and following discharge into the community one and two years later. Intent-to-treat analyses indicated that patients in COP learned significantly more information about psychosis, and had greater reductions in overall symptoms and depression/anxiety over the treatment and follow-up period than patients in SUP. Patients in both groups improved significantly in other symptoms and psychosocial functioning. There were no differences between the groups in hospitalization rates, which were low. The results were interpreted as indicating that participation in a skills based program, even when administered during a hospitalization stay, can provide lasting benefits.

Taken together, we offer these studies to demonstrate the efficacy of the specialized mental health interventions designed, administered, or overseen by psychologists in the treatment of SMI/SED compared to typical care. These benefits are found across a range of domains, including symptoms, community functioning, and quality of life.

4. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of settings or organizational arrangements where this specialty is practiced. Summarize and discuss the relevance of the findings of these studies in relation to the specialty practice.


One of the appealing attributes of the profession of health service psychology is its flexibility in settings and activities. Within the context of SMI/SED, psychologists make a contribution in inpatient
hospital settings, residential settings, and outpatient clinics, as direct care providers, treatment developers, and as managers/supervisors. Furthermore, psychologists have assumed a leadership role in enhancing dissemination of psychological techniques using e-health and mobile technologies, which may greatly expand the capacity of the field to support positive outcomes from SMI/SED research (Furth & Tourse, 2015). Recent developments and research in the role of psychology in these various settings and technologies are discussed here. As we will show, a reverberating theme in this work is bringing recovery-oriented values and practices to these settings and interventions.

With regard to the impact of psychology in more traditional treatment settings, Zuehlke, Kotecki, Kern, Sholty, and Hauser (2016) conducted a quality improvement project to determine whether recovery interventions would yield positive outcomes when delivered on an inpatient unit in a VA medical center. Novel recovery interventions on the unit included recovery-focused interdisciplinary team meetings, opportunities for stakeholder feedback, recovery staff education, increased group programming, peer support, and changes to treatment planning to include increased veteran engagement and responsibility. Participants included 352 patients and 27 staff. Outcomes were number of restraints/seclusions used, 30-day readmission rates, and staff satisfaction. The results showed an overall decrease in restraint/seclusion use by over 50% and an increase in staff satisfaction after the transition to the new program.

In their study of community residential settings, Malinovský, et al. (2013) note that several states and organizations are currently developing plans to transform their mental health systems in accordance with recovery-oriented care, although the data on the specific benefits of these efforts have been limited. The investigators conducted a longitudinal study to evaluate the effectiveness of a recovery-oriented transformation carried out in the housing component of a large, private, not-for-profit psychiatric rehabilitation organization serving individuals with SMI. The outcome variables selected to evaluate the impact of the transformation were grouped into the following categories: (a) objective indicators of recovery, (b) self-report indicators of recovery, (c) indicators of staff competency, and (d) processes that promote recovery. Six-hundred and 27 residents and 490 staff participated in the evaluation. The findings suggest that recovery-oriented services had a positive impact on rates of overnight hospitalization, residents’ ability to function in the community, some professional skills of employees, and working alliance between direct care providers and residents from pre to post transition.

VanMeerten, et al. (2013) examined the impact of implementation of several recovery-oriented outpatient psychosocial interventions on inpatient usage and cost savings in a large mid-western VA. They included veterans (over 75% having a schizophrenia spectrum or bipolar disorder) who had been receiving mental health treatment at the facility before and after a program of psychosocial interventions (CBSST, family education, supported employment, and illness management and recovery) were implemented. They compared veterans who participated in at least one of the psychosocial interventions with those who did not; the two groups did not differ in age, gender, GAF functioning scores, and rates of alcohol or substance abuse diagnoses, although there were somewhat higher rates of schizoaffective and bipolar disorders and a lower rate of schizophrenia in individuals who received the psychosocial interventions compared with those who did not. The investigators report that veterans who utilized at least one of the interventions during the six years between the baseline and second data collection period had less frequent and shorter hospitalizations in the interim, resulting in a greater reduction in overall treatment cost than those who did not utilize the interventions.

The first three studies we presented demonstrate the efficacy of psychology’s services for dealing with the types of settings or organizational arrangements where this specialty is practiced, while the remaining two broaden the discussion to implementation to new settings and organizational arrangements, focusing on advances in technology.

Ben-Zeev, et al. (2014) reported on the development of the FOCUS smartphone intervention, which was designed to provide automated real-time/real-place illness management support to individuals with schizophrenia. The system was specifically designed to be usable by people with psychotic disorders who may have cognitive impairment, psychotic symptoms, negative symptoms, and/or low reading levels.
FOCUS offers users both prescheduled and on-demand resources to facilitate symptom management, mood regulation, medication adherence, social functioning, and improved sleep. In a pilot quasi-experimental study, 33 individuals with schizophrenia or schizoaffective disorder used FOCUS over a one month period in their own environments. Completers (n=32) used the system on 86.5% of days they had the device, an average of 5.2 times a day. Approximately 62% of use of the FOCUS intervention was initiated by the participants, and 38% of use was in response to automated prompts. Baseline levels of cognitive functioning, negative symptoms, persecutory ideation, and reading level were not related to participants’ use of the intervention. Approximately 90% of participants rated the intervention as highly acceptable and usable. Paired samples t tests found significant reductions in psychotic symptoms, depression, and general psychopathology, after 1 month of FOCUS use. This study supports the feasibility, acceptability, and preliminary efficacy of the FOCUS intervention for schizophrenia.

While the Ben-Zeev et al. (2014) intervention discussed above addressed schizophrenia, Depp, et al. (2015) investigated the use of mobile technology in bipolar disorder. They argued that mobile technology may improve access to evidence-based interventions and may increase their efficacy. They evaluated the feasibility, acceptability and efficacy of an augmentative mobile ecological momentary intervention targeting self-management of mood symptoms using a randomized single-blind controlled trial with 82 consumers diagnosed with bipolar disorder. Participants completed a four-session psychoeducational intervention and were assigned to 10 weeks of either: 1) mobile device delivered interactive intervention linking patient-reported mood states with personalized self-management strategies, or 2) paper-and-pencil mood monitoring. Participants were assessed at baseline, 6 weeks (mid-point), 12 weeks (post-treatment), and 24 weeks (follow up) with clinician-rated depression and mania scales and self-reported functioning. Retention at 12 weeks was 93% and both conditions were associated with high satisfaction. Compared to the paper-and-pencil condition, participants in the augmented mobile intervention condition showed significantly greater reductions in depressive symptoms at 6 and 12 weeks (Cohen’s d for both were d=0.48). However, these effects were not maintained at 24-week follow up. Conditions did not differ significantly in the impact on manic symptoms or functional impairment. The results suggest that technology may impact on symptoms during a period of use, but these benefits are not sustained when access to the technology ceases.

Taken together, these five studies indicate that recovery-based transformations of psychological services in physical settings lead to desired improvements in the programs, and that mobile technologies are feasible with individuals diagnosed with SMI/SED, but that further work is needed to fully understand the benefits that can accrue from these interventions.
Criterion X. Quality Improvement

A specialty promotes ongoing investigations and procedures to develop further the quality and utility of its knowledge, skills, and services.

Commentary: The public interest requires that a specialty provides the best services possible to consumers. A specialty, therefore, continues to seek ways to improve the quality and usefulness of its practitioners’ services beyond its original determination of effectiveness. Such investigations may take many forms. Specialties promote and participate in the process of accreditation in order to enhance the quality of specialty education and training. Petitions describe how research and practice literatures are regularly reviewed for developments which are relevant to the specialty’s skills and services, and how this information is publicly disseminated.

1. Provide a description of the types of investigations that are designed to evaluate and increase the usefulness of the skills and services in this specialty. Estimate the number of researchers conducting these types of studies, the scope of their efforts, and how your organization and/or other organizations associated with the specialty will act to foster and communicate these developments to specialty providers. Provide evidence of current efforts in these areas including examples of needs assessed and change that resulted.

   Dozens of academic journals publish empirical and systematic review articles that inform the work of psychologists who treat persons with SMI and SED. There is a broad scope of psychological and behavioral interventions ranging from psychotherapies, such as cognitive behavioral therapy for psychosis, cognitive remediation approaches, as well as psychiatric rehabilitation practices which are often delivered by multidisciplinary teams of providers, including psychologists. Because the research is quite broad and multidisciplinary, this makes estimates of the number of researchers in the field difficult to calculate. A Google Scholar search conducted for articles on the psychological treatment for just schizophrenia alone (psychological treatments in schizophrenia) returned approximately 382,000 results; given the heterogeneity of diagnosis and age groups in SMI/SED, as well as the diversity of keywords that could be used to describe the continuum of interventions, we expect the number of publications on effective skills and services to be many times more than this. As another estimate, the *Psychiatric Rehabilitation Journal*, an interdisciplinary journal published by APA and edited by a member of this Specialty Council, with a focus on psychological interventions for individuals with SMI/SED, has published slightly over 50 research articles each year since 2014, representing a likely pool of several hundred researchers alone. Given that there are dozens of appropriate journals for such articles, the number of researchers in the field internationally is undoubtedly sufficient to support the increased growth and quality improvement necessary to justify a specialty in this area.

   Because the specialty has not yet been approved, we have not had the opportunity to assess the needs of members of the specialty and the resultant change.

2. Describe how the specialty seeks ways to improve the quality and usefulness of its practitioners’ services beyond its original determinations of effectiveness.

   The Specialty Council will communicate to members of the specialty the importance of life-long learning and quality improvement processes. Members of the Specialty Council have proven their commitment to ensuring that the quality and usefulness of practitioners’ services are continuously improving. For example, the applicants have a long history of providing relevant continuing education opportunities in the assessment and treatment of persons with SMI/SED. Continuing education symposia and workshops on the assessment and treatment of persons with SMI/SED are offered each year at the APA convention, coordinated by the member organizations of the Specialty Council. These symposia and workshops are presented by experts in the field and are designed to highlight the latest developments in
this area of specialization and offer attendees the opportunity to connect with the presenters. Additionally, the APA’s *Recovery to Practice Curriculum* was written by a member of the Specialty Council. The Recovery to Practice Curriculum is a comprehensive curriculum designed to supplement training of psychologists in the specialty area. Two members of the Specialty Council further developed the curriculum into a series of APA continuing education webinars. This demonstrates the commitment of the member organizations of the Specialty Council to the importance of continuous quality improvement and the education of psychologists in the core areas.

Another member of the Specialty Council has been involved in the widespread promotion of measurement based care, an evidence-based practice in which repeated standardized client-reported outcome measurement is used to guide shared decision making and treatment planning to ensure effectiveness of services for individuals receiving healthcare. Measurement based care is increasingly becoming the standard for the delivery of psychological interventions, as noted by the Kennedy Forum, and in the 2018 mandate by the Joint Commission to include measurement based care in behavioral health services, including some services delivered by psychologists that serve individuals with SMI/SED. Measurement based care ensures that practitioners are routinely evaluating the services they provide, and striving to improve the quality of services delivered on an ongoing basis. The Specialty Council will communicate practice trends such as these to members of the specialty in order to continuously improve the quality and usefulness of practitioners’ services.

When this post-doctoral specialty is approved, we will join the Council of Specialties and we will seek ABPP designation. ABPP certification requires that those seeking certification document the steps they have taken to remain up to date and abreast of the most current and effective practices in the area. As part of the process, a work sample is required. All information and materials provided are reviewed by a committee of experts in the specialization, ensuring that practitioners are knowledgeable, qualified and able to provide the most efficacious services possible. A recently initiated Maintenance of Certification program requires documentation of specialty-relevant experiences and CE to sustain one’s specialty credentialing; this will be incorporated into all efforts to ensure psychologists remain fully competent in the areas of this specialty.

As we will describe in more detail in question 3, the Research Committee and the Practice Committee of the Specialty Council also routinely review the literature for updates to the practice of the specialty and share this with the Marketing and Communications Committee for dissemination.

3. Describe how the research and practice literature are regularly reviewed for developments which are relevant to the specialty’s skills and services, and how this information is publicly disseminated. Give examples of recent changes in specialty practice and/or training based upon this literature review.

The structure of the Specialty Council has been created to support the review and dissemination of new and important advances in the treatment of persons with SMI/SED. The Research Committee of the Specialty Council is responsible for reviewing the scientific literature to identify current relevant developments, with a particular focus on the publication of relevant clinical practice guidelines, meta-analyses, and other major syntheses of the evidence on effective treatments, skills and services for the target population. The Practice Committee of the Specialty Council is similarly charged with reviewing the literature on the practice of psychology, and the literature impacting the training of psychologists providing services to individuals from the specialty’s target population. When a committee determines that there has been a significant development in the scientific and/or practice community that warrants communication to members of the specialty, this information will be sent to the Marketing and Communications Committee of the Specialty Council. The Marketing and Communications Committee of the Specialty Council is responsible for dissemination of this material, including but not limited to linking to or summarizing this information on the Council’s website. The Marketing and Communications Committee will also recommend other methods of communication with members of the specialty and training programs, such as but not limited to email groups (e.g., listservs), newsletters, and periodic conference calls.
Because the specialty has not yet been approved, there can be no examples of how practice or training has been changed by this specific process. However, there are many examples of how the skills and services in the treatment of persons with SMI/SED have been shaped by advances in practice. Two notable recent widespread changes influenced by the scientific literature include the expansion and uptake of integrated primary care and behavioral healthcare for individuals with SMI/SED, as well as the increased emphasis on comprehensive services for individuals experiencing first-episode psychosis. Members of the Specialty Council have been leaders in research and practice in these two areas, as well as implementation and dissemination of these practices as reflected by recent publications and national presentations at APA Conventions, the Psychiatric Rehabilitation Association National Workforce Summit, and national webinars through the SAMSHA Recovery to Practice initiative, and other educational sessions for practicing and training psychologists.

4. This criterion includes two components: one focusing on past activities around accreditation (X.4.a), and the other on future activities around accreditation (X.4.b).

For X.4.a, describe how the specialty has promoted and participated in the process of accreditation in order to enhance the quality of specialty education and training. Also, indicate how many programs in this specialty have been accredited at the doctoral and/or postdoctoral level.

Because this request is for a new specialty designation, those working in the specialty area have not formally or officially participated in the accreditation process under the rubric of this specialty, i.e., Psychological Assessment and Treatment of Persons with Serious Mental Illness/Severe Emotional Disturbance. However, there are some doctoral and post-doctoral training programs that are accredited under an existing specialty designation (e.g., Clinical, Counseling) and that offer a specialized emphasis in SMI/SED. In addition, some of those who participated in the development of this specialty petition have served as accreditation site visitors, on the Commission on Accreditation, or on other committees under the direction of APA’s Board of Educational Affairs.

Since this petition is for designation as a new specialty, there are currently no accredited doctoral or post-doctoral programs in this specialty. As we indicated previously, there are programs at all three training levels that are accredited in an existing specialty area and that have a specialized track or area of emphasis in the area of SMI/SED.

For X.4.b, describe how the specialty will promote and participate in the process of accreditation in the future in order to enhance the quality and sustainability of specialty education and training. Also, explain how the future accreditation support activities will be consistent with the Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties (see: http://www.apa.org/ed/graduate/specialize/taxonomy.pdf) and will be sustained (e.g., training CoA site reviewers with specialty expertise, sponsoring CoA self-study workshops, fostering the development or ongoing operation of a specialty training council, administrative agreements and protections, financial support, etc.). Explain how these activities will result in an increase in the number of specialty programs that are accredited at the doctoral and/or postdoctoral level.

When this specialty is approved, the Accreditation Committee of the Specialty Council will promote accreditation expertise and involvement. This committee will undertake activities to recruit and train site visitors for specialty accreditation, and will offer CoA self-study workshops. The Specialty Council will also work to grow the specialty by ensuring that post-doctoral residency programs are aware of the area’s specialty status; those with an existing emphasis in SMI/SED will be encouraged to seek accreditation in this post-doctoral specialty.
These future accreditation support activities will be consistent with the *Taxonomy for Education and Training in Serious Mental Illness/Severe Emotional Disturbance*, which is attached. As such the Exposure, Experience, Emphasis, and Major Area of Study categories of the Taxonomy will be promoted at the doctoral, internship, and post-doctoral levels in order to enhance uptake of the specialty’s topical content.

**Attachment for Criterion X**

**Taxonomy for Education and Training in Serious Mental Illness/Severe Emotional Disturbance**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Assessment &amp; Treatment of Serious Mental Illness (SMI/SED)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of Training</strong></td>
<td>Doctoral</td>
</tr>
<tr>
<td><strong>Major Area of Study</strong></td>
<td>4 courses in SMI/SED, 1 SMI/SED practicum, and 1 SMI/SED major paper or research project</td>
</tr>
<tr>
<td><strong>Emphasis</strong></td>
<td>1 SMI/SED courses and 1 SMI/SED practicum or major paper or research project</td>
</tr>
<tr>
<td><strong>Experience</strong></td>
<td>2 SMI/SED courses and 1 SMI/SED practicum or major paper or research project</td>
</tr>
<tr>
<td><strong>Exposure</strong></td>
<td>1 SMI/SED course, practicum or research project</td>
</tr>
</tbody>
</table>

**SMI/SED Course** – Each course must have predominant content specific to the recovery paradigm and/or psychosocial rehabilitation for persons with SMI/SED and be taken for at least 3 hours of credit.

**SMI/SED Practicum** – Minimum experience of 9 months of applied, clinical supervised experience for at least 10 hours per week working with persons with SMI/SED.

**Applied, Clinical Supervised Experience** – Must include at least 80% clinical contact with persons with SMI/SED and pertain to assessment, treatment, and/or consultation. If offered, seminar attendance, interdisciplinary team participation, readings, and research may count as part of the supervised experience for interns and postdoctoral fellows. Supervision must be provided by a psychologist meeting requirements for Major Area of Study in SMI/SED at the post-licensure stage.

**CE coursework** – Must be approved by the American Psychological Association and have content specific to SMI/SED.

**Post-doctoral specialization in SMI/SED** is intended to follow broad and general training in clinical, counseling or school psychology.
Criterion XI. Guidelines for Specialty Service Delivery

The specialty has developed and disseminated guidelines for practice in the specialty that expand on the profession's general practice guidelines and ethical principles.3

Commentary: Such guidelines are readily available to specialty practitioners and to members of the public and describe the characteristic ways in which specialty practitioners make decisions about specialty services and about how such services are delivered to the public.

1. Describe the specialty-specific practice guidelines for this specialty. Please attach. How do such guidelines differ from general practice guidelines and ethics guidelines? (In this context, professional specialty guidelines refer to modes of conceptualization, identification and assessment of issues, and intervention planning and execution common to those trained and experienced in the practice of the specialty. Such professional guidelines may be found in documents or websites including, but not limited to, those bearing such a title or as described in a variety of published textbooks, chapters, and/or articles focused on such contents.)

As with most areas of clinical practice, there are no APA published practice guidelines for this specialty targeted to psychological practice. There are however, published guidelines that are generic, i.e., designed to be used by any professional working with individuals with SMI/SED. The most comprehensive of these is entitled Psychosis and schizophrenia in adults: prevention and management (National Institute for Health and Care Excellence, 2014) [NICE] which can be accessed at https://www.nice.org.uk/guidance/cg178. The NICE guideline also contains a section on SED in youth and young adults, and as such is a comprehensive reference. Note that there is also a NICE guideline for bipolar disorder and a guideline for substance use disorders. Both of these are also excellent and comprehensive documents.

In addition to the full practice guidelines directed to all mental health professions, a short clinical practice guideline tool has been developed for this specialization of psychological practice. The guideline tool consists of a flowchart depicting the stages of psychological practice and each stage is accompanied by a short explanation of the step. Unlike traditional practice guidelines, the guideline tool contains very little detail about the disorders, specialized assessments, or appropriate interventions because clinicians providing services to people with SMI/SED should have received the specialized training needed to deliver appropriate services for those with these disorders. The guideline tool is not meant as a substitute for comprehensive training in psychological assessment and treatment for those with SMI/SED. Rather it is meant as a quick reference guide that can be used by frontline psychologists and by those serving as program managers or administrators in this area. The guideline tool is attached as Appendix II.

The guideline tool that is attached to this petition has been adapted for use by all mental health professionals and is currently in press (Jansen, in press).

2. How does the specialty encourage the continued development and review of practice guidelines?

The APA Task Force on SMI/SED has encouraged APA to develop a clinical practice guideline for psychologists working with persons with SMI/SED. Additionally, the guideline tool mentioned above and information about the NICE guideline have been posted on the Specialty Council website. Psychologists working with individuals with SMI and SED are encouraged to use this information and to stay abreast of the literature and new developments in this area of practice.
3. Describe how the specialty’s practitioners assure effective and ongoing communication to members of the discipline and the public as to the specialty's practices, practice enhancements, and/or new applications.

Psychologists who work in this specialty are actively involved in conducting research and in publishing their results in peer reviewed journals, book chapters, books, newsletter articles, and other outlets. More specifically, there are several journals devoted to SMI/SED and while not all are professional psychology journals, they are all highly respected outlets for psychological research, policy pieces, articles representing new clinical practices, and recent developments in the field. Psychologists regularly publish in these journals (and many others) and are members of some of their editorial boards. These journals include: *Psychiatric Services*, *Psychosocial Rehabilitation Journal* (an APA journal edited by a psychologist who specializes in this area), *Schizophrenia Bulletin, Schizophrenia Research, World Psychiatry*.

In addition to these journals, there are many others that also publish work by psychologists in the area. Some of those that routinely publish articles by psychologists about SMI/SED are: *American Journal of Psychiatry, Archives of General Psychiatry, British Journal of Psychiatry, BMJ* (British Medical Journal), *Community Mental Health Journal, Psychological Services* (an APA journal), *World Psychiatry*.

Additionally, many psychologists who specialize in this work are board and committee members of major national organizations and many others contribute their time at state and local levels. National, state, and local organizations work with professionals and the public to:

- Advocate for individuals with these conditions in a variety of contexts from clinical treatment to criminal justice and forensic settings;
- Promote community inclusion and end stigma experienced by individuals and their families;
- Promote evidence based and promising practices, and
- Work with legislators and policy makers to develop legislation and policies that assure adequate treatment and social justice for people with SMI/SED.

In addition to bringing their expertise to the forefront, this advocacy work helps to inform members of the discipline and the public about ongoing work and also about issues needing greater attention.

4. How does the specialty communicate its identity and services to the public?

In addition to the research, publication, and advocacy work we discussed above and in other sections of this petition, those specializing in this work routinely present symposia and workshops at the annual APA convention, and at regional psychological association conferences and other psychology related venues. Often, these events receive media attention and the work presented is highlighted in articles and television spots about the conference. Public information about specialty services is also promoted by psychologists who are frequently invited speakers at non-psychology conferences and who are featured on webinars and other training events sponsored by advocacy organizations. Services are also promoted on the websites of these advocacy organizations and in their newsletters.

When this specialty is recognized, training programs will be able to provide this information on their websites so that prospective trainees and others will be made aware. Ads may also be placed in the major national advocacy print outlets to inform the public about the specialty. Also, as we mentioned previously, we will join the Council of Specialties and an application will be developed and submitted to the ABPP for recognition. As that is accomplished, psychologists will be able to use the ABPP notation after their name indicating their expertise and recognition in the specialty. Members of the public seeking services for themselves, a family member or a friend with SMI/SED will be able to refer to these specially trained psychologists.
Reference


Appendix

Appendix II: Clinical Practice Guideline Toolkit for Psychologists Working with Persons with Serious Mental Illness/Severe Emotional Disturbance
Criterion XII. Provider Identification and Evaluation

A specialty recognizes the public benefits of developing sound methods for permitting individual practitioners to secure an evaluation of their knowledge and skill and to be identified as meeting the qualifications for competent practice in the specialty.

**Commentary:** Identifying psychologists who are competent to practice the specialty provides a significant service to the public. Assessing the knowledge and skill levels of these professionals helps increase the ability to improve the quality of the services provided. Initially practitioners competent to practice in the specialty may simply be identified by their successful completion of an organized sequence of education and training. As the specialty matures it is expected that the specialty will develop more formal structures for the recognition of competency in practitioners.

1. Describe the formal peer review-based examination process of board certification including its use of a review and verification of the individual’s training, licensure, ethical conduct status, and a peer assessment of specialty competence.

Presently, there is no formal peer review based examination process for board certification. The organization that conducts such examinations (ABPP) for most if not all psychological specialties is not accepting applications for additional specialty recognition unless the area is already recognized as an APA specialty. Thus, once APA recognizes this specialty in SMI/SED, we will develop an application for submission to the ABPP and a formal peer review based examination process for board certification with all the attendant requirements (review and verification of training, licensure, ethical conduct status, peer assessment and any other indicators of competence) will be implemented.

*If this is a new petition for recognition describe a) current methods by which individual practitioners can secure an evaluation of their knowledge and skill and be identified as meeting the qualifications for competent practice in the specialty and b) efforts to establish a formal peer review-based examination process of board certification including a detailed plan and timeline.

Both individual practitioners and supervisors can evaluate knowledge and skills in the area of this specialty by using a tool called the Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED). This instrument is a modification of the evaluation tool developed by the Council of Professional Geropsychology Training Programs known as the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel, et al., 2012). Permission was received to modify and use the Pikes Peak tool.

Due to its size, the evaluation tool (Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED) is attached as Appendix III.

2. Describe how the specialty educates the public and the profession concerning those who are identified as a practitioner of this specialty. How does the public identify practitioners of this specialty?

Members of the public and mental health professionals, including psychologists, are informed about psychologists who are trained to provide specialized services to people with SMI and SED in many ways. These include:
Licensing board listings of psychologists who specialize in the area

Websites and listservs made up of professionals, advocacy groups, and organizations that have an interest in specialized services and research for this population. Some of these are listed below:

- The Council for Psychological Training in Assessment and Treatment of People with Serious Mental Illness/Severe Emotional Disturbance (www.psychtrainingsmi.com)
- Several divisions of the APA to which specialized psychologist practitioners belong include Divisions 12, 17, 18, 22, 29, 35, 38, 53 (among others). Some of these divisions have sections or task forces on SMI/SED, such as the Division 18 Section on SMI/SED and the Division 35 Task Force on SMI/SED and Women.

The APA Task Force on SMI/SED
- Psychiatric Rehabilitation Association (PRA)
- Association for Behavioral and Cognitive Therapies (ABCT) Special Interest Group on SMI/SED
- Articles in publications such as the APA Monitor, the American Psychologist, other APA journals such as Psychiatric Rehabilitation Journal, Psychological Services, journals published by other organizations that are interested in this field such as the American Journal of Psychiatric Rehabilitation, Psychiatric Services, Schizophrenia Bulletin and World Psychiatry.

3. Estimate how many practitioners there are in this specialty (e.g., spend 25% or more of their time in services characteristic of this specialty and provide whatever demographic information is available) and how many are board certified through the process decried in item 1.

Although the actual number is not known, a very conservative estimate that is based only on numbers drawn from hospital and correction facilities surveys is that there are at least 4,451 psychologists in the US (hospital and corrections only), who spend 25% or more of their time in services characteristic of this specialty. This number is derived based on the following:

First, according to the American Hospital Association (AHA), there are 401 AHA registered non-Federal psychiatric hospitals as of 2017. Registration with the AHA is voluntary; therefore this number may not account for all non-Federal psychiatric hospitals in the US but this figure does include private and public facilities. No other information is publicly available; information is only available to AHA members or by purchase of detailed information.

Since these are registered psychiatric hospitals, we have assumed that there will be 2 psychologists at each for a total of 800 psychologists in these facilities.

Secondly, an article published in Health Affairs in 2009 (Fisher, Geller & Pandiani) indicated that as of 2006, there were 228 state psychiatric hospitals in the US. Relatedly, a report from SAMHSA (2012) indicated that as of 2010 there were 204 state psychiatric hospitals. It is not known if, or to what extent, the hospitals from these two sources are included in the AHA figure, but we have assumed that it is likely that most state hospitals do not belong to the AHA and therefore are not included. However, to be conservative, we have “split the difference” between the two reports and then used one half of that figure (116) as the number of state psychiatric hospitals to be used for this calculation.

Since these are state psychiatric hospitals whose population is comprised virtually entirely of individuals with SMI/SED, we have assumed that each facility has 5 psychologists for a total of 580 psychologists in these facilities.

Thirdly, as of April 2017, according to a report from the U.S. Department of Veterans Affairs National Center for Veterans Analysis and Statistics, there were 145 VA hospitals and 1,235 outpatient facilities. Virtually all VA hospitals and many outpatient centers employ psychologists. Overall, the VA
employs more than 5000 psychologists; the actual number fluctuates depending on several variables. We can assume that at least twenty-five percent of those spend most of their time working with this population. The number of VA psychologists that are estimated to spend most of their time working with this population is 1,250 psychologists.

Fourthly, many individuals with SMI and SED are incarcerated in Department of Justice corrections facilities. As of the end of 2005 (the latest year for which data are available), there were 1,821 state or federal correctional facilities. According to the same report, as of the end of December 2005, there were 1,430,208 persons incarcerated in those facilities (U.S. Department of Justice, 2008). In a report prepared for the American Jail Association, Trotter and Noonan (2016) indicated that serious psychological distress among jail inmates was present in approximately 3 percent of the population. This means that roughly 42,906 individuals (3% of the 1,430,208 persons) in U.S. state or federal correctional facilities have SMI/SED. A conservative estimate of the number of psychologists who would be employed in these facilities is one per facility or 1,821.

We estimate the total number of psychologists from these four sources to be 4,451.

We were unable to identify either the number of community mental health centers or the number of psychologists who might work in those settings. Though that number is unknown, it seems safe to say there would be a considerable number of psychologists in those settings, adding to the estimated total given above.

The estimated number we presented above also does not account for psychologists who may see persons with SMI/SED in other settings (private practice, academic counseling centers, non-psychiatric hospitals, etc.), nor does it account for psychologists outside the US. Most relevant to this discussion is Canada whose population and settings mirror those of the US., although in smaller numbers (the population of Canada is roughly one-tenth that of the US).

Additionally, psychologists in countries outside of North America are likely to have a keen interest in this specialty because many, particularly those in countries such as the United Kingdom, Australia and New Zealand, where many researchers and clinicians have published extensively on the topic and in many ways have more fully embraced the recovery paradigm and psychosocial rehabilitation interventions than have psychologists in the US.

The final question in this criterion asks about the number that are board certified in the specialty. As this will be a new specialty, there is currently no board certification process; as we noted in other sections of this petition, we will develop this certification in concert with ABPP once the specialty is approved by APA.

References


**Appendix**

Appendix III: Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)
An important component of the recognition process is to develop a public description of the specialty that can be used to inform the public about the specialty area. Please develop a brief description of the specialty by responding to the question below (total combined word limit for all five questions must not exceed 400 words). This provides the foundation for what will appear on the APA website upon recognition of the specialty and should be understandable to the general public (wording should not exceed an eighth-grade level). Descriptions will be edited for consistency to conform to the CRSPPP website standards.

1. Provide a brief (2-3 sentences) definition of the specialty.

Psychologists with a specialization in Psychological Assessment and Treatment of Persons with Serious Mental Illness (SMI) and Severe Emotional Disturbance (SED) apply specialized individual, societal, and systems level assessment and intervention methods to assist those who have developed SMI or who are at risk of developing these illnesses (SED) recover and attain their full functional capability.

2. What specialized knowledge is key to the specialty?

   Specialized knowledge is key for health service psychologists with this specialty and includes:

   • Targeted Individual-level strengths-based, functional and resource assessments developed for people with SMI/SED
   • Evidence-based treatments designed and developed specifically for this population
   • Methods to implement social and community integration
   • Stigma reducing approaches, including those aimed at reducing health disparities
   • Most appropriate research techniques including mixed methods approaches
   • Systems change processes and procedures.

3. What problems does this specialty specifically address?

   Approaches used at individual, societal and systems levels apply to the wide range of special problems individuals in the SMI/SED population face, including:

   Individuals:

   • Difficulties in thinking, remembering, problem solving, and social skills that depend on cognitive functioning such as relating, communicating well and appropriately, and interpreting social cues;
   • Deficits related to when the illness developed, including inability to have appropriate relationships, lack of insight and knowledge about the illness; inability to understand how to manage symptoms, inability to work with mental health professionals to determine basic goals and best treatments; deficits in basic educational and employment skills.

   Societal:

   • Societal restrictions placed on individuals with these disorders such as exclusion from the rights and privileges enjoyed by others;
   • Stigmatization which often makes access to health care and other essential services extremely difficult.
Systems:

• Organizational unwillingness or inability to provide the most efficacious interventions to help individuals recover and attain their full functional capability.

4. What populations does this specialty specifically serve?

The populations served by this specialty are those with SMI/SED including individuals with psychosis manifested by disorders such as schizophrenia, schizo-affective illness, severe depression, serious bi-polar illness, severe post-traumatic stress disorder, and other SMI/SED that result in sustained loss of functional capability.

5. What are the essential skills and procedures associated with the specialty?

For individuals:

• Specialized assessments to assist individuals determine goals based on their life experiences and strengths;
• Evidence-based and promising practice interventions that are efficacious for helping individuals with SMI/SED recover, attain full functional capability and achieve goals including population-specific psychotherapeutic interventions, cognitive remediation and social cognitive interventions, illness management strategies, family interventions, institutional interventions, educational and employment approaches.

Societal:

• Interventions to help individuals live in their chosen community and access the services they need or desire;
• Interventions to help communities recognize the benefits of full participation for people with SMI/SED.

Systems:

• Strategies to effect change in organizations and systems where individuals with SMI/SED are served.
Appendix I: SMI/SED Education and Training Guidelines

Training Guidelines for Post-Doctoral Psychology Residency Programs in Serious Mental Illness/Severe Emotional Disturbance (SMI/SED)

December 2017

Introduction

These Training Guidelines provide guidance for post-doctoral psychology residency programs in serious mental illness/severe emotional disturbance (SMI/SED). These Guidelines are designed to assist programs as they develop and implement formal post-doctoral residency programs in SMI/SED and are intended to promote competence in the specialized practices needed to assist persons who have SMI/SED. These Guidelines are just that – guidelines – and are not meant to take precedence over the judgment of program-specific education and training faculty, or of those individuals more generally responsible for education and training at educational institutions. The Guidelines will be updated as new information becomes available.

In accordance with relevant state laws and administrative regulations, the establishment and recognition of specialties in professional psychology does not constrain the general practice of psychology or require specialty credentialing of licensed psychologists practicing within their areas of competence and functioning within the bounds of the APA Ethical Principles of Psychologists and Code of Conduct.

These Guidelines were developed with the participation and input of several groups of interested psychologists. These groups include the APA Task Force on Serious Mental Illness/Severe Emotional Disturbance, APA’s Division 18, Psychologists in Public Service, the Division 18 Section on Serious Mental Illness/Severe Emotional Disturbance, the Training Directors and Program Leaders of post-doctoral programs offering this specialized training, and participants at a meeting sponsored by the above groups and convened following the APA 2016 Convention in Denver, CO. This meeting was funded by grants from the APA Board of Educational Affairs and the Division 18 Section on Serious Mental Illness/Severe Emotional Disturbance and included representatives from the groups mentioned above and a representative from the APA Board of Professional Affairs. Following development of a draft of these Guidelines, they were sent for review and comment to members of interested groups, revised based on feedback received, and finalized.

For greater detail regarding all aspects of these Guidelines, please consult the Petition for Recognition of a Post-Doctoral Specialty in Assessment and Treatment of Persons with Serious Mental Illness / Severe Emotional Disturbance which can be found at: http://www.psychtrainingsmi.com. For information about the accreditation standards that must be met for accreditation of all post-doctoral residency programs, see the APA Standards of Accreditation for Health Service Psychology and the Commission on Accreditation Implementing Regulations. These documents can be found on the APA website at http://www.apa.org/ed/accreditation.
These Guidelines contain information specific to post-doctoral residency programs in SMI/SED and also contain information that is more generic and required for all APA accredited post-doctoral residency programs. As with any training program desirous of achieving accreditation, residency programs wishing to become accredited in this specialty must fully meet the APA Standards of Accreditation (SOA) and must comply with all of the APA Implementing Regulations (IR) that accompany the SOA. Please consult those two documents for further information; both can be found on the APA website at http://www.apa.org/ed/accreditation/

Information Regarding the Population, Problems Faced, Procedures and Techniques Used

Psychologists with a specialization in SMI/SED serve individuals from youth through older adulthood and work in partnership with the person served to help each individual recover and attain the functional capacity needed to achieve his or her goals in areas such as family and peer group socialization and participation, education, and employment - always based upon the individuals’ preferences, needs, goals, and developmental level.

The specialized competencies needed for work in the SMI/SED specialization are typically acquired through post-doctoral didactic and experiential education and training. These competencies are necessary for psychologists to appropriately assist persons with SMI/SED because they are considerably different from those learned by psychologists in most doctoral programs and in other post-doctoral residency training programs.

Due to the different and more severe nature of the problems encountered by individuals with these disorders, the specialized practice of psychology with persons with SMI/SED requires knowledge and skills in assessment and interventions that have been designed and empirically tested for this particular population. This population includes adults and adolescents with primary DSM-5 diagnoses that include the following:

- Schizophrenia
- Schizoaffective Disorder
- Bipolar Illness
- Delusional Disorder
- Other Psychotic Disorders
- Depression with a severe impact on functioning
- May have co-morbid, but not primary, substance use and/or exposure to trauma
- (and does not include individuals with primary personality disorders).

The problems experienced by these individuals are complex, severe, and not singular, i.e., individuals within this population experience multiple problems. Some of the serious problems experienced by individuals with SMI/SED include:

- Severe symptomatology such as hallucinations, delusions, extreme mood swings, disorganized thinking, bizarre or disorganized behavior, and disordered or flattened affect
- Neuropsychological/cognitive deficits and resultant problems
- Social skill/interpersonal deficits
- Trauma and resultant severe anxiety, depression, co-morbid substance use, and other psychological problems that arise either prior to onset of the SMI/SED or as a result of trauma associated with the health care system or as a result of incarceration or hospitalization in forensic psychiatric facilities
- Greater morbidity and earlier mortality from natural (cancers, cardiovascular disorders, metabolic syndrome, etc.) and unnatural causes (suicide and violence)
- Stigma and self-stigma often resulting in an inability to access timely and appropriate health care
- Poverty, homelessness, inability to complete educational goals or work competitively
- All of the above problems are frequently magnified for women, people from non-majority cultures, those with co-morbid disabling conditions, members of the LGBTQ population, immigrants and refugees who have SMI/SED, and other disenfranchised or stigmatized groups.

The procedures and techniques used by psychologists who work with persons with SMI/SED build on the basic knowledge and skills acquired by psychologists in doctoral level training but go beyond those basics due to the need for a different and expanded knowledge base, a unique approach to assessment, and specialized interventions that address the complex problems experienced by this population.

**Post-Doctoral Residency Training - Specialty Specific Information**

**Admission Requirements**

In accord with APA’s Standards of Accreditation for Health Service Psychology (American Psychological Association, Commission on Accreditation, 2015), (downloaded from APA website December 2017):

i. The program has procedures for resident selection that ensure residents are appropriately prepared for the training offered.

ii. At the initiation of training, residents will have completed doctoral and internship training in programs accredited by an accrediting body recognized by the U.S. Secretary of Education or by the Canadian Psychological Association. If the program accepts residents who attended unaccredited programs, the residency must describe how the program ensures that selected residents are otherwise qualified and appropriately prepared for advanced training in the residency program. (p. 38).

Accordingly, residency programs are advised to ensure that residents have completed doctoral and internship training that meets these requirements.

Post-doctoral residency programs in SMI/SED require official transcripts from the doctoral or re-specialization program and from the internship program, a cover letter indicating previous clinical
experience with persons with SMI/SED or in settings where persons with SMI/SED are seen, commitment to a career working with those diagnosed with SMI/SED, statement of future goals as they relate to SMI/SED, letters of recommendation, and the applicant’s CV. Programs may also have other requirements such as submission of a work sample, graduation from an APA or CPA accredited program, etc.

Sample SMI/SED specific evaluation admission forms that can be used in addition to more general admission forms required by the institution can be found in the Petition for Recognition of a Post-Doctoral Specialty in Assessment and Treatment of Persons with Serious Mental Illness / Severe Emotional Disturbance (Criterion VII) which can be found at www.psychtrainingsmi.com. Please note these are samples only. Programs should ensure their forms comply with current guidance and requirements from APA.

Importantly, post-doctoral residency programs in SMI/SED ensure a welcoming, supportive, and encouraging learning environment for all residents, including residents from diverse and underrepresented communities. Every effort is made to recruit residents and faculty representing the full range of human diversity.

Qualifications of Faculty and Directors of Training in This Specialty

Core faculty who teach in a clinical area of a post-doctoral residency program in SMI/SED may be from a variety of relevant disciplines and must be licensed in their respective discipline (e.g., psychology, psychiatry, occupational therapy, nursing, social work, etc.), or if in the process of becoming licensed, they must be directly supervised by a licensed practitioner in their discipline. All teaching faculty should have training, experience, or exposure in the area of SMI/SED and have expertise in the specific courses or practice areas in which they are teaching. Faculty who are not yet fully qualified would not qualify as core faculty but they too should have some training and experience, although may be continuing their learning and education.

Faculty who teach in the research component of the program do not need to be licensed but should also have experience in the area of SMI/SED and would typically be affiliated with an active SMI/SED research program. In model programs, research faculty would work with individuals with SMI/SED in a clinic or other setting.

Directors of Training may oversee several training programs including those in this area of specialization. They should be experienced psychologists who have advanced academic and experiential qualifications such as an ABPP, Fellow status in APA, other recognized status in APA, ABPP, APPIC, certification from the Psychiatric Rehabilitation Association, or similar recognition of their advanced qualifications. Where the program is university affiliated, faculty should have an academic appointment and be active in the university program. Where Training Directors oversee multiple training programs, it is possible they may not have direct experience or expertise in SMI/SED; however, they should be familiar with and have a working knowledge of the principles and practices in the field and be able to provide oversight and guidance to faculty.
Doctoral Level Foundational and Functional Competencies

Doctoral-level foundational competencies consist of the knowledge, skills, and attitudes/values that form the basis for how and why professional psychologists do what they do. Examples of foundational competencies include, but are not limited to: (a) processes of self-assessment and reflective practice, (b) understanding of scientific knowledge and methods, (c) effective relationship skills, (d) knowledge of ethical and legal standards and policy, (e) understanding and valuing individual and cultural diversity; and (f) ability to function in interdisciplinary systems.

Doctoral-level functional competencies reflect professional psychologists’ application of knowledge, skills, and attitudes/values. Functional competencies include, but are not limited to: (a) assessment, diagnosis, and case conceptualization; (b) intervention; (c) consultation; (d) research and evaluation; (e) supervision and teaching; and (f) management and administration.

Specialized Competencies Required for Practice in the Specialization of SMI/SED

Advanced scientific and theoretical knowledge is acquired via specialized didactic and experiential training that builds on and extends basic preparation in health service psychology. The specialized training needed to develop competence to treat persons with SMI/SED builds on, and expands doctoral level foundational and functional competencies, and includes: additional assessment methods that assess strengths and functional capability rather than solely symptomatology and deficits, evidence-based and promising practices designed specifically for this population, interventions modified and found to be effective with people in this population within the forensic mental health system, research methods adapted for populations such as this, and systems transformation methods specific to large mental health systems that serve this population, to name but a few – these are the major areas of specialized training needed by psychologists to work with individuals with SMI/SED. While post-doctoral specialty programs could not include detailed training in all of these, post-doctoral residents should receive exposure to all of these domains and more intensive experience and training in as many as possible. The following competencies are those that would ideally be included or available to trainees (a broad, general descriptive narrative follows the listing):

Assessment

Competence in Strengths Based and Functional Assessment Skills:

Comprehensive assessment is essential to any recovery service plan. Residents should be able to appropriately assess, evaluate and then develop practical interventions for individuals with severe and persistent mental illnesses, including those with complicated mental, substance abuse, and medical co-morbidities, often with histories of trauma.

☐ Comprehensive knowledge of strengths based and functional capability assessments, subjective perceptions of recovery and quality of life, and ability to conduct assessments using these measures

☐ Ability to utilize standardized assessments in ways that may require modification in light of the fact that these assessments were not developed or normed using persons with SMI/SED
Ability to competently utilize specialty assessments such as the Structured Clinical Interview for the DSM (SCID), the Positive and Negative Syndrome Scale (PANSS), the Brief Psychiatric Rating Scale (BPRS), and the Brief Psychiatric Rating Scale for Children (BPRS-C) as needed and appropriate.

Ability to conduct an assessment of an individual’s readiness and desire for psychosocial interventions.

Ability to conduct an assessment of resources available to the individual and the person’s ability to utilize those resources.

Ability to assess perceived recovery and life satisfaction/quality of life.

Ability to assess and address positive and negative symptoms using measures such as the Scale for the Assessment of Positive Symptoms (SAPS) and Scale for the Assessment of Negative Symptoms (SANS).

Ability to recognize psychosis and thought disorder and understand in depth the nuances of each condition considered within the purview of SMI/SED.

Ability to recognize and screen for potential cognitive deficits that are core areas of dysfunction for people with SMI/SED including processing speed, verbal memory, and attention.

Ability to recognize and screen for social deficits that often accompany these disorders.

Ability to recognize the limitations posed by cognitive impairments and the potential for lessened insight and, as needed, ability to conduct behavioral observational assessments that accurately account for these.

Ability to assess for the potential risk for suicide and violence to self or others.

Ability to recognize and understand etiology of co-occurring substance use disorders and the importance of trauma in SMI/SED disorders and be competent in differential diagnosis of similarly presenting diagnoses such as PTSD and personality disorders.

Knowledge of medication side effects especially those specific to psychotropic medications and ability to assess for medication adherence and barriers to adherence.

Ability to integrate the intersection of diversity related to age, gender and gender orientation, race, cultural, spiritual/religious beliefs, etc. specifically related to the presentation of symptoms unique to SMI/SED.

Ability to recognize the level of capacity and competence of an individual with SMI/SED in order to make appropriate recommendations regarding interventions or to refer to appropriate specialty services including those provided by other disciplines.
Goal Setting and Treatment Planning

Competence in Helping Individuals Set Goals and Develop Appropriate Treatment Plans:

☐ Ability to assist clients assess their values as they develop individualized goals using shared decision making and person centered planning approaches

☐ Competence in developing tailored clinical and recovery-oriented interventions that meet the client's identified goals and develop action steps for goal achievement

☐ Ability to recognize when modifications to treatment plans are needed to reflect the needs and values of the client and determine satisfaction of services provided.

Interventions

Competence in Psychosocial Rehabilitation Interventions

By the completion of their training year, residents should demonstrate an ability to use appropriate self-disclosure and sharing of case studies/real-world examples to normalize experiences of persons with SMI/SED. Residents should also demonstrate skill in applying and adapting evidence-based psychosocial rehabilitation interventions with SMI/SED individuals. Residents also are expected to manage crisis situations and identify opportunities for transition of services. Residents are expected to provide appropriate interventions in response to a range of presenting psychosocial problems and treatment concerns and demonstrate the ability to effectively work with diverse populations, interprofessional providers, and various program specialties.

The schizophrenia PORT evidence based and promising practices recommendations (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010) include:

☐ Assertive Community Treatment (ACT) – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others

☐ Supported Employment (SE) – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others

☐ Cognitive Behavioral Therapy (CBT) and CBT for psychosis (CBTp) – knowledge of differences between CBT and CBTp and ability to competently practice and supervise others in both interventions

☐ Skills Training – knowledge of fidelity criteria and ability to implement intervention and supervise others

☐ Family Intervention/Psychoeducation – knowledge of fidelity criteria and ability to implement intervention and supervise others

☐ Social learning programs (Token Economy) – knowledge of intervention, its appropriate use, ability to implement and train and supervise others
Integrated Dual Diagnosis Treatment (IDDT)/Co-occurring disorders treatment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others

Weight management approaches and Smoking cessation approaches – ability to competently implement appropriate interventions and supervise others

Illness Self-Management including Wellness Recovery Action Planning (WRAP) and behavioral tailoring for medication – knowledge of interventions, how to implement and supervise others

Cognitive Remediation and Social Cognition Training – knowledge of interventions, ability to competently practice and supervise others

Psychosocial interventions for first episode psychosis (FEP) – knowledge of recent research indicating the effectiveness of a set of interventions (RAISE) and ability to implement interventions, participate on teams, and supervise others

Peer Support/peer delivered services – knowledge of interventions and ability to implement and supervise peers

Additional Interventions to Address Critically Important Problems for People with SMI/SED:

Stigma/Self-stigma interventions – knowledge of, and ability to implement interventions to change attitudes and decrease discriminatory behaviors among health providers and the public at large

Trauma interventions (trauma informed and trauma specific care) – ability to competently implement trauma interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care

Suicide prevention – ability to recognize when individuals may be at risk and provide high levels of support, refer for appropriate intervention and provide treatment for depression to mitigate hopelessness and other risk factors

Violence prevention – ability to recognize when individuals may be at risk and refer for appropriate intervention while providing high levels of support

Interventions to decrease homelessness – ability to provide a comprehensive array of services designed to facilitate supported housing, e.g., trauma informed care, relapse prevention for substance abuse, and other supports to maintain housing

Supported education interventions to help individuals achieve their educational goals

Motivational Interviewing (MI) for those with SMI/SED – ability to competently implement motivational interviewing as appropriate and to supervise others in practice
Specialized Interventions for Forensic/Criminal Justice Populations with SMI/SED - including knowledge of the factors that impact on success of interventions for forensic and criminal justice populations with SMI/SED:

☐ Forensic Assertive Community Treatment (FACT) – ability to ability to implement intervention, participate on team, and supervise others

☐ CBT for those in criminal justice/forensic settings – ability to competently provide specialized CBT services and to supervise others in practice

☐ IDDT/Co-occurring disorders treatment for those in criminal justice/forensic settings – knowledge of the specialized needs of people with SMI/SED in these settings, ability to provide integrated mental health and substance use services targeted to the population, and supervise others in practice

☐ Trauma interventions for those in criminal justice/forensic settings (trauma informed and trauma specific care) – recognition of trauma as the norm for those with SMI/SED in the forensic and criminal justice systems, ability to competently provide trauma specific interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care, including services for those at highest risk and to supervise others in provision of services

☐ Supported housing interventions for those in criminal justice/forensic settings – ability to implement comprehensive services to assure supported housing is available for individuals being released into the community

☐ Transition planning and follow-up for criminal justice/forensic settings – ability to implement adequate and appropriate transition planning and follow up for individuals being released into the community

Specialized Intervention for People with Bipolar Disorder - in addition to demonstrating competence with the above interventions for people with SMI/SED (several of which are also recommended specifically for this population), residents should also:

☐ Demonstrate an ability to competently provide Interpersonal and Social Rhythm Therapy (IPSRT) and Family Focused Treatment (FFT) for bipolar disorder and to supervise others in practice

☐ Understand the potential of Dialectical Behavior Therapy (DBT) which may also be helpful for individuals with bipolar disorder and personality disorders

Consultation

Competence in Consultation Skills:

Within the bounds of confidentiality and privacy, residents must be able to listen, understand, communicate, and display excellent rapport with relevant stakeholders including: the person served,
family members, relevant community members, other healthcare providers within and outside of the system, and partnering agencies. The resident is expected to exhibit comfort and proficiency in providing effective consultation and feedback to the person served, family members, clinical programs, interprofessional staff and community partners.

☐ Ability to effectively present information and develop treatment recommendations that are understandable to the person, his or her support team, and in accord with his or her goals

☐ Ability to competently work with an interprofessional team and present information about persons with SMI/SED so that team members can understand and learn from the presentation

☐ Ability to apply specialty knowledge and expertise concerning SMI/SED symptomatology and diagnosis to problems that arise in professional settings

☐ Comprehensive knowledge of psychosocial functioning and recovery and ability to describe this to team members, other colleagues, and members of the public

☐ Ability to provide education and training for mental health staff on all aspects of the recovery paradigm and psychosocial rehabilitation assessments and interventions

☐ Ability to integrate all information into a case formulation that presents an opportunity for use of psychosocial interventions designed to promote recovery and attainment of the goals articulated by each person

☐ Ability to assist supervisees and team members in the management of difficult behaviors that may be exhibited by persons with SMI/SED

☐ Ability to integrate the knowledge, values, and attitudes critical for successful work with people with SMI/SED into interprofessional team settings to facilitate shared decision making

☐ Ability to work with staff in specialized facilities such as supported housing, etc. to help them recognize and respond appropriately to symptoms and problem behaviors to help individuals with SMI/SED thrive in the community

☐ Ability to educate, train, and supervise staff at all levels of training, from front-line behavioral health staff through to highly trained staff and managers/administrators, in the best ways to help people with SMI/SED manage symptoms, set and achieve goals for themselves, and access resources available to them. Some examples of potential issues and difficult behaviors include limit setting, stigma, empathy, delusions/hallucinations, and crisis intervention

☐ Ability to educate and consult with families about their family member’s illness and the role of family in treatment

☐ Knowledge of resources to help with access to care (e.g., family members trying to get members into care and navigate a complex healthcare system)
Ability to educate and train staff in facilities and on specialized units for youth, young adults, and older persons where knowledge and expertise is lacking about behavioral health particularly SMI/SED

**Research and Evaluation**

*Competence in Scholarly Inquiry and Application of Theoretical and Scientific Knowledge to Practice:*

Residents are expected to participate in scholarly inquiry, and apply theoretical and scientific knowledge to their clinical practices. They are expected to engage in their own scholarly endeavors which may include research, grant proposal writing, as well as program development, implementation, and evaluation.

Residents should be able to demonstrate awareness of current literature, and have the ability to search relevant literature and evaluate it.

Recognition of the importance of incorporating persons with lived experience of SMI/SED into all aspects of research and evaluation from conception to completion and publication. This includes formulation of hypotheses, study questions and design, determination of statistical methods, participants to be recruited, etc.

Knowledge of and ability to use mixed methods research designs.

Familiarity with and ability to use single case designs (disorders may be persistent over time and multiple baselines provide a clearer picture of the impact of different treatment components and their helpfulness to individuals).

Recognition of ability to incorporate family members and first degree relatives into designs (research provides insight into how the illness manifests in individuals vs. family members looking at the phenotypes in individual and family).

Recognition of importance of involvement of caregivers and other stakeholders in research and willingness to incorporate them into designs.

Ability to collaborate with other disciplines (e.g., psychiatry, rehabilitation services, nursing, occupational therapy, etc.).

Up to date knowledge of the latest assessments and interventions for this population.

Ability to utilize research/evaluation knowledge to adapt/modify assessments and interventions that have excluded persons with SMI/SED and to do so appropriately recognizing when fidelity to the original practice is essential.

Recognition and understanding the needs of vulnerable populations vis a vis their participation in research efforts.
Recognition and understanding of the ability of persons with SMI/SED to provide informed consent

Ability to inform and educate IRBs about the type of intervention research common with SMI/SED populations such as psychosocial interventions

Understanding of the unique needs of persons with SMI/SED vis a vis study design and ability to apply this knowledge to prevent/minimize drop out as typically this is different for persons with SMI/SED 1) drop outs tend to be doing worse and 2), severe economic disadvantages impact people with SMI/SED disproportionately 3), follow up studies need to include more time (>1 year) due to the nature of the illness

Knowledge of and ability to conduct multifactorial designs of programs as these are the norm with SMI/SED populations; understanding of the importance of controls for non-specific factors

Ability to identify appropriate outcomes for program evaluation efforts due to broad nature of quality of life, psychosocial functioning, and recovery

Ability to undertake program evaluation which is critical so that a developed program can be improved - systems within which SMI/SED persons are seen may be more difficult to work with than structured research settings due to presence of multiple stakeholders

Ability to obtain buy-in from multiple under-resourced clients and stakeholders

**Supervision/Teaching**

*Competence in Teaching and Supervision Skills:*

By the completion of the training year, residents should demonstrate the ability to give presentations in a formal didactic setting, develop mentoring skills for working with small groups and/or one to one to teach skills, communicate knowledge, and provide feedback to those they serve, their support networks, other professionals, trainees, para-professionals, and/or community partnering agencies. When providing supervision and teaching, residents should demonstrate sensitivity to ethical, legal, and cultural issues and demonstrate ability to teach the principles of psychosocial rehabilitation.

Comprehensive knowledge of psychosocial assessments and interventions and ability to impart knowledge about these and to supervise others in practice

Ability to provide education and training for mental health staff on aspects of the recovery paradigm and psychosocial rehabilitation interventions

Ability to impart knowledge and help others develop an understanding of, and ability to convey the importance of hope, respect, positive regard, and acceptance of person’s goals, wishes, and preferences in the development of the therapeutic relationship (which is key and sometimes difficult to form) and to supervise others in their development of these factors
Ability to impart an understanding of the pace and non-linear process for recovery and ability to develop positive expectations for the person’s progress despite the combination of social, functional, and cognitive impairments that are commonly observed

Ability to help trainees and supervisees recognize incremental improvements and utilize the process of shaping in goal setting and recovery

Ability to impart knowledge of the phenomenology of the disorders of SMI (e.g., auditory hallucinations, negative symptoms such as diminutions of basic drives, conceptual disorganization, etc.)

Ability to supervise effective goal setting with persons with SMI/SED that is often different in quality (i.e., level of difficulty) and outcome (i.e., type of goals set) than those without SMI/SED

Ability to promote self-reflection and self-examination of fear, stereotypes, pre-conceptualizations of, and biases toward people with SMI/SED including stigma and self-efficacy

Ability to teach and supervise trainees about appropriate boundaries and differences in working with this population

Knowledge of standard tools for fidelity measures and ability to supervise trainees in their use

Ability to use live or audiotape feedback to understand the often complex nuances of work with persons with SMI/SED

Ability to supervise a range of other mental health providers (e.g., psychiatrists, peers, nurses, social workers, pharmacists, occupational therapists)

Management/Administration

*Competence in Understanding Organizational and Systemic Dynamics:*

By the completion of their training, residents should demonstrate an advanced level of knowledge of the various healthcare systems in which they have operated and have a broader understanding of health and mental healthcare systems both nationally and to some extent globally. They should show awareness of and sensitivity to systemic issues that impact the delivery of services. They should demonstrate a good understanding of organizational dynamics as well as systemic issues within programs, effectively functioning within various institutional contexts and appreciating how such forces impact and influence clinical care.

Knowledge of the complexity of systems change issues and ability to promote resiliency as resistance is encountered

Knowledge of needed systems of care and the importance of integration and interprofessional cooperation
Familiarity with reimbursement structures and with psychosocial services that are not funded or are partially funded and ability to secure funding for needed specialized services

Knowledge of Commission on Accreditation of Rehabilitation Facilities (CARF) requirements for accreditation and ability to implement policies and procedures needed to secure and maintain accreditation

Knowledge of Joint Commission and Centers for Medicare and Medicaid Services (CMS) standards and ability to implement policies and procedures needed to secure and maintain accreditation and ensure CMS standards are met

Knowledge of the Americans with Disabilities Act and its amendments and application to those with SMI/SED

Ability to lead effectively within complex interprofessional teams and settings

Knowledge of implementation and dissemination challenges and opportunities of EBPs for those with SMI/SED and the challenges of this in multiple, complex, uncoordinated settings

Recognition of the importance of conducting program evaluation and/or quality improvement studies and ability to convince management and team members of this

Ability to develop comprehensive programs across the full continuum of care that incorporates needed interventions such as supported employment and others

Ability to assist organizations to understand the importance of providing services within a recovery orientation

Knowledge of the complexity of systems change issues and ability to implement needed changes

Comprehensive knowledge of psychosocial assessments and interventions and ability to impart knowledge about these and ensure cooperation and implementation within teams and overall system

Advocacy

Competence in Working for Adequate, Appropriate and Equitable Systems of Care for Persons with SMI/SED:

Residents should have an understanding of, and appreciation for, the impact that stigma, self-stigma, discrimination, and social and community exclusion have on persons with disabilities and impairments of all kinds, especially those with SMI/SED. Residents should be prepared to work on behalf of, and together with clients, their families and friends to encourage, promote, and assist persons with SMI/SED to develop social networks, access appropriate health/mental health care, access needed social services, and fully participate in their communities.
- Ability to create opportunities for people with SMI/SED to meet and interact with others with and without SMI/SED, build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion

- Knowledge of community resources and ability to reach out to these as a means of expanding access to services for people with SMI/SED

- Knowledge of community resources and ability to intervene to help with access to care (e.g., family members trying to get members into care and navigate complex system)

- Knowledge of laws that affect individuals with SMI/SED negatively and may lead to human rights violations (e.g., laws about competency restoration process, not guilty by reason of insanity, etc.).

**Description of Training**

The goal of treatment is an individual’s recovery, measured not only as a reduction in symptoms but also as improved functioning and life satisfaction, and participation in environments of one’s choice. The majority of services provided are psychosocial rehabilitation interventions, although residents in this specialty may also provide traditional treatments such as psychotherapy, illness management, and supportive therapy. Embedded in this model is an interprofessional approach based on a recovery model that empowers persons with SMI/SED to develop personalized goals and choose from a menu of treatment program opportunities, including inpatient and outpatient services that are designed to help each person achieve the goals he or she has determined to be personally relevant. The goal of services is to improve community functioning and quality of life for persons with SMI/SED. Ensuring an active partnership with consumers and community linkages is an essential element of this work.

Training for post-doctoral residents in this specialty occurs in several main areas: primary and secondary placements, seminars, didactics, research, supervision, consultation, teaching, and administration. While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training experiences should exist across all programs. These may be called by different names but the content should be focused on learning how to use the specialized psychosocial rehabilitation assessments and interventions to help people with SMI/SED recover and attain their full functional capability – all within a recovery orientation.

Training is sufficiently broad to build on and enhance the foundation of knowledge, skills, and proficiencies that define professional health service psychology, and of sufficient depth to develop more focused competence and expertise in the specific area of SMI/SED. This is accomplished through involvement in focused didactics and clinical experiences on an SMI/SED team/unit and more general placements and didactics with post-doctoral psychology residents in other specialty areas where these exist at a given academic training site.
**Required Education and Training and Other Experiences**

Each resident’s training plan should be individually created to meet the specific training needs of the resident and to develop competence in the range of mental health and psychosocial rehabilitation skills specifically designed for individuals with SMI/SED. Training activities include attention to advancing development of core skills such as: specialized assessments, treatment interventions developed and researched specifically for this population, consultation and multi-disciplinary teamwork, research and scientific inquiry, supervision and teaching, ethics, program management and administration, and cross-cultural and diversity sensitivity. Residents should be prepared to leave their residency well-prepared to function successfully as independent scientist-practitioner and work effectively with persons with SMI/SED. Another goal of the residency is to train residents to function in leadership positions in settings to persons with SMI/SED. As a result, the resident should be prepared to transition to practice with an interprofessional team, promoting client-centered, recovery oriented care and interprofessional collaboration for specialized assessment and treatment of persons with SMI/SED.

Residents should expect to spend approximately at least 20 hours per week in a supervised, primary placement setting working with persons who have SMI/SED. This and all placements should operate based on a recovery orientation and utilize psychosocial rehabilitation practices as primary interventions. As residents increase their skill, confidence, and levels of responsibility, they should receive more complex cases, more independent clinical work, the ability to pursue their own training goals, and take on additional cases if desired. Residents also typically work with pre-doctoral interns and practicum students (where these are present), and are involved with the hierarchical supervision of these interns and students along with their clinical responsibilities on their rotations. The intensity and level of these activities would be determined in a collaborative nature between trainee, supervisors, and the Director of Training.

**Required Primary Placement**

All psychology post-doctoral residents should participate as members of an interprofessional team for approximately 20 hours per week for their primary clinical placement for the duration of the training year. The primary placement could take place in an outpatient unit or on an in-patient unit. The focus of the unit or team should be on recovery oriented psychosocial rehabilitation for those with SMI/SED. Residents would conduct screening, provide diagnostic clinical and strength based functional and resource assessments, work on goal-setting, provide psychoeducation to meet the person’s expressed needs, help motivate individuals to engage in treatment, provide evidence-based and promising practices specific to persons with SMI/SED, and assist in data collection, program evaluation, and quality improvement. Residents will also participate in one-to-one (and possibly group) supervision regarding specialized psychosocial rehabilitation and related clinical activities for an SMI/SED population. In settings such as these, residents learn about recovery-driven systems and the kinds of services provided and are members of interprofessional teams. Residents and other trainees also typically meet to review cases and process their experiences. They would also have the
opportunity to lead rounds and facilitate discussions, offering supervision and team leading experiences.

Core components that recovery oriented psychosocial rehabilitation units/teams would include (each residency program would determine which are best suited for their program):

- **Individualized assessment/re-assessment** including intakes, diagnostic clarifications, cognitive screening, functional assessment, rehabilitation readiness assessment, and recovery/treatment planning
- **Evidence-based and promising practices** such as family psychoeducation, assertive community treatment, supported education and supported employment (particularly the individual placement and support model), concurrent disorders treatment, social cognition and cognitive remediation training, early intervention and psychosocial treatments for recent onset psychosis, trauma informed and trauma specific care, illness management, issues and interventions for those in criminal justice and forensic settings, among others.
- **Individual or group psychotherapy** such as CBT for psychosis, social skills training, illness management and recovery, anger management skills, relationship skills, family psychoeducation, cognitive behavioral social skills training (CBSST), cognitive enhancement therapy, interpersonal psychotherapy, weight and smoking interventions, and solution-focused approaches including WRAP, etc.
- **Community integration skills**: interviewing skills, leisure/recreation skills, finding and retaining housing, practice applying the skills learned or developed in groups; working with community partners (e.g., NAMI; libraries, community recreation centers, senior centers, etc.).

**Required Secondary Placements and Other Training Experiences**

During the remaining 20 hours of the week, residents would participate in an additional rotation (also one that focusses on recovery and psychosocial rehabilitation for persons with SMI/SED), attend weekly didactic seminars, have supervisory sessions, and participate in other experiences designed to round out their understanding and knowledge of SMI/SED service provision. These are described below.

For their secondary placement, SMI/SED post-doctoral residents should participate as members of an interprofessional team on one or more units or teams that that are different from the primary placement but that also focus on recovery and provision of psychosocial rehabilitation services. These should be selected to broaden the resident’s training experiences. Examples could include: outpatient clinics, community programs, a short stay unit where treatment services for acute episodes of psychiatric illness are offered and where an individual is helped to stabilize, his or her level of functioning is improved, and connections with outpatient treatments that will help promote community integration are established, e.g., social skills training groups, providing family psychoeducation, etc. A number of distinct clinical programs should be available to residents for secondary placements. Within each of these, residents would work closely with a wide range of allied healthcare providers (nurses,
social workers, psychiatrists, occupational therapists, vocational specialists, recreational therapists, medical residents, dietitians, art therapists, peer support specialists, etc.), family members, and other partners. Clinical supervision should be provided by a licensed psychologist.

Seminars, Didactics and Teaching/Giving Presentations (see below for examples)

In addition to completing required primary and secondary placements, residents would also be required to attend seminars, didactic presentations, and supervision sessions. Readings are provided to enhance discussion during seminars and meetings. In order for residents to gain experience in teaching, participants would be encouraged to teach at least one session in an area of interest, and to submit abstracts for talks to be given at relevant conferences such as those of the Psychiatric Rehabilitation Association, Association of Behavioral and Cognitive Therapies, the American Psychological Association convention and/or local, state, or regional conferences with an interest in SMI/SED. If applicable, time is devoted to teaching the mechanics of giving psychosocial rehabilitation presentations, and providing feedback to participants as they rehearse these talks for presentation for larger audiences.

Topics and Concepts that are Relevant to Training in SMI/SED – (Note: Described below in seminar format; may be covered in Seminars, Workshops or Other Training Venues)

Principles of Psychosocial Rehabilitation: This weekly didactic seminar mirrors the training philosophy of the scientist-practitioner model and is designed to provide participants with a broad and thorough understanding of psychosocial rehabilitation interventions, principles, theories, and current research in clinical and community psychology. Sessions focus on the specialized assessments and evidence-based and promising practices designed, developed and empirically validated for persons with SMI/SED, stigma, ethics and boundaries (and how they differ from those in traditional mental health), and other relevant topics.

Interprofessional Case Assessment Seminar: This seminar should focus on learning about the unique assessment skills of each discipline to effectively work in a collaborative manner to create and provide a comprehensive, recovery-focused, holistic and interprofessional approach to treatment for persons with SMI/SED. In order to facilitate this learning, residents would be assigned to interprofessional teams where they work with a number of different individuals with SMI/SED. Assessments would be carried out outside of the seminar meetings. Residents would be expected to work collaboratively with each other throughout the entire process of the assessment from beginning to end which includes selecting assessment tools, scheduling times to conduct the assessment, writing the assessment report and presenting feedback to the treatment team and the individual. Residents would be assigned at least one case, and preferably two or more, as part of the interprofessional team.

Systems Change Seminar: A didactic seminar comprised of discussions about leadership, management styles and professional development. Residents should meet with a range of leaders and managers, who lead discussions on topics ranging from mentoring, decision-making, workforce development, career paths, negotiation styles, politics in organizations and leadership in education and
community organizations, all with an eye toward effecting systems change to reflect relevant mental health policies for recovery and rehabilitation for persons with SMI/SED.

**Diversity Seminar:** NOTE: While targeted diversity training is required, note that diversity training for all those working with persons with SMI/SED is primarily practical and applied. Issues related to the full range of human diversity should be incorporated into all aspects of training including primary and secondary placements, seminars, lectures, and supervision sessions.

In the Diversity Seminar itself, training is provided in terms of addressing ethical issues, as well as attitudes, knowledge, and skills in relation to all forms of diversity. Residents are expected to demonstrate sensitivity to the full range of human diversity and make a substantial effort to recognize, understand, appreciate and discuss topics such as age, sex, gender, ability/disability/illness, culture, ethnicity, race, language/culture of origin, sexual orientation, socioeconomic status, and religious/spiritual beliefs and attitudes, among others, as well as the intersection of these and how they are considered and integrated in provision of services.

While topics and speakers will likely cover a broad range, those that are particularly pertinent to persons with SMI/SED should be highlighted. Among others, important topics include: the poor attention often given by health care providers to physical health complaints of persons with SMI/SED, misattributions of legitimate health concerns to psychotic symptoms, discriminatory practices including failure to follow treatment guidelines when people of color and diverse cultural backgrounds are seen, and need for attention to language barriers, traditional beliefs about mental illness, and religious/cultural issues.

The exploration of power differentials, dynamics, and privilege should be at the core of understanding issues of diversity and impact on social structures and institutionalized forms of discrimination that may influence the person’s perception of her/his potential for improved quality of life. In addition to the presence of mental health symptoms, factors such as gender, age, ethnicity, race, sexual orientation, migration history, trauma history, and childhood adversity have all been found to influence patterns of diagnosis and access to treatment among persons diagnosed with SMI/SED, and thus must be considered as psychologists engage in assessment, case conceptualization and formulation, and intervention.

**Laws and Ethics Seminar:** This seminar would cover information such as informed consent, HIPAA, confidentiality, reporting laws, an individual's access to his or her own medical record, code of conduct, acting ethically / avoiding ethical complaints, patient-therapist relationship issues, record keeping guidelines, forensic issues, research ethics, and other topics that may be of timely interest.

**Research / Program Evaluation and Dissemination Seminar:** Residents should gain experience in identifying, reviewing, and contributing to the scientific literature and knowledge base. Each resident should be expected to design, develop, and implement an educational dissemination project that can be presented at a relevant national, regional or local conference. The purpose of this project is to disseminate novel approaches to psychosocial rehabilitation for people with SMI/SED. This seminar
is designed to assist in the formulation and execution of the education dissemination project and would focus on topics such as overviews of research and evaluation of psychosocial rehabilitation assessment and intervention, research and evaluation methods, research dissemination, and critical reviews of research. An educational dissemination project could include designing a new psycho-educational group or program, implementing a focus group, evaluating an existing treatment program, participating in an ongoing research study and presenting research findings, writing a literature review manuscript, submitting a grant application, developing an impact statement or a policy initiative, designing and evaluating a new group or program, etc.

Consultation Seminar: This seminar should provide didactic training and opportunities to discuss issues pertaining to consultation at the individual, team, and system levels. Within the bounds of confidentiality and privacy, residents must be able to listen, understand, communicate, and display excellent rapport and proficiency with relevant stakeholders including persons with SMI/SED, family members, relevant community members, interdisciplinary staff and other healthcare providers within and outside of the system, and community agencies and partners. Leaders, faculty, and staff from other disciplines should be involved to serve as discussants to provide multiple perspectives.

The seminar also provides training to assist residents in providing consultation to interdisciplinary teams within the medical and or academic setting on how to implement EBPs for SMI/SED, best practices in psychosocial rehabilitation and community integration, and recovery-oriented mental health care. Residents provide consultation to community providers working with individuals with SMI/SED (examples may include providing training, technical assistance, case consultation, etc.).

Professional Development Seminar: This seminar should focus on professional development and would typically include all psychology post-doctoral residents at the academic site. Topics would include: applying for a career development award, general licensure requirements, both broadly and specific to the jurisdiction of the residency, studying for the EPPP, obtaining employment, managing a research and clinical career, and other timely topics of interest to professional health service psychologists.

Teaching and Supervision

Residents should perform clinical supervision of pre-doctoral practicum students and doctoral interns (where the residency setting also has interns and pre-doctoral students), be supervised themselves by experienced clinical trainers, and take part in workshops or other training opportunities to develop their own supervisory skills. Residents should demonstrate knowledge of methods of teaching specific to psychosocial rehabilitation and related clinical activities for the SMI/SED population in case conferences, seminars, didactics, journal clubs or other venues and be able to effectively translate knowledge of specialized psychosocial rehabilitation and related clinical activities for the SMI/SED population to interprofessional audiences.
Residents should also demonstrate knowledge of methods of providing supervision to other psychology trainees that emphasize skill building in providing patient care, consulting with other professionals, identifying relevant scientific data and conducting research, and practice management specific to psychosocial rehabilitation and related clinical activities for the SMI/SED population. Topics could include: models of supervision, clinical competency, goals of supervision, reducing anxiety in supervision, silence, countertransference, supervision and ethics, risk management, self-care for the therapist and supervisor, and awareness and understanding of the full range of human diversity.

**Supervision Meetings**

**Clinical Consultation Meetings:** These meetings provide residents opportunities to learn more about how to work with those who have SMI/SED and can include processing past group or individual sessions, reviewing skills, role playing exercises, and learning more about various theories as well as practice tools and techniques. Residents may also participate in interprofessional educational activities such as patient-care rounds, case conferences/team meetings, and/or formal educational opportunities.

**Individual Supervision with Training Faculty:** Residents should have the opportunity to meet with a faculty member to discuss program matters including administrative needs, educational plans, professional development, systems issues, and other matters of individual interest.

**Didactic Content Covered in Seminar or Lecture Format and in Supervision**

**NOTE:** The information presented below is comprised of examples of current assessments and interventions. These could not all be covered in depth in a one year or even in a two year post-doctoral residency program. However, residents should be made aware of the breath and distinctiveness of assessments and interventions available and provided information about them. Each residency program would decide which of the assessment instruments and interventions would be required and/or emphasized. An overview of the assessments and interventions is provided in Criterion VI of the Petition for Recognition of a Post-Doctoral Specialty in Assessment and Treatment of Persons with Serious Mental Illness / Severe Emotional Disturbance which can be accessed at [www.psychtrainingsmi.com](http://www.psychtrainingsmi.com).

For an excellent scholarly review of the many assessments that have been developed, see the chapter by Glynn and Mueser (in press) which presents a comprehensive review along with information about the psychometric properties of each instrument. Additionally, a short presentation is offered in APA’s curriculum for training psychologists for work with persons with SMI/SED (American Psychological Association & Jansen, 2014). The curriculum provides information about many relevant recovery-oriented assessments and most of the psychosocial rehabilitation evidence based and promising practice interventions and is available for free at [www.apa.org/pi/rtp](http://www.apa.org/pi/rtp).
Assessments and Interventions Specific to SMI/SED

Assessment – General

• Selection, administration, scoring and interpretation of psychological tests for persons with SMI/SED

Integrating data and preparing written reports specific to SMI/SED population
Dissemination of psychological test findings to individual and relevant stakeholders

Assessment – Specific

• Culturally Informed Assessment

The DSM 5 Cultural Formulation Interview

• Symptom Assessment/ Diagnostic Assessment

Structured Clinical Interview for DSM-5 (SCID-5)
The Brief Psychiatric Rating Scale (BPRS)
Scale for the Assessment of Negative Symptoms and Positive Symptoms (SANS-SAPS)
The Positive and Negative Syndrome Scale (PANSS)
The Revised Behavior and Symptom Identification Scale (BASIS-R)
Mini International Neuropsychiatric Interview (MINI)
Clinician Administered PTSD Scale (Schizophrenia) (CAPS-S)
Clinical Assessment Interview for Negative Symptoms (CAINS)
Brief Negative Symptoms Scale (BNSS)

• Cognitive Screening/Evaluations

Mini–Mental State Examination (MMSE)
Montreal Cognitive Assessment (MoCA)
Brief Neurocognitive Assessment (BNA)
Cognitive Assessment Inventory (CAI)
The MATRICS Consensus Cognitive Battery (MCCB)
Standard neuropsychological measures

• Decision making capability/capacity

Aid to Capacity Evaluation (ACE)
MacArthur Competency Assessment Tool for Treatment (MacCAT-T)

• Strength Based Assessment

The Self-reported Quality of Life Measure for People with Schizophrenia
The Client's Assessment of Strength, Interests, and Goals (CASIG)
The Psychiatric Rehabilitation Services Toolkit
• Readiness Assessments

Psychiatric Rehabilitation Training Technology - Readiness Assessment

• Functional Assessment

The University of California San Diego Performance-based Skills Assessment (UPSA-B)
Specific Levels of Functioning (SLOF)
The Multidimensional Scale of Independent Functioning (MSIF)
The Maryland Assessment of Social Competence (MASC)
Camberwell Assessment of Need (CAN)
Social Adjustment Scale-II (SAS-II)
MIRECC-GAF

Psychiatric Rehabilitation Training Technology - Functional Assessment

The Social Performance Schedule
The Social Functioning Scale (SFS)
The Social-Adaptive Functioning Evaluation (SAFE)
The Independent Living Skills Inventory (ILSI)
The DSM-IV Social and Occupational Functioning Assessment Scale (SOFAS)

• Risk Assessment – (Note: the predictive accuracy of instruments in this category “remains a source of considerable uncertainty” (Fazel, Singh, Doll, & Grann, 2012)

Psychopathy Checklist-Revised (PCL-R)

*Goal Setting and Treatment Planning*

• Recovery paradigm and model of care

• Methods for engaging individuals with SMI and SED, their families and support systems in treatment

• Client Centered and Shared Decision methods

• Treatment and recovery planning methods that differ from traditional treatment planning

*Interventions and Related Content*

• Assertive community treatment

• Family psychoeducation

Family therapy - includes Behavioral Family Therapy
Family Education Workshops
Multi-Family groups

• Supported Education and Employment
Individual Placement and Support (IPS) model
  • Structured/focused psychotherapy

CBT
CBTp
Acceptance & Commitment Therapy
Dialectical Behavior Therapy
  • Skills training

Social Skills Training (SST)
Cognitive Behavioral Social Skills Training (CBSST)
Behavioral Management for Auditory Hallucinations – Managing Voices
Anger Management for people with SMI/SED
  • Illness Management and Recovery

Medication management
Wellness Recovery Action Plans (WRAP)
Psychosis Support Group
  • Cognitive Retraining

Cognitive remediation
Social Cognition and Interaction Training
  • Peer Services

Peer Support
Peer run/delivered services
  • Token Economy

  • Psychosocial Interventions for Weight Management

  • Psychosocial Interventions for Stopping Smoking

Physical health/common health problems/health behaviors
  • Integrated Dual Diagnosis Treatment for Co-morbid Substance Use Disorders

  • Psychosocial treatments for recent onset schizophrenia (RAISE/NAVIGATE protocol)

  • Trauma Specific Interventions, (e.g., Cognitive Processing Therapy, Prolonged Exposure, CBT for PTSD)

  • Interventions for individuals with SMI and SED in the Criminal Justice and Forensic systems
• Interventions for those who are homeless or at risk of homelessness.
• Interventions to reduce stigma, social isolation, and community exclusion
• Interventions for suicide prevention
• Implementation and Dissemination Strategies Specific to SMI/SED Interventions

Other Content Specific to SMI/SED

Etiology/Epidemiology

• Stress-vulnerability Model of SMI/SED
• Neurobiologically/neurophysiologically/neurocognitive phenomena
• Biopsychosocial Model

Premorbid/Prodromal
1st episode
Untreated psychosis
Residual
Older adult/aging
Physical health/common health problems/health behaviors

Co-occurring conditions

Substance use, trauma, suicidality, personality disorders)

Psychopharmacology for SMI/SED

Medications and side effects /iatrogenic effects of treatment, treatment adherence

History/Community Advocacy/Ethics/Diversity/Other Issues

• History of Treatment of Persons with SMI/SED

Deinstitutionalization, history of coercion, clubhouse model, empowerment movement

• Advocacy groups/community resources
• Diversity/Individual differences specific to persons with SMI/SED
• Ethical treatment of persons with SMI/SED
• Legal Considerations/civil rights/criminal justice; decision making capacity
• Violence and Aggression – by persons with SMI/SED and against persons with SMI/SED
• Systems of Care/settings for care provision
• Discrimination, stigma

• Self stigma

• Decision making capacity

Research, Evaluation and Scientific Methods

• The most appropriate methods for conducting research with and for this population, including participatory action research and mixed methods approaches

Consultation and Systems Change Methods

• Methods for changing mental health systems to incorporate a recovery and psychosocial rehabilitation perspective.

Sequence of Training

A resident’s clinical training follows a progression from didactic learning and observing supervisor modeling (in vivo service delivery with persons with SMI/SED and role plays in supervision), to continued learning and delivering services to persons with SMI/SED with direct observation of resident-delivered services by the supervisor and/or with supervisor and resident as co-therapists, to increasingly autonomous, albeit monitored and supervised, service delivery. All services should be provided within the context of the recovery orientation building on the client’s strengths, and focused around the person’s goals and psychosocial rehabilitation services designed to meet those goals.

In the beginning of the training year, caseloads are lower, with increasing intensity as the year progresses. Resident progress is assessed by clinical supervisors during the course of informal and formal supervision, and supervisors and residents are expected to exchange feedback routinely as a part of the supervisory process; the evaluation procedures are meant to formalize this continuous information flow. While it is the responsibility of the training director and supervisors to ensure that evaluation occurs in a timely and constructive fashion, residents are encouraged and expected to take an active role. As trainees progress and increase their confidence and levels of responsibility, they receive more complex cases, more independent clinical work, the ability to pursue own training goals, and take on additional cases if desired. This is all determined in a collaborative nature between trainee, supervisors, and the Director of Training.

While training will build on and enhance the foundation of knowledge, skills, and proficiencies that define the practice of professional health service psychology, post-doctoral training in this specialty must be of sufficient depth to develop more focused competence and expertise in the specific area of SMI/SED. This is accomplished through involvement in focused didactics and clinical experiences on teams and units devoted to working with persons with SMI/SED. Residents may also take part in more general placements and didactics with post-doctoral psychology residents in other specialty areas where these exist at a given academic training site.
A sample curriculum along with a sample sequence of training can be found in the Petition for Recognition of a Post-Doctoral Specialty in Assessment and Treatment of Persons with Serious Mental Illness / Severe Emotional Disturbance (Criterion VII) which can be accessed www.psychtrainingsmi.com.

**Supervision**

At a minimum, two weekly hours of individual supervision must be conducted by doctoral-level licensed psychologists who are involved in an ongoing supervisory relationship with the resident and have professional clinical responsibility for the cases on which they provide supervision. A postdoctoral resident must have a minimum of two doctoral level licensed psychologist supervisors, at least one of whom serves as the resident’s primary supervisor.

Supervisory hours beyond the two hours of individual supervision may be provided either individually or via group supervision and must be provided by professionals who are appropriately credentialed for their role/contribution to the program. The primary licensed psychologist supervisor maintains overall responsibility for all supervision, including oversight and integration of supervision provided by other mental health professionals with psychological research and practice.

**Resident and Program Evaluation**

During each rotation, there should be a written evaluation of the residents’ progress as well as verbal feedback given to the residents by each supervisor and the Director of Training. Feedback should be provided at several times during the rotation with the exact timing dependent on the duration of the rotation. Competency evaluations would typically be behaviorally based and any deficit areas addressed with the resident. Particular attention should be paid to ensuring that residents act ethically and with understanding of and respect for the full range of diversity issues, particularly as these relate to persons with SMI/SED. Additionally, rotation learning objectives would be reviewed mid and end of rotation to determine appropriateness and status.

Residents would also be evaluated on their knowledge, skills and abilities related to their understanding and ability to use didactic and seminar information, ability to participate in supervision and to supervise others, provide consultation, teach and or provide training, work in interprofessional and discipline specific teams, and conduct research/evaluation activities.

At the end of each rotation, residents would normally complete an evaluation of supervisors and rotations, and at the end of the residency, evaluations of the residency overall, research opportunities, didactics, seminars and other components. This feedback will be used to modify, improve, and/or enhance the quality of residency training.

The Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED), is attached and may be used to evaluate residents and others who are developing competency for work with persons with SMI/SED.
This instrument is a modification (modified and used with permission) of the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel, et al., 2012).

The Petition for Recognition of a Post-Doctoral Specialty in Assessment and Treatment of Persons with Serious Mental Illness / Severe Emotional Disturbance contains additional useful information and sample forms and may be accessed at www.psychtrainingsmi.com.

In Conclusion

These Training Guidelines were developed to provide guidance for post-doctoral psychology residency programs in SMI/SED but may be used by any level of training program desirous of providing training for those wishing to work with persons with SMI/SED. A taxonomy for training psychologists in SMI/SED by level of training is available and is included in the Specialty Petition. The Guidelines are supported by additional information and materials previously developed including APA’s Curriculum to train psychologists in recovery and rehabilitation practices for persons with SMI/SED (American Psychological Association & Jansen, 2014) and the Petition for Recognition of a Post-Doctoral Specialty in Assessment and Treatment of Persons with Serious Mental Illness / Severe Emotional Disturbance developed for submission to APA in application for recognition of this specialty. These and other materials are free and available on line and will be updated as new information and developments become available.

References


Petition for Recognition of a Post-Doctoral Specialty in Assessment and Treatment of Persons with Serious Mental Illness / Severe Emotional Disturbance (www.psychtrainingsmi.com)
Appendix II: Clinical Practice Guideline Toolkit

Clinical Practice Guideline Toolkit for Psychologists Working with Persons with Serious Mental Illness/Severe Emotional Disturbance

Introduction

This document presents a short, easy to use guideline for psychologists working with people with SMI/SED, particularly those with schizophrenia, schizoaffective disorder, delusional disorders, other psychotic disorders, or depression with a significant impact on functioning, and may be of use for those working with individuals with bipolar disorder. Persons with these disorders may have co-morbid, but not primary, substance use, exposure to trauma, or personality disorders. Individuals with severe emotional disturbance (SED) are typically youth/adolescents who have early warning signs of psychosis or early onset psychosis. For youth with early warning signs, this period is often referred to as the prodromal syndrome.

The guideline presented here is comprised of a 6 page flowchart depicting the assessment and treatment steps psychologists should be aware of and be able to use with this population. Each step in the flowchart is accompanied by a short (1 – 3 page) explanation of the components of that step. The explanation is fully referenced for those wishing further information or clarification. This document is a modification of an article in press by the writer (Jansen, in press) which was written for a more general audience.

This guideline is not meant to supplant the more detailed, and excellent clinical practice guidelines that have been developed and published. Rather, the flowchart and explanation are designed as a short, step by step guide or tool that busy psychologists can use to ensure they are following the most appropriate course of action and providing the best psychosocial rehabilitation services possible for persons with these disorders. Program managers and administrators can also use this tool to evaluate the processes used in their service system to ensure that appropriate services are offered for the individuals in their care.

This guideline is also not meant as a substitute for comprehensive training in the practice of assessment and treatment for individuals with SMI/SED. As such, very little detail about the disorders, appropriate assessments and interventions is provided. Those providing services to people with SMI/SED should have received the specialized training needed to appropriately deliver the services needed by those with these disorders. Well trained psychologists will recognize that the process may appear to be simple and short; in reality providing services to this population is typically a lengthy and complex process requiring specialized training, knowledge, skills, and experience.

This information can be useful either for psychologists in frontline positions or in management and administrative positions. But, it does not include guidance about assessments and approaches that members of every profession might need such as prescription and management of medication, provision of substance abuse treatment, provision of independent living skills training, provision of
peer support services, or provision of assistance with placements for specialized housing, to name but a few. These other treatments and services are often needed by those with SMI/SED due to the many comorbidities and difficulties they frequently encounter and psychologists should help individuals access these services to ensure a comprehensive approach.

This guideline tool focuses on the process of delivering psychological and psychosocial rehabilitation services within a recovery framework. At this time, our knowledge about which services, or combination of services will work best for whom, under what specific circumstances, at what stage in a person’s illness, and which providers are likely to have the most success is evolving. Presently, there is evidence that a combination of services provided to those in the prodromal period before onset of full psychosis or those experiencing a first episode of psychosis can be useful for preventing, delaying or reducing the severity of future psychotic illness. There is also emerging evidence that for those beyond the first episode, a combination of services that includes a range of cognitive treatments may be the best approach. These examples are provided in more detail in this guideline because the evidence is fairly clear at this time; however, suggestions about particular combinations of services beyond these two circumstances are not provided because to date, the evidence has not coalesced around any particular combination of treatments.

Other, more comprehensive guidelines such as the National Institute for Health and Care Excellence (NICE) (2014) guideline entitled Psychosis and schizophrenia in adults: prevention and management present detailed recommendations for each stage in psychosis from prevention through to first episode intervention, and on to comprehensive assessment and treatment. Psychologists as well as those in leadership positions such as team management and or administration should consult this and other comprehensive documents to ensure that the full range of needed services is provided, either through referral to appropriate agencies and providers, or through appropriate professionals within the team or agency, and to ensure that fidelity to evidence based practices is followed wherever possible. As of the writing of this document, the most comprehensive of these other guideline documents is the NICE guideline which can be accessed at https://www.nice.org.uk/guidance/cg178. The NICE guideline also contains a section on SED in youth and young adults, and as such is a comprehensive reference. There is also a NICE guideline for bipolar disorder, a guideline for substance use disorders, and guidelines for trauma and violence among others. These are excellent and comprehensive documents which are available on the website.

Notably, implementing the array of services that persons with SMI/SED find useful and desire can be challenging. This document is not meant to imply that providing this array of services is easy; on the contrary there are often substantial challenges to implementation and sustainability. A short discussion of some of these is presented in the final section along with some suggestions which may be helpful for overcoming these challenges.
Clinical Practice Guideline Flowchart

Step 1: Determination of Client’s Desire for Services

Step 1: An Individual is Referred for Services

- Individuals with SMI or those with early warning signs who have SED can be referred for clinical services or they may refer themselves for services. In either case, it is important to explain the kinds of services available and determine if the person wishes to receive such services.

- In the event the person indicates a desire to not receive services, determining if the person would be open to learning more about the services available, including the potential benefits he or she could expect to receive is the first step. If the person declines to receive such information, it may be that the individual is experiencing the period before onset of full psychosis. This period has been called the “prodromal period”, and those in this state have been said to be at “ultra high-risk”, or to be experiencing an “attenuated psychosis syndrome” (Yung, Woods, Ruhrman, Addington, Schultze-Lutter, et al., 2012); the rate of onset of a psychotic disorder has been shown to be thirty six percent within three years (Fusar-Poli, Bonoldi, Yung, Borgwardt, Kempton, et al., 2012). For those at this stage, early intervention with a combination of interventions can be critical to help individuals avoid the severe developmental delays that often occur when SED is left untreated and progresses to SMI.

- If the person is in the prodromal state or is experiencing a first episode of psychosis, a referral for early psychosis intervention services should be made because evidence indicates that reducing the duration of untreated psychosis leads to better long term outcomes (McGlashan, Evensen, Haahr,
Hegelstad, Joa, et al., 2011) and the longer intervention is delayed, the poorer the long term outcome. Although there are many factors that influence functional outcomes, there is growing evidence that early intervention with pharmacologic and psychosocial interventions during the first episode of psychosis can lead to improved outcomes (Álvarez-Jiménez, Parker, Hetrick, McGorry, et al. 2011; Bertelsen, Jeppesen, Petersen, Thorup, et al., 2008; Bird, Premkumar, Kendall, Whittington, et al., 2010; Kane et al., 2015) and may prevent or delay relapse (Álvarez-Jiménez, et al., 2011). Early intervention programs generally include the provision of multimodal psychosocial interventions (cognitive behavioral therapy, family based psychoeducation, illness management, educational and vocational interventions), pharmacotherapy, and some form of case management with lower case-loads and an assertive approach to treatment, all provided as early as possible.

If the person has progressed beyond the prodromal or first episode period and has developed an SMI, and declines to receive information about possible services, he or she should be given information about how to re-establish contact if desired at a later time and the referral would be terminated.

In the event the individual is unsure about taking part in services but agrees to receive the information offered, a description of the process, focus on attainment of client determined goals, and expected outcomes should be explained without exerting pressure on the person to continue. Presentation of such information is sometimes referred to as readiness assessment or readiness development (Anthony & Farkas, 2009) and is offered to encourage hope that by taking part in the services, the person’s goals have a greater chance of being realized. Employing stages of change models and intensive assertive outreach can help people come to terms with their illness, the prior experiences they’ve had, the multiple issues they face, and potentially become ready to confront these challenges (Davidson, Roe, Andres-Hyman & Ridgway, 2010).

Following presentation of the information, the person should be asked if he or she wishes to participate in services. If the person declines, he or she should be referred for early psychosis intervention services if in the prodromal state or experiencing a first episode of psychosis; in all cases, information about how to re-establish contact if desired at a later time should be provided and the referral would be terminated. For everyone with mental health concerns, peers can be helpful and can enable an individual to feel more comfortable talking about the problems that are occurring and the opportunity to connect with a peer supporter should be offered.

If the person has decided to participate in services, or at least to take the first step toward participation, he or she is asked to identify one or more supporters who will assist as he or she moves through the process. These individuals, referred to in the flowchart as the support team, are full participants with the individual (as he or she wishes) and can assist in many ways. Note that the process is fully participatory, i.e., based on the notion that every person, including those with SMI/SED, has the right to make choices about the services to be received. Thus psychologists will likely offer suggestions and guidance about potential services, but the individual identified as the client should be the one directing his or her own service delivery plan (Green, Estroff, Yarborough, Spofford, Solloway, Kitson & Perrin, 2014).
Step 2: Goal Identification and Assessment of Clinical Indicators, Strengths and Resources

NOTE: This and all remaining steps are carried out with the client & the team supports identified by the client unless otherwise directed by the client.

A true partnership with recipients of services, based on establishment of trust and rapport must be established if clinician suggestions are to be taken seriously and for services to be effective. Such a partnership is at the heart of person centered planning and shared decision making and can only be accomplished when the individual is the one who decides what goals he or she wishes to achieve, what services will best help him or her achieve the goals he or she has, and which providers would be best to facilitate the process (Zisman-Illani, Barnett, Harik, Pavlo, & O'Connell, in press).

At the beginning of Step 2, a process is initiated whereby the person identifies his or her short and long term goals. Those goals that can reasonably be expected to be accomplished within one year are chosen as short term goals and constitute those that become the focus of services. Longer term goals can be returned to once short term goals have been accomplished and a progress or monitoring review determines that the person is satisfied and wishes to continue and move on to longer term goals. Typically, the goal identification process would be repeated as the person’s original long term goals may have changed after short term goal attainment has been accomplished.
Each person’s goals should be written in the language used by the individual and can be written fairly broadly. Examples of broadly written goals include: “I want to be symptom free” or “I need to be able to deal with my symptoms”, “I want to be able to think more clearly”, “I want to return to school”; “I want to have a job”; “I want to live on my own”, etc. All should be discussed fully including those that, to the clinician, may seem unrealistic; importantly the biases of the clinician should not supersede the wishes of the person receiving services. Each goal must be written down so that it is clear to the person and to all involved in the process, i.e., support team members and service providers.

Once the individual has decided on the goals he or she wishes to achieve, the assessment process can begin. In broad terms, two kinds of assessments are conducted: clinical assessments and assessments designed to identify the person’s strengths and the resources available to the person.

Clinical assessments that provide information about medical history, diagnosis, distressing symptoms, medication use, alcohol and drug use, physical health/co-morbidities, neuropsychological status and cognitive functioning, etc., can be useful to psychologists as this information may be important when goals, skills, resources, and interventions are considered. It is crucial for psychologists to be aware of the potential for bias that is often introduced upon learning about a person’s clinical status, and the potential impact of that bias on service planning and implementation of psychosocial interventions (Kaplan, 2013; Kopera, et al., 2015; Thornicroft, Rose, & Kassam, 2007).

A strengths based assessment measures skills, competencies and characteristics that contribute to a person’s sense of accomplishment and self-worth and contribute to satisfying relationships with family members, peers, and friends, enhance one’s ability to deal with adversity and stress, and promote development. A strengths based assessment that includes functional capability and resources available is needed for each goal the individual has identified.

More specifically, this component of the assessment process identifies strengths, skills, talents, accomplishments and challenges, in as much detail as possible; this approach also includes a determination of resources available or desirable in the person’s surrounding environment such as his or her natural support network including family strengths, peer and community supports, and social service system network. A strengths based approach recognizes that every individual, no matter how severe the person’s illness might be, has the capacity to continue to learn and develop. This capacity means that each person has the potential for future accomplishments that will facilitate continuing to attain the life he or she wishes to achieve (Davidson, Rowe, Tondora, O’Connell, et al., 2008; Pratt & Mueser, 2002).

Information for this assessment should be gathered about several life domains including emotional and psychological aspects, living situation, educational and vocational accomplishments and aspirations, socialization and leisure, financial and legal situation, and everyday circumstances in such realms as independent living, transportation, money management, etc., i.e., all the things considered most important to an individual.
There are many strengths-based assessments that have been developed; most are limited to one or more domains such as independent living and many have little empirical validation information available. Two that are broader in scope and have been empirically tested are the Client's Assessment of Strength, Interests, and Goals (CASIG), a version completed by a clinician (Wallace, Lecomte, Wilde & Liberman, 2001), the CASIG-SR, a self-report version, and the CASIG-I, an informant version (Lecomte, Wallace, Caron, Perreault, et al., 2004), and the Psychiatric Rehabilitation Training Technology: Functional Assessment (Cohen, Farkas & Cohen, 2007). These are by no means the only instruments available; psychologists should investigate the range of available measures and determine which will best meet the needs of the individuals they serve.

An important component of both clinical assessment and assessment of strengths and resources is the impact of the many cultural factors that can influence an individual’s responses, experiences, development, health status and functioning. Examples include racial and cultural identity, gender identity and sexual orientation, social and economic factors, to name just a just a few. Psychologists need to be aware of the literature and be able to monitor their own biases, including their own prejudices and resulting stigma. Be especially cognizant of subtle language differences, beliefs about the etiology and acceptability of mental illness and gender concerns. These factors become critically important for assessment of immigrants, refugees, and children of these groups (Ellis, Lincoln, Charney, Ford-Paz, et al., 2010; Ellis, Miller, Baldwin, & Abdi, 2011; Said-Foqahaa, 2011).

Given the critical nature of trauma and the role that this may play or have played in a person’s life, psychologists need to be especially sensitive as they help the person identify the many facets and components of their life situation. Information from all domains should be factored into treatment planning recommendations to ensure a comprehensive plan is developed.

Determining an individual’s strengths and capabilities is important for children and young people as well. The Outcomes Roundtable for Children and Families (a consortium of researchers, youth, family members, providers, and policymakers) identified important outcomes that all families want for their children, and noted that families seeking services for children with mental health concerns want services that promote the development of competencies, and functional lifetime outcomes. This focus transcends symptom reduction, and goes beyond reduction of deficits (Bellonci, Jordan, Massey, Lieberman, Zubritsky & Edwall, 2012). Psychologists conducting an assessment with youth should take these factors into account as well.

Once all components of the assessment have been completed a meeting is held with the client and the person’s support team where all aspects of the assessment are reviewed and discussed. Following this, a comprehensive summary should be written that pulls together all information into an integrated whole that paints a coherent picture of the person and his or her world. All aspects of the assessment and summary are shared with the person, support team, and others according to the person’s wishes.
Step 3: Plan Development

Following establishment of broadly defined goals and assessment of clinical status, strengths, functional capabilities, and available resources, objectives, i.e., the next steps needed to reach each identified goal must be identified. Objectives should be based on the results of completed assessments and are designed with the strengths and abilities of the person in mind. Objectives usually include the steps needed to overcome a challenge or barrier that was identified during the assessment or that is identified as the process moves forward. Objectives are developed with the person and should be achievable and realistic in that person’s eyes.

The SMART (Doran, 1981) mnemonic adapted by Tondora (2011) for identifying objectives and the steps within each objective for every goal can be used in this process. Using this mnemonic means that each objective or step should be specific, measurable, attainable, realistic and have a realistic time frame for each. For each objective, there will likely be several steps and each of these will require an intervention. Specific guidance for accomplishing this step can be found at www.ct.gov/dmhas/lib/dmhas/publications/CSP-GoalsObjInt.pdf

Once all of the objectives and steps have been identified, fully discussed and a copy of all provided to the client and support team, it is time to determine which interventions or services are
needed to accomplish each step in each objective. Like objectives, interventions should be written in detail and should identify what the intervention will consist of, who will provide it, how often it will be provided, where it will occur, and for how long it will be provided. This requires a discussion of the strengths, resources and supports available, based on the assessments already completed. While interventions are often thought of as the purview of professionals, they may also be activities that are carried out by family members, supporting individuals, or by utilizing resources available in the community.

For people with SMI/SED, attainment of life goals often requires substantial assistance in the form of specially designed psychosocial rehabilitation services. While some people with SMI/SED may recover without assistance, many are unable to recover sufficiently to achieve the quality of life they desire without these specialized services (Moseley, Shen, & Cochran, 2008; Priester, et al., 2016; Silverstein, 2000; Therien, Lavarenne, & Lecomte, 2014; Van Hasselt, Oud, & Loonen, 2013). Several psychosocial rehabilitation services have been developed to overcome the psychological and behavioral deficits that so many individuals with SMI/SED confront. Those that have been shown in multiple randomized clinical trials to be highly effective are known as evidence based practices (EBPs); there are also several promising practices that are considered highly beneficial interventions (Dixon, Dickerson, Bellack, Bennett, et al., 2010).

Within the last few years research evidence has accumulated indicating that an integrated approach combining multiple interventions within a recovery oriented context may be the most effective approach (Lyman, Kurtz, Farkas, George, Dougherty, et al., 2014; Spaulding & Deogun, 2011) and scholars are increasingly calling for such an integrated, recovery oriented system (Davidson & Chan, 2014). Such an approach must be targeted to the unique needs of each individual including those in forensic and criminal justice systems (Epperson, Wolff, Morgan, Fisher, Frueh & Huening, 2011; Strauss, 2014). Because cognitive impairment impacts the functional skill deficits so commonly experienced by people with SMI/SED, integrated approaches should include cognitive enhancement approaches as a fundamental component (Ikebuchi, et al., 2017; Mueser, et al., 2013; Pfammatter, Brenner, Junghen & Tschacher, 2011; Roder, Mueller & Schmidt, 2011). Social cognition training and cognitive remediation to improve community functioning and executive processing skills are considered by some to be essential. Indeed, some have stated that including cognitive remediation “may result in a magnitude of change that exceeds that which can be achieved by targeted treatments alone” (Pinkham & Harvey, 2013, p. 499).

Notwithstanding the above, no definitive combination of approaches has been determined to be most effective, although some combination of cognitive therapies (cognitive remediation, social cognition training, cognitive behavioral therapy), supported employment, psychoeducation (client/family approaches, illness management approaches), peer support services, and social and communication skills training, seems to be most promising. At the end of the day however, the range of interventions decided upon must be those that the client determines to be most appropriate for helping him or her to accomplish the goals he or she has chosen.
The totality of this information constitutes the treatment plan and, depending on the skills and resources available to the person, could be quite long with a long list of objectives, steps and interventions needed in order to reach the goal. Ensuring coordination among all involved is crucial. Thus, the person to be served, members of the support team, agency professionals - all involved in helping to accomplish a specific step or objective - need to be on board and working in sync.
Step 4: Implementing Services to Accomplish Identified Goals

In order for services to be successful, some conditions must be met. While there are several, three of the most important are mentioned below.

First, interventions must be provided within the context of an empathic, genuine, trusting relationship where the person with SMI/SED is involved in a partnership to agree on and design the components of services he or she will receive. Secondly, services must be provided within a cultural context, i.e., attention must be paid to the nuances of language, values, upbringing and potential implications and limitations that may impact acceptance of services. Thirdly, because of the very high rate of trauma experienced by individuals with SMI/SED, and our increasing knowledge of the importance of services that take this into account (Lu, Yanos, Silverstein, Mueser, Rosenberg, et al., 2013; Thompson, Nelson, Yuen, Lin, Amminger, et al., 2014; Varese, Smeets, Drukker, Lieverse, Lataster, et al., 2012), it is critical that services be provided within a trauma informed system and by providers with specialized training in this area (Manitoba Trauma Information and Education Centre, 2013).

While interventions are often thought of as the purview of professionals, they may also be activities that are carried out by family members, supporting individuals, peer support workers, or from resources available in the community. Many of the evidence based and promising practices require a
team of professionals and supporters in order for the service to be implemented accurately and with fidelity. Further, our definition of professional is changing and most psychologists and administrators now recognize the tremendous value that is added by inclusion of peer support personnel within the treatment team. In fact, peer support services are often cited by clients as one of the most helpful services they have received (Davidson, et al., 2012; Repper & Carter, 2011; Trachtenberg, et al., 2013). With respect to resource development, many interventions can be implemented by members of the client’s support team with supervision by the psychologist. Some examples include provision of supported education, behavioral training to ensure success in supported housing, assistance with accessing health services, and advocacy and action to enhance social and community inclusion.

Interventions to enhance and build on a person’s strengths are not limited to adults; these are ideal for children, young people, and older adults as well. Interventions that draw on strengths should be implemented across the age span at both individual and community levels (McCammon, 2012).

Helping individuals become accepted and included within their communities is an important but often overlooked component of the recovery model because psychologists and administrators may see this as outside their purview. The graphic below depicts the reality that can be experienced by a person who is stigmatized, marginalized, socially isolated and excluded (either intentionally or because he or she has not been involved before and is inadvertently left out). Exclusion leads to loss of opportunities (for employment, housing, fulfillment of civic duties, etc.) and further marginalization and isolation. A person in such a circular circumstance can find it difficult to become involved, leading to further exclusion and isolation. Anyone who has ever been left out knows that this kind of situation can be hurtful and it is easy to see how it could be traumatic for a person trying to recover from SMI/SED.

Source: Office of the UK Deputy Prime Minister, 2004

Because of the devastating effects of exclusion, all involved in the mental health service delivery system have a responsibility to work to ensure full integration as part of the treatment and rehabilitation services provided rather than assuming that these will be taken care of by someone else after the person leaves the service system (Farkas & Anthony, 2010; Salzer & Baron, 2016; Tondora,
Interventions to help ensure that persons with SMI/SED are integrated into the community in which they live are components of the treatment process and should be built into all aspects of treatment planning.

Cognitive behavioral treatments including behavioral shaping to improve social and communication skills and help individuals feel confident about accessing health and other community services are often needed (Thornicroft, Brohan, Kassam & Lewis-Holmes, 2008); members of the person’s support team can be helpful and may need to be trained to carry out this work and assist the person in learning the skills needed to be more integrated into the community.

People with SMI/SED very often internalize the stigma they experience from others; this is referred to as self-stigma (Corrigan, Morris, Michaels, Rafacz & Rüsch, 2012). Creating opportunities for people with and without SMI/SED to meet and interact has been shown to break down stereotypes and reduce stigma (Vaughan & Hansen, 2004). Many believe that peer support programs help to normalize the experience of having SMI/SED while traditional treatment tends to medicalize and stigmatize it (Nemec, Swarbrick, & Legere, 2015). Because of the very real negative impact that stigma and self-stigma can have on an individual’s recovery efforts, several interventions have been developed and tested to help combat it (Conner, McKinnon, Ward, Reynolds, & Brown, 2015; Harris, et al., 2015; Mackay, Bradstreet, McArthur, & Dunion, 2015; Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2015).

Due to resource limitations and the fact that many evidence based and promising practices require a large team working over several months in order to implement the practice with fidelity, every service needed to help an individual reach his or her goals may not be available within the team or agency. In such cases, it will be necessary to find an alternative source for the service or if there is no other source, attempt to develop it within the agency. Recognizing that developing new services can be resource intensive, it may be necessary to think creatively to find alternative ways to help the individual realize his or her goals.

Additionally, any conditions or problems identified during the assessment process that require services not traditionally found within the mental health system need to be addressed and persons should be referred to appropriate services. Physical health problems can easily be overlooked but are critically important because of the very high rate of serious health conditions such as cancers of all kinds, cardiovascular diseases, diabetes and metabolic syndrome that often lead to the premature morbidity and mortality seen in persons with SMI (Chiu, Chen, Chen, Yu, & Lu, 2010; Manu, 2011; Mitchell, Vancampfort, Sweers, van Winkel, Yu & de Hert, 2013). Due to the little recognized but highly prevalent stigma felt and demonstrated by health care practitioners toward persons with SMI/SED, following up such referrals is especially important (Joy, Clement, & Sisti, 2016; Pearlmutter, et al., 2017).

Assessing client satisfaction is an essential component of service provision and should be done quarterly and whenever milestones are achieved or problems arise.
Clinical Practice Guideline Flowchart

Step 5: Conduct Progress / Monitoring Reviews and Revise Plan as Needed

Continually monitoring progress and assessing the client’s satisfaction are important steps that can be easily overlooked. These are critically important and should be carried out whenever a milestone has been reached or something has happened to impede progress. Setbacks are never seen as failures; rather they are an opportunity to re-direct as necessary. Progress reviews should be conducted as needed and at least quarterly. Planning can occur as often as the person wishes; it does not need to be an annual event or occur only when transitions are on the horizon.

Recently, the importance of formalized routine outcome monitoring (ROM) to assess service effectiveness has been recognized and systems in several countries have been developed to implement these efforts. Consistency of these efforts varies, however (Roe, Drake, & Slade, 2015). Results of outcome monitoring should be translated into treatment plan revisions/update. This step can easily be overlooked; psychologists and managers should work to ensure that monitoring results are utilized (Tasma, et al., 2016).

There are several points when transitions will occur and planning for these is important. Some of these include times when the person is satisfied that goals have been achieved, requested services have been received, the person indicates a readiness to move on, or other life changes require
transitioning to a different planning process with the person. If the individual is to remain connected to
the service system, a new planning process may be needed for the next phase of services.

At every progress review, the person’s satisfaction should be ascertained and as with all clinical
and other services, the individual should not feel expected to report satisfaction with progress, the plan
for service, those working with him or her, or any other aspect of the process. Since the service plan is
a partnership between the individual and his or her team of professionals and supporters, readiness to
re-direct the plan as needed and respect for the individual’s point of view must always be
communicated.

Whenever the plan for services or resource development needs to be changed, it will be
necessary to repeat one or more of the steps in the process in order to ensure that the revised plan can
be implemented appropriately.
Step 6: Transition Planning for Longer Term Goals or for Termination of Services

Once the individual has accomplished as many of the short term goals as desired, he or she will need to determine the desirability of working on additional goals, typically those that are longer term. If the person indicates a desire to continue on to additional goals, the process would continue by returning to Step 3, Plan Development.

Often, individuals will have accomplished all that they wish to or will no longer need help from the clinician or mental health agency to tackle future goals. In this case, a transition plan would be developed with the individual and his or her support team. Importantly, information regarding availability of future services should be provided and referrals to other agencies/services would also be made as desired. Services would then be terminated.
Implementation: Challenges and Some Suggestions

There are several challenges faced by psychologists, program managers and administrators who seek to implement comprehensive programs aimed at helping persons with SMI/SED recover and achieve a satisfying and productive life in the community. These challenges are difficult to overcome, not to be taken lightly, and require flexibility and creative thinking. But, challenges should not deter us from working to provide the best possible array of services in an environment that is welcoming, respectful, normalized, and that views those who receive services as partners in the process. A thorough discussion of this topic is beyond the scope of this guideline, however, following is a short listing of some of the more frequently encountered challenges and a few suggestions; admittedly these suggestions seem lofty but may lead to creative solutions and service system improvements.

Some Challenges Frequently Encountered

Practitioner bias and negative attitudes;

Change is very difficult no matter how flexible we might be;

Resource limitations are a reality – comprehensive service provision is expensive and requires well trained staff;

Leadership changes are frequent leading to ever changing priorities;

Sustainability can be difficult even after changes have been implemented.

Some Suggestions

Assess the attitudes and vision of all stakeholders within the service or system;

Form partnerships of all stakeholders including service users, peers, families, advocates, community leaders, etc., and empower members with decision making authority;

Advocate for increased, sustainable funding;

Work toward hiring well trained professionals with a vision for recovery and rehabilitation;

Require and provide on-going training and supervision in recovery principles and psychosocial rehabilitation practices;

Objectively monitor and evaluate changes; provide accurate feedback to all stakeholders and be willing to modify plans based on feedback and monitoring results.

The challenges and suggestions presented above have been thoughtfully discussed by several authors including Clossey & Rowlett, 2008; Green, et al., 2014; Morris, Day & Schoenwald, 2010, to cite but a few.
Summary and Conclusions

This document presents a short, easy to use guide for those providing psychological and psychosocial rehabilitation services to persons with SMI/SED. It is designed to be a useful reference tool for psychologists and administrators who want to be sure that they or their service are providing the kind of comprehensive, evidence based care required for this population.

The guideline should be used by trained psychologists; it is not meant as a replacement for the specialized training required to provide the level and kind of assessment and treatment services needed by individuals with SMI/SED. Such training can be obtained by psychologists via their professional association, from accredited training programs, via post graduate training opportunities and through continuing education. In 2010 the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) initiated a program to develop a curriculum designed to train psychologists for work in this area and provided funding for APA to develop the curriculum. APA released free the curriculum in 2014 and it can be accessed via the APA website at https://apa.org/pi/rtp.

This guideline should also be used together with the more comprehensive and detailed practice guidelines that are available such as those developed by the UK’s National Institute for Health and Care Excellence (NICE) which can be accessed at https://www.nice.org.uk/guidance/cg178.


Improving Interventions. New Brunswick, NJ: Rutgers University, Center for Behavioral Health Services & Criminal Justice Research.


Appendix III: SMI/SED Evaluation Instrument

Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*

Council for Psychological Training in Serious Mental Illness and Severe Emotional Disturbance*

Purpose
This instrument can be used to evaluate psychologists who are developing knowledge and skills to provide services to adults with SMI or youth/young adults with SED, their families, those who support them, and their care systems. Psychology trainees, their supervisors, and practicing psychologists can use this instrument, in whole or in part, to evaluate progress in developing SMI/SED competencies, and to help define ongoing learning goals and training needs.

Development of SMI/SED Competencies and this Assessment Instrument
Competencies for professional psychology practice with individuals with SMI/SED and their families and supporters were delineated during the 2016 meeting of experts which was convened for this purpose and supported by a grant from the Board of Educational Affairs, and Division 18 of the APA. The meeting was convened by the APA Task Force on Serious Mental Illnesses and Severe Emotional Disturbance (TF SMI/SED) and by Division 18 of the APA, both of which are organizing members of the Council for Psychological Training in Serious Mental Illness and Severe Emotional Disturbance.

Those in attendance at the meeting included a representative of the Board of Professional Affairs, members of the APA TF on SMI/SED, leaders of Division 18 and the Division’s Section on SMI/SED, and a representative from each of four post-doctoral programs with a specialization in SMI/SED. Both the APA TF and the Division 18 Section include members who are also psychologists with lived experience of SMI/SED.

The meeting focused on two principal themes: 1) ascertaining the distinctiveness of assessment and treatment approaches for persons with SMI/SED and 2) identifying the competencies important for post-doctoral specialized training. Following the meeting, all in attendance reviewed and provided input into the documents produced at the meeting, and agreed with their content. Specifics regarding the distinctiveness of post-doctoral training in SMI/SED were included in the Specialty Council’s Petition to APA for recognition of the post-doctoral specialty in SMI/SED and a summary of the competencies developed at that meeting is included at the end of this document.

Subsequent to identification of the competencies, the Council requested and received permission from the Council of Professional Geropsychology Training Programs to modify the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel, et al., 2012) which was developed to assess the competencies outlined in the Pikes Peak Model of Training (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009) to meet the needs of psychologists working with individuals with SMI and SED, their families and supporters. The Council is most grateful to the Council of Professional Geropsychology Training Programs for granting this permission.

The CoPGTP Task Force on Geropsychology Competency Assessment developed the original version of this tool. Members were: Michele J. Karel, Chair; Jeannette Berman, Jeremy Doughan, Erin E. Emery, Victor Molinari, Sarah Stoner, Yvette N. Tazeau, Susan K. Whitbourne, Janet Yang, Richard Zweig. The original Geropsychology tool was adapted from previous efforts, as summarized by Hatcher and Lassiter (2007) and was developed for learners and supervisors to have a measure by which to gauge competence in serving older adults.

The instrument adapted for SMI/SED use retains the purpose of a measure to gauge competence but in serving those with SMI/SED. Like the original tool, this instrument contains competencies that are

* Adapted with permission from the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool developed by the Council of Professional Geropsychology Training Programs
specified by behaviorally descriptive items, and can be rated along a continuum from Novice to Expert. Some redundancy is inherent in this measure. The intent is to evaluate both the learner’s knowledge base and skill set separately for the same domains, as the awareness of information and ability or experience in applying it may differ. The competencies are aspirational, rather than “required” of any particular psychologist. Even the most accomplished psychologist will have relative strengths and weaknesses across the spectrum of competencies for practice.

**Professional Psychological Practice for SMI/SED**
Psychologists who work with individuals with SMI/SED, their families and supporters provide assessment, intervention, consultation, and other professional services across a wide range of medical, mental health, residential, community, and other care settings with a population of demographically and socioculturally diverse adults, adolescents, and young adults. The SMI/SED competencies are applicable across varied treatment settings and populations. It is recognized also that each work area or training setting may call for the development of particular competencies, not all of which may be addressed in this document. Rather, core competencies for practice are highlighted. The knowledge and skill competencies reflect core practice attitudes needed to work with this population, including: recognition of scope of competence, self-awareness of attitudes and beliefs about the ability of individuals to recover and gain or re-gain functional capabilities, and achieve a satisfying and productive life.

**Using the Competency Evaluation Instrument**
This tool is intended to be used both by supervisors to assess trainees, and by psychologists to assess their own knowledge and skills. Supervisors in psychology training programs may choose to evaluate the domains relevant to the goals of their program. Evaluation should include the learner's perspective (self-assessment), observation of the learner's work (e.g., direct observation, audiotape, videotape, co-therapy), as well as regular supervision involving case discussion. Psychologists and trainees conducting self-assessments can use the instrument to evaluate their training and supervision needs in each area. The instrument also can gauge a learner's progress over time.

The learner can be rated on each knowledge domain and skill competency as Novice (N), Intermediate (I), Advanced (A), Proficient (P), or Expert (E), as described below. Each competency (highlighted in light gray in the chart below) is delineated by several specifiers (indicated by letters a., b., c., etc. in the chart). The specifiers are designed to help define the knowledge domain or skill competency and do not need to be rated separately. However, the specifiers can be rated individually if that level of assessment is desired. The tool can be modified to suit the needs of individuals or programs.

**Rating Scale Anchors**
This rating scale assumes that professional competence is developed over time, as learners develop knowledge and skills with ongoing education, training, and supervision. The anchors reflect developmental levels of competence, from Novice through Expert. Because the scale reflects development of competence, the same scale can be used at different levels of training. For example, graduate practica students would be expected to perform at Novice through Advanced levels, while Postdoctoral Fellows would be expected to perform from Intermediate to Proficient levels. Development of knowledge and skills may differ significantly across domains, depending upon previous training experiences.

To illustrate use of the scale, below we provide a brief vignette and how an individual at each level might approach the case.

N = Novice: Possesses entry-level skills; needs intensive supervision
I = Intermediate: Has a background of some exposure and experience; ongoing supervision is needed
A = Advanced: Has solid experience, handles typical situations well; requires supervision for unusual or complex situations
P = Proficient: Functions autonomously, knows limits of ability; seeks supervision or consultation as needed
E = Expert: Serves as resource consultant to others, is recognized as having expertise
Vignette: A 24 year-old African-American man is referred to the mental health clinic by his primary care physician because his mother reported that his erratic behavior has become more frequent and disturbing. In recent months, he has become depressed, increasingly disoriented, withdrawn, and is absent from home for several days at a time. His employer has reported him missing from or reporting late for work. He no longer takes care of his personal hygiene and sometimes complains of stomach problems, although the primary care physician has not offered a diagnosis for this. At the insistence of his mother, he very reluctantly has come to the clinic for an initial evaluation.

**Novice (N):** Possesses entry-level skills; needs intensive supervision

Novices have limited knowledge and understanding of case conceptualization and intervention skills, and the processes and techniques of implementing them. Novices do not yet recognize consistent patterns of behavior relevant for diagnosis and care planning and do not differentiate well between important and unimportant details.

*Example:* The learner is able to identify salient symptoms, but does not appreciate possible contributions of potential medical or behavioral co-morbidities, neuropsychological complications, practitioner bias, family system factors, and fear of stigmatization to the individual’s presentation, and does not know how to formulate differential diagnosis questions.

**Intermediate (I):** Has a background of some exposure and experience; ongoing supervision is needed

Experience has been gained through practice, supervision, and instruction. The learner is able to recognize important recurring issues and select appropriate strategies. Generalization of skills is limited and support is needed to guide performance.

*Example:* The learner recognizes multiple possible contributions to the person’s presentation, is able to collect history from the patient (and his mother with his permission), administer clinical, cognitive, and functional screening tools, and consult with supervisor to discuss possible implications and to plan further evaluation. Learner may not appreciate complex family and cultural systems issues, and the possibility of practitioner bias of the family physician.

**Advanced (A):** Has solid experience, handles typical situations well; requires supervision for unusual or complex situations

Knowledge of the competency domain is more integrated, including application of appropriate research literature. The learner is more fluent in the ability to recognize patterns and select appropriate strategies to guide diagnosis and treatment.

*Example:* The learner is able to integrate multiple sources of information (e.g., behavioral observation, cognitive testing data, medical records, collateral reports [mother, employer, supporters, (with the person’s permission)], and complex history (medical, psychiatric, family, occupational, and cultural context) to rule out possibility of co-morbid physical and or behavioral conditions and make recommendations to the individual, his primary care provider and family about further assessment and treatment options. Learner consults with supervisor about local resources for persons with first episode psychosis early intervention programs, and how best to handle issues around the primary care provider’s belief that “there is nothing physically wrong” with the patient.
**Proficient (P):** Functions autonomously, knows limits of ability; seeks supervision or consultation as needed

Proficiency is demonstrated in perceiving situations as wholes and not only summations of parts, including an appreciation of longer term implications of current situation. The psychologist has a perspective on which of the many existing attributes and aspects in the present situation are important ones, and has developed a nuanced understanding of the clinical situation.

*Example:* Learner is able to integrate information, as above, collaborate with family and relevant providers (e.g., family physician, psychiatrist, neuropsychologist, early intervention team, substance abuse team if appropriate, psychosocial rehabilitation team, and social service providers for ongoing assessment and intervention for the patient and family, explore community support options). Learner functions as a full member of an interdisciplinary team to address the biopsychosocial needs of the client and his family, and is able to assume a leadership role.

**Expert (E):** Serves as resource or consultant to others, is recognized as having expertise

With significant background of experience, the psychologist is able to focus in on the essentials of the problem quickly and efficiently. Analytical problem solving is used to consider unfamiliar situations, or when initial impressions do not bear out.

*Example:* The psychologist is frequently contacted by other psychologists in the community to provide consultation regarding assessment and intervention options for persons with serious mental illness and severe emotional disturbance (SMI/SED). The psychologist is able to use the above case as a teaching example for the need to provide a thorough biopsychosocial assessment in complex cases, to implement an interdisciplinary team plan, and to be knowledgeable about the multiple resources needed to assist individuals with SMI and SED in the community.

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N = Novice: Possesses entry-level skills; needs intensive supervision
I = Intermediate: Has a background of some exposure and experience; ongoing supervision is needed
A = Advanced: Has solid experience, handles typical situations well; requires supervision for unusual or complex situations
P = Proficient: Functions autonomously, knows limits of ability; seeks supervision or consultation as needed
E = Expert: Serves as resource consultant to others, is recognized as having expertise
**NOTE**: Ratings are only needed where the anchors are provided (highlighted in light gray). Specifiers (indicated by letters a., b., c., etc. in the chart) are designed to help define the knowledge domain or skill competency and do not need to be rated separately, unless that level of assessment is desired.

<table>
<thead>
<tr>
<th>I. General Knowledge about Serious Mental Illness/Severe Emotional Disturbance (SMI/SED)</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>I. A. Knowledge Base - The psychologist/trainee has KNOWLEDGE OF:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Models of Development</td>
<td>N</td>
</tr>
<tr>
<td>a. Development as a life-long process encompassing early to late life, and encompassing both gains and losses over the lifespan, especially those that impact on the development of serious mental illness</td>
<td></td>
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<tr>
<td>b. Different theories of normal versus pathological development and adaptation</td>
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<tr>
<td>c. Biopsychosocial perspective for understanding an individual’s physical and psychological development within the sociocultural context</td>
<td></td>
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<tr>
<td>d. Concept of, and variables associated with, development of illness</td>
<td></td>
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<tr>
<td>e. Relevant research on development and the impact of the various factors that can lead to illness and or functional impairment, including methodological considerations in cross-sectional and longitudinal research</td>
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<tr>
<td>2. Epidemiology and Demographics</td>
<td>N</td>
</tr>
<tr>
<td>a. Demographic trends related to mental illness, particularly SMI and SED, including gender, racial, ethnic, and socioeconomic heterogeneity</td>
<td></td>
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<tr>
<td>b. Resources to remain updated on the demographics of the population, including internet sites for: Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, Social Security Administration, Bureau of Labor Statistics, National Institutes of Health particularly National Institute of Mental Health, World Health Organization</td>
<td></td>
</tr>
<tr>
<td>3. Biological, Psychological, Social Aspects</td>
<td>N</td>
</tr>
<tr>
<td>a. Biological and physiological (medical/health) aspects that may impact on development of SMI/SED</td>
<td></td>
</tr>
<tr>
<td>b. Psychological characteristics/factors (behavioral, cognitive including attention, memory, executive functioning, language, and intellectual functions, personality, emotional expression and coping mechanisms) that may impact on development of SMI/SED</td>
<td></td>
</tr>
<tr>
<td>c. Social and environmental factors (socialization, family dynamics, educational and work related) that may impact on development of SMI/SED</td>
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<tr>
<td>d. Interactions among the three processes above that may impact development of SMI/SED</td>
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<tr>
<td>4. Functional Capability</td>
<td>N</td>
</tr>
<tr>
<td>a. Relationship between functional abilities and decisions individuals make with regard to life domains including education, employment, healthcare, relationships, lifestyle and leisure activities, and living environment</td>
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<tr>
<td>b. Relationship between functional ability and psychopathology, including how functional abilities of individuals with SMI and/or SED affect family and significant others</td>
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<tr>
<td>c. Strategies commonly used to cope with functional limitations</td>
<td></td>
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<tr>
<td>d. Impact of stereotypes and stigma on an individual's functional status and self-efficacy</td>
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</tr>
<tr>
<td>e. Ethical and legal issues which arise in the context of markedly impaired functional status and decision making capacity</td>
<td></td>
</tr>
<tr>
<td>4. Psychopathology</td>
<td>N</td>
</tr>
<tr>
<td>a. Common types of psychopathology in terms of onset, etiology, risk factors, clinical course, associated behavioral features, and medical and psychological management of these disorders</td>
<td></td>
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</tbody>
</table>

N = Novice: Possesses entry-level skills; needs intensive supervision
I = Intermediate: Has a background of some exposure and experience; ongoing supervision is needed
A = Advanced: Has solid experience, handles typical situations well; requires supervision for unusual or complex situations
P = Proficient: Functions autonomously, knows limits of ability; seeks supervision or consultation as needed
E = Expert: Serves as resource consultant to others, is recognized as having expertise
b. Differential presentation, associated features, age of onset, and course of psychological disorders and syndromes

c. Under-recognized aspects of psychopathology which affect functional impairment and safety (e.g., trauma, suicide risk, substance use)

d. Interaction of SMI/SED with the more common medical illnesses and medications and implications involved for assessment and treatment

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<thead>
<tr>
<th>5. Diversity in the Population</th>
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<tbody>
<tr>
<td>a. The diversity of the population in general and the impact of cultural experiences on illness development and expression</td>
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<tr>
<td>b. The unique experience of each individual: demographic, sociocultural, and life experiences and the interaction of multiple factors that my interact to influence an individual’s patterns of behavior</td>
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<tr>
<td>c. The varied preferences individuals with SMI/SED have in discussing mental health problems and their effect on functional capability with family, primary care providers, treatment team members, spiritual advisors, etc.</td>
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| I. B. Professional Functioning – The psychologist/trainee is ABLE TO: |
|--------------------------|---|---|---|---|---|
| 1. Apply Ethical and Legal Standards by identifying, analyzing, and proactively addressing complex ethical and legal issues: |
| a. Tension between sometimes competing goals of promoting autonomy and protecting safety of at-risk clients |
| b. Decision making capacity and strategies for optimizing an individual’s participation in informed consent regarding a wide range of medical, residential, financial, and other life decisions, and the possible presence of a psychiatric living will |
| c. Surrogate decision-making as indicated regarding a wide range of medical, residential, financial, and other life decisions, e.g., changes in capacity depending upon current mental status/acute psychotic episode/in remission |
| d. State and organizational laws and policies covering committal, assisted outpatient treatment, advance directives, conservatorship, guardianship, multiple relationships, and confidentiality |

| 2. Address Cultural and Individual Diversity of those with SMI/SED, their families, communities, & systems/providers by being able to: |
|-----------------------------|---|---|---|---|---|
| a. Recognize gender, age, cohort, ethnic/racial, cultural, linguistic, socioeconomic, religious, disability, sexual orientation, gender identity, and urban/rural variations |
| b. Articulate integrative conceptualizations of multiple aspects of diversity influencing those with SMI/SED, psychologists and other providers, and systems of care |
| c. Adapt professional behavior in a culturally sensitive manner, as appropriate to the needs of the client |
| d. Work effectively with diverse providers, staff, and students in care settings serving those with SMI/SED |
| e. Initiate consultation with appropriate sources as needed to address specific diversity issues |

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<tr>
<th>3. Recognize Importance of Teams</th>
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<tbody>
<tr>
<td>a. Understand the importance of diverse team members and their professional expertise</td>
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<td>b. Value the role that other providers play in the assessment and treatment of persons with SMI/SED</td>
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<tr>
<td>c. Demonstrate awareness, appreciation, and respect for team experiences, values, and discipline-specific conceptual models</td>
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<tr>
<td>d. Understand the importance of teamwork in settings where individuals with SMI/SED are seen to address the varied bio-psycho-social needs of this population</td>
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E = Expert: Serves as resource consultant to others, is recognized as having expertise
4. Practice Self-Reflection

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<tbody>
<tr>
<td>a. Demonstrate awareness of personal biases, assumptions, stereotypes, and potential discomfort in working with people with SMI/SED, particularly those of backgrounds divergent from the psychologist/trainee</td>
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<td>b. Monitor internal thoughts and feelings that may influence professional behavior, and adjust behavior accordingly in order to focus on needs of the patient, family, significant others, and treatment team</td>
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<tr>
<td>e. Demonstrate self-awareness and ability to recognize differences between the clinician’s and the client’s values, attitudes, assumptions, hopes and fears related to the illness, symptoms, functional capabilities, stigma, treatment, social supports</td>
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<tr>
<td>d. Demonstrate accurate self-evaluation of knowledge and skill competencies related to work with diverse individuals, including those with particular diagnoses, or in particular care settings</td>
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<td>e. Initiate consultation with or referral to appropriate providers when uncertain about one’s own competence</td>
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<td>f. Seek continuing education, training, supervision, and consultation to enhance competence related to practice</td>
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5. Relate Effectively and Empathically

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<tr>
<td>a. Use rapport and empathy in verbal and nonverbal behaviors to facilitate interactions with individuals, families, and treatment teams</td>
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<td>b. Form effective working alliances with wide range of clients, families, colleagues, and other stakeholders</td>
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<td>c. Communicate with individuals and their families, adjusting language and complexity of concepts based on the person’s and family’s level of sensory and cognitive capabilities, educational background, knowledge, values, and developmental stage</td>
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<tr>
<td>d. Demonstrate awareness, appreciation, and respect for those with SMI/SED, families, and team perspectives, experiences, values, and conceptual models</td>
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<tr>
<td>e. Demonstrate appreciation of client, family, and organizational strengths, as well as deficits and challenges, and capitalize on strengths in planning interventions</td>
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<td>f. Tolerate and understand interpersonal conflict and differences within or between clients, families, and team members, and negotiate conflict effectively</td>
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6. Apply Scientific Knowledge

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<tbody>
<tr>
<td>a. Demonstrate awareness of the scientific knowledge base related to individuals with SMI/SED including areas such as biological, psychological, social, and community influences; physical and mental health care, and incorporate this knowledge into interdisciplinary health and mental health practice</td>
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<td>b. Apply review of available scientific literature to case conceptualization, treatment planning, and intervention</td>
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<tr>
<td>c. Acknowledge strengths and limitations of knowledge base in relation to individual case</td>
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<tr>
<td>d. Demonstrate ability to cite scientific evidence to support professional activities in academic, clinical and policy settings</td>
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7. Appropriate Business Practice

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<tbody>
<tr>
<td>a. Demonstrate awareness of Medicare, Medicaid, and other insurance coverage for diagnostic conditions and health and mental health care services</td>
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<tr>
<td>b. Demonstrate appropriate diagnostic and procedure coding for psychological services rendered</td>
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| c. Demonstrate medical record documentation that is consistent with Medicare, Medicaid, HIPAA, and other federal, state, local or organizational regulations, including appropriate documentation of

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II. Assessment

II. A. Knowledge Base -- The psychologist/trainee has **KNOWLEDGE OF:**

1. Assessment Methods for Individuals with SMI/SED

<table>
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<tbody>
<tr>
<td>a.</td>
<td>Current research and literature relevant to understanding theory and current trends in assessment of strengths, functional abilities and limitations, and resource needs</td>
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<td>b.</td>
<td>Assessment measures or techniques which have been developed, normed, validated and determined to be psychometrically suitable for use with this population</td>
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<td>c.</td>
<td>Importance of a comprehensive interdisciplinary assessment approach (e.g., including other health professionals’ evaluations of medical or social issues)</td>
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<td>d.</td>
<td>Multi-method approach to assessing those with SMI/SED (including cognitive, psychological, personality, functional and behavioral assessments, drawn from standardized instruments, self-report, interviews, and observational methods)</td>
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<td>e.</td>
<td>Importance of integrating collateral information from family, friends, and providers, with appropriate consent, especially when cognitive impairment is suspected</td>
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<td>f.</td>
<td>Need for baseline and repeated-measures assessments in order to understand complex diagnostic problems with multiple co-morbidities</td>
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<td>g.</td>
<td>Assessment of aspects essential to understanding individuals with SMI/SED (e.g., trauma, potential abuse, suicide, etc.)</td>
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2. Limitations of Assessment Methods

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<tr>
<td>a.</td>
<td>Criterion and age requirements, as well as specific standard normative data for testing instruments</td>
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<tr>
<td>b.</td>
<td>Limitations of testing instruments, including those not validated with SMI/SED samples, for assessing diverse individuals</td>
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3. Contextual Issues in Assessment of Individuals with SMI/SED

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<tr>
<td>a.</td>
<td>The range of potential individual factors that may affect assessment performance (e.g., medications, substance use, medical conditions, cultural, educational, language background)</td>
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<td>b.</td>
<td>The potential impact of the assessment environment on test performance (e.g., noise, lighting, distractions, etc.)</td>
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<td>c.</td>
<td>The person’s capabilities and resources that impact on recommendations from assessment data, e.g., ability to manage one’s affairs vis a vis capabilities and demands</td>
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II. B. Professional Functioning – The psychologist/trainee is **ABLE TO:**

1. Utilize Assessment Instruments

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<tr>
<td>a.</td>
<td>Utilize assessment tools for mood, cognition, substance use, personality, and other clinical issues to guide and inform comprehensive assessment</td>
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**E** = Expert: Serves as resource consultant to others, is recognized as having expertise

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medical necessity for services and insurance companies

d. Remain updated on policy and regulatory changes that affect practice, such as through professional newsletters and e-mail for a

e. Demonstrate understanding of quality indicators for the care of individuals with SMI/SED

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8. Advocate for and Provide Care Coordination

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<tbody>
<tr>
<td>a.</td>
<td>Demonstrate awareness of possible individual and psychosocial barriers to individuals with SMI/SED accessing and utilizing health, mental health, or community services</td>
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<td>b.</td>
<td>Advocate for clients’ needs in interdisciplinary and organizational environments when appropriate</td>
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<td>c.</td>
<td>Collaborate with clients, families, and organizational and community providers to improve access to needed health care, and residential, transportation, social, or community services</td>
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</table>
b. Evaluate the person’s understanding, appreciation, reasoning, and choice abilities with regard to capacity for decision making

c. Utilize functional assessment tools to understand basic functional capabilities

d. Evaluate age, educational, and cultural appropriateness of assessment instruments

e. Consider reliability and validity data in using standardized instruments with individuals with SMI/SED

f. Assess a person’s ability to provide informed consent for psychological evaluation

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<tr>
<th>2. Utilize Information from Psychological Assessments</th>
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<tbody>
<tr>
<td>a. Interpret meaning and implications of testing data or reports for case conceptualization</td>
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<tr>
<td>b. Integrate testing results with information from clinical interview with the person and collateral sources, including behavioral observations and interviews with family members and other supports, to formulate impressions and recommendations</td>
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<td>c. Assess an individual’s motivation and readiness for treatment</td>
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<td>d. Make specific and appropriate recommendations, based on testing results, to inform treatment planning</td>
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<td>e. Translate testing results into practical conclusions and recommendations for clients, families, and other care providers</td>
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<th>3. Interpret Assessment Information and Conduct Differential Diagnosis</th>
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<tr>
<td>a. Distinguish between symptoms of lesser versus more severe pathology in making diagnoses</td>
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<tr>
<td>b. Consider base rates, risk factors, and distinct symptom presentations of psychological disorders when making diagnoses</td>
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<td>c. Conduct differential diagnosis, including consideration of co-morbid medical issues and or substance use, and of medications that may influence an individual’s presentation</td>
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<td>d. Utilize biopsychosocial case conceptualization based on clinical evaluation to inform initial recommendations or treatment plan</td>
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<th>4. Assess Risk</th>
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<tr>
<td>a. Identify risk factors for harm to self or others</td>
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<td>b. Screen and comprehensively assess suicide risk</td>
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<td>c. Screen and assesses capacity for self-care including activities of daily living</td>
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<td>d. Screen and assesses for trauma and for risk of abuse in emotional, physical, sexual, financial, and neglect</td>
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<th>5. Refer for Other Evaluations as Indicated</th>
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<tbody>
<tr>
<td>a. Acknowledge personal level of expertise regarding appropriate and comprehensive assessment of individuals with SMI/SED and know when to refer or consult with other health care professionals</td>
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<td>b. Collaborate with professionals from other disciplines to assess specific functional capacities (e.g., social and communication skills, ability for work, continued education, ability to live independently or with supports)</td>
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<tr>
<td>c. Utilize assessment data to inform need for more comprehensive, multidisciplinary assessment</td>
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<td>d. Recognize when a medical evaluation is indicated to rule out underlying medical or pharmacological causes of presenting symptoms</td>
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<th>6. Goal Development</th>
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<tr>
<td>a. Work with the person and his/her support team to develop short and long term goals and objectives based on results of clinical, functional, and available resource assessments</td>
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<td>b. Identify interventions and resources needed for each goal and objective</td>
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<th>7. Communicate Assessment Results and Recommendations</th>
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### III. Intervention

#### III. A. Knowledge Base – The psychologist/trainee has **KNOWLEDGE OF:**

<table>
<thead>
<tr>
<th>1. Theory, Research, and Practice</th>
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<tbody>
<tr>
<td>a. Basic clinical interventions which target behavioral features and psychological problems in individuals with SMI/SED and their caregivers</td>
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<td>b. Specialized interventions for individuals with SMI/SED (e.g., illness management, assertive community treatment, family psychoeducation, social integration strategies, skills training, cognitive remediation and social cognition strategies, employment and educational interventions, substance use interventions, weight management strategies, peer delivered services, interventions for those with SMI in forensic settings, token economy in residential/institutional settings)</td>
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<td>c. Broad research knowledge regarding the effectiveness of psychological interventions with individuals with SMI/SED (e.g., application of behavioral, cognitive, interpersonal, psychodynamic, family, early intervention, trauma, environmental/social inclusion, psychoeducational, group interventions)</td>
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<td>d. Psychosocial, psychotherapeutic and psychopharmacological approaches to treating psychological disorders, as well as the consequences of not treating and side effects of possible treatments</td>
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<th>2. Health, Illness, and Pharmacology</th>
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<td>a. The complexity and interplay of medical problems and health issues of concern for those with SMI/SED (smoking, weight gain, health system failures, stigma and reluctance to seek medical intervention, reluctance to use psychotropic medication)</td>
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<td>b. The possible impact of medications and procedures for medical and psychiatric problems, including detrimental side effects on symptom presentation, mental status, and treatment effectiveness</td>
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<td>c. The frequent comorbidity between chronic medical and psychiatric problems including substance use, and need to address both medical and mental health issues</td>
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<th>3. Specific Settings</th>
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<td>a. The salience and presentation of ethical issues when employing interventions across varied care settings (e.g., confidentiality in context of team treatment planning, family and other supporters, privacy constraints in institutional settings)</td>
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<td>b. Adaptations of interventions appropriate to particular settings (e.g., focus on staff education and behavioral, environmental interventions in residential settings)</td>
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<th>4. Recovery and Rehabilitation Services</th>
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<tr>
<td>a. The underlying concepts and necessary components of the recovery paradigm for persons with SMI/SED</td>
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<td>b. Specific referral sources that are knowledgeable about and experienced in delivering appropriate services for persons with SMI/SED</td>
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E = Expert: Serves as resource consultant to others, is recognized as having expertise
C. Referral processes and procedures to local community resources

D. Follow-up mechanism(s) regarding referrals for PSR services

5. Ethical and Legal Standards

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III. B. Professional Functioning – The psychologist/trainee is ABLE TO:

1. Provide Effective, Evidence-based Interventions for Those with SMI/SED Including:

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2. Apply Individual, Group, and Family Interventions

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IV. Consultation

IV. A. Knowledge Base – The psychologist/trainee has KNOWLEDGE OF:

1. Prevention, Health Promotion and Social Integration

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### 2. Diverse Clientele and Contexts

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<td>a.</td>
<td>Multiple levels of intervention/consultation, including individuals, families, healthcare professionals, organizations, and community leaders</td>
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<td>b.</td>
<td>Systems-based consultative and intervention models and their use with appropriate modifications in different settings</td>
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<td>c.</td>
<td>Strategies and methods for collaboration to address individual and organizational needs</td>
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### 3. Interdisciplinary Collaboration

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<tr>
<td>a.</td>
<td>The roles, and potential contributions, of a wide range of healthcare professionals in the assessment and treatment of individuals with SMI/SED</td>
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<td>b.</td>
<td>How team composition and functioning may differ across settings of care</td>
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<td>c.</td>
<td>Appropriate research methodology, including mixed methods in order to capture the best data for use in studying intervention effects</td>
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### IV. B. Professional Functioning – The psychologist/trainee is ABLE TO:

#### 1. Provide Consultation to Improve Assessment and Treatment for People with SMI and SED

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<td>a.</td>
<td>Recognize situations in which consultation is appropriate</td>
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<td>b.</td>
<td>Demonstrate ability to clarify and refine a referral question</td>
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<td>c.</td>
<td>Demonstrate ability to gather information necessary to answer referral question(s)</td>
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<td>d.</td>
<td>Advocate for quality care for individuals with SMI and SED with their families, professionals, health care services, facilities, programs, legal systems, and other agencies or organizations</td>
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#### 2. Provide Training

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<tr>
<td>a.</td>
<td>Assess learning needs of trainees related to varying levels of training and amount of experience within and across disciplines</td>
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<td>b.</td>
<td>Define learning goals and objectives as a basis for developing educational sessions</td>
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<td>c.</td>
<td>Provide clear, concise education that is appropriate for the level and needs of trainees</td>
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#### 3. Participate in Interprofessional Teams

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<tr>
<td>a.</td>
<td>Work with professionals in other disciplines to incorporate information about psychological assessment and treatment of those with SMI/SED into team treatment planning and implementation</td>
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<td>b.</td>
<td>Communicate psychological conceptualizations clearly and respectfully to other providers</td>
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<td>c.</td>
<td>Appreciate and integrate feedback from interdiscipliary team members into case conceptualizations</td>
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<td>d.</td>
<td>Work to build consensus on treatment plans and goals of care, to invite various perspectives, and to negotiate conflict constructively</td>
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<td>e.</td>
<td>Demonstrate ability to work with diverse team structures (e.g., hierarchical, lateral, virtual) and team members (e.g., including the ethics board, chaplains, families and support team members)</td>
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#### 4. Communicate Psychological Conceptualizations for SMI/SED

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<td>a.</td>
<td>Provide clear and concise written communication of psychological conceptualizations and recommendations for assessment and treatment of people with SMI/SED</td>
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<td>b.</td>
<td>Provide clear and concise oral communication of psychological conceptualizations and recommendations for assessment and treatment of people with SMI/SED</td>
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<td>c.</td>
<td>Use appropriate language and level of detail for the target audience of the communication</td>
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#### 5. Implement Organizational Change

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<tr>
<td>a.</td>
<td>Advocate for appropriate services for persons with SMI/SED within and across various settings</td>
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b. Conduct needs assessment for service delivery within the setting or program that serves individuals with SMI/SED

c. Develop policies and procedures for service delivery that involve all appropriate disciplines and staff members

d. Evaluate effectiveness of service delivery model or program

6. **Participate in a Variety of Models of Service Delivery**

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<td>a. Differentiate goals and models of care in community, residential, rehabilitation, acute, primary, home, supported housing, and other care settings</td>
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<td>b. Appreciate and be able to work within a variety of models of mental health care for this population, including integrated mental health services in primary care, specialty consultation, and home or community-based services</td>
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<td>c. Demonstrate awareness of strengths and constraints of various care models</td>
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<td>d. Demonstrate flexibility in professional roles to adapt to the realities of work in a variety of healthcare delivery systems</td>
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7. **Collaborate and Coordinate with Other Agencies and Professionals**

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<tr>
<td>a. Work with team members to create smooth and efficient transitions across health care settings for individuals with SMI/SED and their families</td>
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<td>b. Demonstrate respect for confidentiality and informed consent, as well as continuity of care, in coordinating with family members, other professionals, and agencies regarding treatment for those with SMI/SED</td>
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<td>c. Establish working relationships with local and national agencies and organizations, including advocacy groups, treatment facilities, service providers, legislative bodies that authorize and provide funding, universities that conduct research, etc.</td>
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8. **Recognize and Negotiate Multiple Roles**

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<td>a. Identify the client and explicate the expectations of the relationship at the outset of the consultation</td>
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<td>b. Advocate on behalf of the well-being of clients within each professional role, including when the individual or group of clients is not the direct client (e.g., the actual client may be the organization)</td>
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<td>c. Discuss potential conflicts of interest with colleagues and teams as indicated</td>
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<td>d. Discuss financial arrangements with all stakeholders</td>
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Summary

It may help psychologists in training and/or supervisors to summarize knowledge and skill strengths, and areas for growth, based on this assessment. Areas for growth may then be linked to further goals for education and training.

**Strengths:** Knowledge and skill domains in which the trainee feels most confident and competent for practice with individuals with SMI/SED:

**Areas for Growth:** Knowledge and skill domains in which the trainee wishes to develop further competency:

**Education and Training Goals** (within a practicum, internship rotation, fellowship, or post-licensure program of self-study)
*Notes on the Development of the Original and this Instrument*

The Council for Psychological Training in Serious Mental Illness and Severe Emotional Disturbance requested and received permission from the Council of Professional Geropsychology Training Programs to modify the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel et al., 2012) which was developed to assess the competencies outlined in the Pikes Peak Model of Training (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009). The SMI/SED Council is most grateful to the Council of Professional Geropsychology Training Programs for granting this permission.

According to the information provided with the original instrument, development was informed by several important previous efforts. This information is included here in order to acknowledge those efforts. These included the APA policies on multicultural and evidence-based practice, extensive work on the assessment of competencies for professional psychology practice, competencies for geriatric and palliative care, and evaluation tools that have been used by geropsychology internship and fellowship programs. An abbreviated reference list of those efforts follows:


SMI/SED Competencies**

The specialized training needed includes: very different assessment methods which assess functional capability rather than symptomatology, EBPs and promising practices designed specifically for this population, interventions modified and found to be effective with people in this population within the forensic mental health system, research methods adapted for populations such as this, and systems transformation methods specific to large mental health systems that serve this population, to name but a few – these are the major areas of specialized training needed by psychologists to work with individuals with SMI/SED. With funding from a Board of Educational Affairs grant and from Division 18, a meeting was convened following the 2016 APA convention to identify the specific competencies that are needed to meet the training needs of psychologists. While it is recognized that not every post-doctoral specialty program could include all of these, the following competencies are those that would ideally be included or available to trainees:

**Assessment**

- **Comprehensive knowledge of strengths based and functional capability assessments and ability to use these**
- **Ability to utilize standardized assessments in ways that may require modification in light of the fact that these assessments were not developed or normed using persons with SMI/SED**
- **Ability to competently utilize specialty assessments such as the Structured Clinical Interview (SCID for DSM), the Positive and Negative Syndrome Scale (PANSS), the Brief Psychiatric Rating Scale (BPRS), and the Brief Psychiatric Rating Scale for Children (BPRS-C) as needed and appropriate**
- **Ability to conduct an assessment of an individual’s readiness and desire for psychosocial interventions**
- **Ability to conduct a strengths based assessment including an assessment of functional capability**
- **Ability to conduct an assessment of internal and external resource availability and the individual’s ability to utilize available resources**
- **Ability to assess perceived recovery and life satisfaction/quality of life**
- **Ability to assess and address positive/psychotic and negative symptoms**
- **Ability to recognize psychosis and thought disorder and understand in depth the nuances of each condition considered within the purview of SMI/SED**
- **Ability to recognize and screen for potential cognitive deficits that are core areas of dysfunction for people with SMI/SED including processing speed, verbal memory, attention, and social deficits**
- **Ability to recognize limitations posed by cognitive impairments and potential for lessened insight and, as needed, ability to conduct behavioral observational assessments that accurately account for these**
- **Ability to assess for the potential risk for suicide and violence to self or others**
- **Ability to recognize and understand etiology of comorbid trauma and substance use disorders in SMI/SED disorders and be competent in differential diagnosis of similarly presenting diagnoses such as PTSD and personality disorders**
- **Knowledge of medication side effects especially those specific to psychotropic medications and ability to assess for medication adherence and barriers to adherence**
- **Ability to integrate the intersection of diversity related to age, cultural, spiritual/religious beliefs, etc. specifically related to the presentation of symptoms unique to SMI/SED**
- **Ability to recognize the level of capacity and competence of an individual with SMI/SED in order to make appropriate recommendations regarding interventions or to refer to appropriate specialty services including those provided by other disciplines**

**Interventions:** Comprehensive knowledge of psychosocial rehabilitation interventions designed to foster recovery and meet the needs identified by each person:

- Schizophrenia PORT evidence based and promising practices (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010) including:
  - **Assertive Community Treatment** – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
• Supported Employment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
• CBT and CBTp – knowledge of differences between CBT and CBTp and ability to competently practice and supervise others in both interventions
• Family intervention/psychoeducation – knowledge of fidelity criteria and ability to implement intervention and supervise others
• Skills and CBT training – knowledge of how to competently practice and supervise others in practice
• Social learning program (Token Economy) – knowledge of intervention, its appropriate use, ability to implement and train and supervise others
• Integrated dual diagnosis treatment/Concurrent disorders treatment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
• Weight management approaches and Smoking cessation approaches – ability to competently implement appropriate interventions and supervise others
• Illness self-management including WRAP, behavioral tailoring for medication – knowledge of interventions, how to implement and supervise others
• Cognitive Remediation and Social Cognition Training – knowledge of interventions, ability to competently practice and supervise others
• Psychosocial interventions for first episode psychosis (RAISE) – knowledge of and ability to implement intervention, participate on team, and supervise others
• Peer support/peer delivered services – knowledge of interventions and ability to implement and supervise peers and other professionals

Additional interventions to address critically important problems for people with SMI/SED including:

• Stigma/Self-stigma interventions – knowledge of, and ability to implement interventions to change attitudes and decrease discriminatory behaviors among health providers and the public at large
• Trauma interventions (trauma informed and trauma specific care) – ability to competently implement trauma interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care
• Suicide prevention – ability to recognize when individuals may be at risk and provide high levels of support, refer for medical intervention and provide treatment for depression in order to reduce hopelessness
• Violence prevention – ability to recognize when individuals may be at risk and refer for medical intervention while providing high levels of support
• Interventions to decrease homelessness – ability to provide a comprehensive array of services designed to facilitate supported housing, trauma informed care, relapse prevention for substance abuse, and support to maintain housing
• Motivational interviewing for those with SMI/SED – ability to competently implement motivational interviewing as appropriate and to supervise others in practice

Specialized interventions for forensic/criminal justice populations with SMI/SED including:

• Knowledge of the factors that impact on success for forensic and criminal justice populations with SMI/SED
• Forensic Assertive Community Treatment (FACT) – ability to ability to implement intervention, participate on team, and supervise others
• CBT for those in criminal justice/forensic settings – ability to competently provide specialized CBT services and to supervise others in practice
• IDDT/Concurrent disorders treatment for those in criminal justice/forensic settings – knowledge of the specialized needs of people with SMI/SED in these settings, ability to provide integrated mental health and substance use services targeted to the population, and supervise others in practice
• Trauma interventions for those in criminal justice/forensic settings (trauma informed and trauma specific care) – recognition of trauma as the norm for those with SMI/SED in the forensic and criminal justice system,
ability to competently provide trauma specific interventions including CBT for trauma, relapse prevention for 
 alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care, 
 including services for those at highest risk and to supervise others in provision of services 
 • Supported housing interventions for those in criminal justice/forensic settings – ability to implement 
 comprehensive services to assure supported housing is available for individuals being released into the 
 community 
 • Transition planning and follow-up for criminal justice/forensic settings – ability to implement 
 adequate and appropriate transition planning and follow up for individuals being released into the community 

Specialized interventions for people with bipolar disorder:

• In addition to demonstrating competence with the above interventions for people with SMI/SED (several 
 of which are also recommended specifically for this population), an ability to competently provide interpersonal 
 and social rhythm therapy (IPSRT) and Family Focused Treatment (FFT) for bipolar disorder and to supervise 
 others in practice 

• Understanding the potential of Dialectical Behavior Therapy (DBT) which may also be helpful for 
 individuals with bipolar disorder and personality disorders dialectical behavior therapy (DBT) and to supervise 
 others in practice 

Consultation

• Ability to effectively present information and develop treatment recommendations that are 
 understandable to the person, his or her support team, and in accord with his or her goals 
 • Ability to competently work with an interdisciplinary team and present information about persons with 
 SMI/SED so that team members can understand and learn from the presentation 
 • Ability to apply specialty knowledge and expertise concerning SMI/SED symptomatology and diagnosis 
 to problems that arise in professional settings 
 • Comprehensive knowledge of psychosocial functioning and recovery and ability to describe this to team 
 members, other colleagues, and members of the public 
 • Ability to provide education and training for mental health staff on all aspects of the recovery paradigm 
 and psychosocial rehabilitation assessments and interventions 
 • Ability to integrate all information into a case formulation using psychosocial interventions designed to 
 promote recovery and attainment of the goals articulated by each person 
 • Ability to assist supervisees and team members in the management of difficult behaviors 
 • Ability to integrate the knowledge, values, and attitudes critical for successful work with people with 
 SMI/SED into interdisciplinary team settings to facilitate shared decision making 
 • Ability to work with staff in specialized facilities such as supported housing, etc. to help them recognize 
 and deal appropriately with symptoms and problem behaviors to help individuals with SMI/SED thrive in the 
 community 
 • Ability to educate, train and supervise staff in the best ways to help people with SMI/SED manage 
 symptoms, set and achieve goals for themselves, and use resources available to them. Some examples of potential 
 issues include limit setting, stigma, empathy, delusions/hallucinations, reflective listening, crisis intervention - at 
 all levels of training from front-line behavioral health staff through to highly trained staff and 
 managers/administrators 
 • Ability to consult with families about their member’s illness and the role of family in treatment 
 • Knowledge of resources to help with access to care (e.g., family members trying to get members into care 
 and navigate complex system) 
 • Ability to educate and train staff in facilities and on specialized units for youth, young adults, and older 
 persons where knowledge and expertise is lacking about behavior health particularly SMI/SED
Research and Evaluation
- Recognition of the importance of incorporating persons with lived experience of SMI into all aspects of research and evaluation from conception to completion and publication. This includes formulation of hypotheses, study questions and design, determination of statistical methods, participants to be recruited, etc.
  - Knowledge of and ability to use mixed methods research designs
  - Familiarity with and ability to use single case designs (disorders may be persistent over time and multiple baselines provides a more clear picture of the impact of different treatment components and their helpfulness with individuals)
  - Recognition of ability to incorporate family members and first degree relatives into designs (research provides insight into how the illness manifests in individuals vs. family members looking at the phenotypes in individual and family)
  - Recognition of importance of involvement of caregivers and other stakeholders in research and willingness to incorporate into designs
  - Up to date knowledge of the latest assessments and interventions for this population
  - Ability to utilize research/evaluation knowledge to adapt/modify assessments and interventions that have excluded persons with SMI and to do so appropriately recognizing when fidelity to the original practice is essential
  - Recognition and understanding the needs of vulnerable populations vis a vis their participation in research efforts
  - Recognition and understanding of the ability of persons with SMI/SED to provide informed consent
  - Ability to inform and educate IRBs about the type of intervention research common with SMI populations such as psychosocial interventions
  - Understanding of the unique needs of persons with SMI/SED vis a vis research/evaluation and ability to apply this knowledge to prevent/minimize drop out as typically this is different for SMI 1) drop outs tend to be doing worse and 2), severe economic disadvantages impact people with SMI disproportionately 3), follow up studies need to include more time (>1 year) due to the nature of the illness
  - Knowledge of and ability to conduct multifactorial designs of programs as these are the norm with SMI populations; understanding of the importance of controls for non-specific factors
  - Ability to identify appropriate outcomes for program evaluation work due to broad nature of quality of life, psychosocial functioning, recovery
  - Ability to undertake program evaluation which is critical so that a developed program can be improved - systems within which SMI/SED persons are seen often more difficult to work with in structured research settings due to multiple stakeholders
  - Ability to obtain buy-in from multiple under-resourced clients and stakeholders

Supervision/Teaching
- Comprehensive knowledge of all psychosocial assessments and interventions and ability to impart knowledge about these and to supervise others in practice
  - Ability to provide education and training for mental health staff on all aspects of the recovery paradigm and psychosocial rehabilitation interventions
  - Ability to impart knowledge about the importance of hope, respect, positive regard, and acceptance of person’s goals and wishes with development of the therapeutic relationship which is key and sometimes difficult to form and to supervise others in their development of these
  - Ability to impart an understanding of the pace and common non-linear process for recovery and ability to develop reasonably positive expectations for the person’s progress despite the combination of social, functional, and cognitive impairments that are common
  - Ability to help trainees and supervisees recognize incremental improvements and utilize the process of shaping in goal setting and recovery
  - Ability to impart knowledge of the phenomenology of the disorders of SMI (e.g., auditory hallucinations, negative symptoms such as diminutions of basic drives, etc.)
  - Ability to supervise effective goal setting that is often different in quality (i.e., level of difficulty) and outcome (i.e., type of goals set)
- Ability to promote self-examination of fear and pre-conceptualization of people with SMI including stigma and self-efficacy
- Ability to teach and supervise trainees about appropriate boundaries and differences in work this population
- Knowledge of standard tools for fidelity measures and ability to supervise trainees in their use
- Ability to use live or audiotape feedback to understand the often complex nuances of work with persons with SMI
- Ability to supervise a range of other mental health providers (e.g., psychiatrists, peers, nurses, social workers, occupational therapists)
- Knowledge of the complexity of systems change issues and ability to promote resiliency as resistance is encountered

**Management/Administration**
- Knowledge of needed systems of care and the importance of integration and interdisciplinary cooperation
- Familiarity with reimbursement structures and with psychosocial services that are not funded or are partially funded and ability to secure funding for needed specialized services
- Knowledge of Commission on Accreditation of Rehabilitation Facilities (CARF) requirements for accreditation and ability to implement changes needed to secure accreditation
- Knowledge of Joint Commission and Centers for Medicare and Medicaid Services standards and ability to implement changes needed to secure accreditation and ensure CMS standards are met
- Knowledge of the Americans with Disabilities Act and its amendments and application to those with SMI/SED
- Ability to lead effectively within complex multi-disciplinary teams and settings
- Knowledge of implementation and dissemination of EBPs for those with SMI/SED and the challenges of this in multiple, complex settings
- Recognition of the importance of conducting program evaluation and/or quality improvement studies and ability to convince team members of this and to implement?
- Comprehensive program development, i.e., full continuum of care that incorporates interventions and general understanding of aspects of the continuum of care
- Knowledge of the complexity of systems change issues and ability to implement needed changes
- Comprehensive knowledge of all psychosocial assessments and interventions and ability to impart knowledge about these and ensure cooperation and implementation within teams and overall system

**Advocacy**
- Ability to create opportunities for people to meet and interact with others, build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion
- Knowledge of community resources and ability to reach out to these as a means of expanding access to services for people with SMI/SED
- Knowledge of community resources and ability to intervene to help with access to care (e.g., family members trying to get members into care and navigate complex system)
- Knowledge of laws that affect individuals with SMI/SED negatively and may lead to human rights violations (e.g., laws about competency restoration process, not guilty by reason of insanity, etc.).

**Developed by representatives of the APA Task Force on SMI/SED, Division 18 of the APA, the Division 18 Section on SMI/SED, and representatives of post-doctoral programs with a specialization in SMI/SED.**

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END OF PETITION FORM