Competencies and Training Guidelines for the Post-Doctoral Specialty in Serious Mental Illness (SMI) Psychology

Specialty Council for Serious Mental Illness (SMI) Psychology

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Table of Contents

Section I: Overview and General Guidance

Background and Introduction

As described by the American Psychological Association (APA),[1] "Psychologists with a specialization in Serious Mental Illness (SMI) Psychology[2] 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 (severe emotional disturbance [SED]), recover and attain their full functional capability." These broad areas listed above are further described in specialty competencies that are the basis for advanced preparation for practice and have been approved by the APA and its Commission on Accreditation (CoA) to specify the elements of training that provide the foundation for a specialization in SMI Psychology.

As part of the development of a Specialty, defined competencies, Training Guidelines (TGs) and supporting documents are provided to assist programs to ensure that their post-doctoral training provides the "…organized sequence of formal education, training, and experience in addition to the broad and general education and core scientific and professional foundations acquired through an APA or CPA accredited doctoral program" as described by APA[3]. To this end, this document has three main sections. In this first section, background information about the SMI Psychology Specialty is presented along with general guidance for post-doctoral training programs in the Specialty. In the second section the document lists the competencies at the core of the SMI Psychology Specialty as approved by CoA along with important training notes that provide context and nuance for the competencies. The third section provides the Training Guidelines that describe the specific training experiences needed to support post-doctoral residents in developing the competences necessary to become qualified SMI Psychologists.

Note that the TGs 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. Rather, the TGs are intended to assist in the development of training programming.

The competencies and TGs were developed with the participation and input of the APA's 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 Association for Behavioral and Cognitive Therapies (ABCT) Psychosis and Schizophrenia Spectrum Special Interest Group (SIG), and the Training Directors and Program Leaders of post-doctoral programs offering this Specialized training. In addition, a meeting was convened following the APA 2016 Convention in Denver, CO to further the development of the TGs. This meeting was sponsored by the above groups and funded by grants from the APA Board of Educational Affairs and Division 18 Psychologists in Public Service. Representatives included members from the aforementioned groups as well as a representative from the APA Board of Professional Affairs. Following development of a draft of the TGs, they were sent

[1] https://www.apa.org/ed/graduate/specialize/serious-mental-illness

[2] The official name of the Specialty is Serious Mental Illness (SMI) Psychology which incorporates individuals with serious mental illness and severe emotional disturbance.

[3] https://www.apa.org/about/policy/principles-recognition.pdf

for review and comment to members of interested groups, revised based on feedback received, and finalized. The TGs will be regularly updated as new information becomes available.

Caveats

- 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 *nor does it 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.
- The TGs contain information specific to post-doctoral residency programs in SMI Psychology and contain information that is more generic and required for all APA accredited post-doctoral residency programs.
- Residency programs wishing to become accredited in this Specialty must fully meet the most recent version of the APA Standards of Accreditation (SOA) and must comply with all of the most recent APA Implementing Regulations (IR) that accompany the SOA.
- Residency programs wishing to become accredited in this Specialty are expected to ensure that their Major Area of Study corresponds closely to the recommended programmatic requirements as presented in the Council of Specialties Taxonomy for SMI Psychology (https://www.cospp.org/).

For greater detail regarding all aspects of these Training Guidelines, please consult the Petition for Recognition of a Post-Doctoral Specialty in Serious Mental Illness Psychology (SMI Psychology) 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

Overview of Population to be Served by SMI Psychologists

Psychologists with a Specialization in SMI Psychology serve individuals across the lifespan with primary DSM-5 diagnoses that include the following:

- Schizophrenia
- Schizoaffective Disorder
- Bipolar Disorder
- Delusional Disorder
- Other Psychotic Disorders
- Depression with a severe impact on functioning
- May have:
    - co-morbid, but not primary, substance use disorder diagnoses
    - exposure to trauma and co-occurring posttraumatic stress disorder

However, this Specialization does not include individuals with primary diagnosis of a personality disorder and/or primary posttraumatic stress disorder. Although these disorders are sometimes considered to be part of the SMI designation (Le et al., 2020), treatment and assessment for these disorders requires unique considerations outside the scope of these Guidelines and competencies.

It is important to note that the problems experienced by people with an SMI or SED diagnosis are typically complex, severe, and not singular in scope. Examples include:

- Severe symptomatology (e.g., hallucinations, delusions, extreme mood swings, disorganized thinking, disorganized behavior, and disordered or flattened affect)
- Neuropsychological and/or cognitive deficits and associated problems
- Social skill/interpersonal deficits
- Trauma and resultant severe anxiety, depression, co-occurring posttraumatic stress disorder and/or co-occurring substance use. Note that these can arise either prior to or post-onset of the SMI/SED. This can include trauma associated with the health care system, incarceration, or hospitalization in forensic psychiatric facilities, etc.
- Greater morbidity and earlier mortality from natural (e.g., cancers, cardiovascular disorders, metabolic syndrome, etc.) and unnatural causes (e.g., suicide and violence)
- Difficulty completing educational goals or working competitively

All of the above problems can be and frequently are magnified for women, people from non-majority cultures, those with co-morbid disabling conditions, members of the LGBTQ+ population, immigrants and refugees, and other disenfranchised or stigmatized groups who have SMI/SED.

Additionally, individuals with SMI and SED may also experience social marginalization and stigma, which may create additional challenges that may interfere with recovery and create negative cycles. For example, morbidity and mortality may be exacerbated by delayed or lack of access to appropriate health care. Poverty and homelessness may worsen one's ability to care for him or herself.

Due to the unique symptoms and severe nature of the problems described above, 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 population. 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. Psychologists working with persons with SMI/SED require an expert and expanded knowledge base which includes a unique approach to assessment and proficiency in and specialized interventions that address the complex problems typically experienced by this population.

Post-Doctoral Residency Training Programs - Specialty Specific Information

I. Admission Requirements

As stated in APA's Standards of Accreditation for Health Service Psychology (page 23-24): [4]

1. **Administrative**
   a. **Resident Recruitment and Selection**
      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

[4] American Psychological Association, Commission on Accreditation, Standards of Accreditation of Health Service Psychology approved February 2015 and Accreditation Operating Procedures approved June 2015 with revisions approved August 2017, June 2018, November 2019, May 2021), (downloaded from APA website November 2021 https://irp.cdn-website.com/a14f9462/files/uploaded/APA-Principles-Accreditation-SoA-AOP_210526.pdf)

Note that "Health Service Psychology" is a term used by the American Psychological Association, Commission on Accreditation, and defined as "…the integration of psychological science and practice in order to facilitate human development and functioning." In short, it a blanket term intended to apply to clinical, counseling, school and other areas of practice. See page 2 in document noted above.

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.

The following is a list of **minimal admission requirements** for post-doctoral residency programs in SMI Psychology:

- Assurance that the above APA SoA for Health Service Psychology standards are met
- 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
- Applicant's CV

Samples of SMI/SED specific evaluation admission forms from several SMI Psychology residency programs can be found in the Petition for Recognition of a Post-Doctoral Specialty in SMI Psychology (Criterion VII) here: www.psychtrainingsmi.com.

Please note that these are intended as samples only and programs should ensure the forms used comply with current guidance and requirements from APA.

Programs may also have other requirements (e.g., submission of a work sample, graduation from an APA or CPA accredited program, admission evaluation forms etc.).

II. Qualifications of Faculty and Training Directors

General qualifications of Faculty:

- *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. Where the post-doctoral program is university affiliated, faculty should have an academic appointment and be active in the university program.
- *Core faculty* staffing SMI Specialty Post-Doctoral programs must have experience in the assessment and treatment of the SMI/SED population.
- *Extended core faculty* teaching in a clinical area of a post-doctoral residency program in SMI Psychology may be from a variety of relevant professions and must be licensed in their respective profession (e.g., psychology, psychiatry, occupational therapy, nursing, social work, etc.). Note: If these faculty are in the process of becoming licensed, they must be directly supervised by a licensed practitioner in their discipline.
- *Faculty teaching in the research component* of the program do not need to be licensed, but should 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.
- *Other faculty* who do not meet the above qualifications would not qualify as core faculty, but are expected to have some training and experience with the SMI/SED population.

Post-Doctoral Training Directors may oversee multiple training programs and, as such, 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 in order to provide oversight and general guidance to faculty.

If the Director of Training does not personally oversee the Specialty in SMI Psychology, the primary psychologist who does oversee the Specialty in SMI Psychology must be a specialist in SMI Psychology. This person should be an experienced psychologist with advanced academic and experiential qualifications (i.e., ABPP, Fellow status in APA, other recognized status in APA, ABPP, APPIC, certification from the Psychiatric Rehabilitation Association, or similar recognition of advanced qualifications).

Section II: Foundational and Functional Competencies

For any doctoral-level program that has an Exposure, Experience, or Major Area of Study in SMI Psychology[5], general *foundational competencies* consist of the knowledge, skills, and attitudes/values that form the basis for practice. Examples of general 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. These 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. Post-doctoral training programs in SMI Psychology should ensure that residents build upon these important foundational and functional competencies through specialized didactic and experiential training aligned with the CoA Competencies described below.

Programs should contact the APA Office of Program Consultation and Accreditation for all questions related to accreditation (accreditation.apa.org or 202 336-5979).

For post-doctoral programs, the APA Commission on Accreditation (APA-CoA) has designated three levels of competencies for program accreditation. Training and evaluation for Level 1 and level 3 competencies are required of all programs at the post-doctoral level. Residency programs may also choose to incorporate Level 2 competencies that the program considers integral to achieving its aims.

NOTE: Competencies in Section I of this document (below) are included verbatim if in standard text. These Competencies are further elaborated upon by the SMI Specialty Council using the blue text boxes entitled "TRAINING NOTE" or in italics.

(For the latest version of the CoA Implementing Regulations see https://apps.apa.org/accredcomment/ website. The direct link to the document is https://irp.cdn-website.com/a14f9462/files/uploaded/Section%20C_092421.pdf

Level 1 – Advanced Competencies

Required by the Commission on Accreditation (CoA) of all accredited post-doctoral programs: Level I.[6] ***These are not specific to the SMI Psychology Specialty area*** *and are standardized across all postdoctoral residency training.*

TRAINING NOTE: ***Competent practice with persons with SMI/SED requires an ability to locate, critically evaluate, and use the scientific and practice literature that provides guidance for clinical and research endeavors with this population.***

[5] See Council of Specialties Taxonomy for Education and Training in Serious Mental Illness Psychology (https://www.cospp.org/)

[6] In order to become accredited by the APA, post-doctoral training programs must meet all CoA requirements as specified in the Standards of Accreditation (SoA) and in the Implementing Regulations (IR)—see the APA Accreditation website: https://www.accreditation.apa.org/

I. Integration of Science and Practice

Demonstration of the integration of science and practice is required at the post-doctoral level. This includes the influence of science on practice and of practice on science.

Post-doctoral Residents are expected to:

- demonstrate the ability to critically evaluate foundational and current research that is consistent with the program's focus area(s) or representative of the program's recognized specialty practice area.
- integrate knowledge of foundational and current research consistent with the program's focus area(s) or recognized specialty practice area in the conduct of professional roles (e.g., research, service, and other professional activities).
- demonstrate knowledge of common research methodologies used in the study of the program's focus area(s) or recognized specialty practice area and the implications of the use of the methodologies for practice.
- demonstrate the ability to formulate and test empirical questions informed by clinical problems encountered, clinical services provided, and the clinic setting within which the resident works.

TRAINING NOTE: ***Mental Health Recovery and the Recovery Movement are key foundational concepts that are intended to shape all aspects of care provision for people with SMI/SED diagnoses.***

II. Ethical and legal standards

Post-doctoral residents are expected to:

- be knowledgeable of and act in accordance with each of the following:
  - the current version of the APA Ethical Principles of Psychologists and Code of Conduct;
  - relevant laws, regulations, rules, and policies governing health service psychology at the organizational, local, state, regional, and federal levels; and;
  - relevant professional standards and guidelines.
- recognize ethical dilemmas as they arise and apply ethical decision-making processes in order to resolve the dilemmas as they pertain to the accredited area.
- conduct self in an ethical manner in all professional activities

TRAINING NOTE: ***Specific to SMI/SED, it is important to understand issues of competency and capacity regarding informed consent for both research and clinical practice. It is critical to balance the need for competent decision-making with a respect for self-autonomy, while considering risks to self and others.***

Legal issues, hospitalization, and other restrictions of freedom are not uncommon in the lives of people with SMI/SED and warrant important consideration when providing treatment. It is key to:

- ***understand issues of social justice and equity as they affect persons with SMI/SED***
- ***identify barriers (e.g., psychological, legal, financial, etc.) to community re-integration after hospitalization, jail, or residential placement***
- ***understand and respect individuals' legal rights—and help them exercise such rights (e.g., registering for and voting, obtaining housing of one's choice, and participating in community social events and services)***

SMI Psychologists often must confer with members of the legal and criminal justice system, as well as those who help individuals access resources (e.g., social security disability payments, housing vouchers, appropriate health services, etc.). With the growing emphasis on integration of behavioral and physical health services, and the high rates of health problems and early mortality in adults diagnosed with schizophrenia and bipolar illness, SMI Psychologists often collaborate with internists and general medical practitioners who are managing the medical care of individuals diagnosed with SMI/SED. Thus, recognition of boundary issues and the legal and ethical practices of psychology and related health disciplines are important for work with this population.

III. Individual and Cultural Diversity

Effectiveness in health service psychology requires that post-doctoral residents develop the ability to conduct all professional activities with sensitivity to human diversity, including the ability to deliver high quality services to an increasingly diverse population. Therefore, post-doctoral residents in SMI Psychology must demonstrate knowledge, awareness, sensitivity, and skills when working with diverse individuals and communities who embody a variety of cultural and personal background and characteristics. The CoA defines cultural and individual differences and diversity as including, but not limited to, age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and socioeconomic status. The CoA recognizes that competence in working with individuals of every variation of cultural or individual difference is not reasonable or feasible.

Post-doctoral residents are expected to demonstrate:

- an understanding of how their own personal/cultural history, attitudes, and biases may affect how they understand and interact with people different from themselves;
- knowledge of the current theoretical and empirical knowledge base as it relates to addressing diversity in all professional activities related to the accredited area including research, training, supervision/consultation, and service;
- the ability to integrate awareness and knowledge of individual and cultural differences in the conduct of professional roles (e.g., research, services, and other professional activities). This includes the ability to apply a framework for working effectively with areas of individual and cultural diversity not previously encountered over the course of their careers. Also included is the ability to work effectively with individuals whose group membership, demographic characteristics or worldviews create conflict with their own.

- The ability to independently apply their knowledge and demonstrate effectiveness in working with the range of diverse individuals and groups encountered during residency and as consistent with the program's aim(s).

***TRAINING NOTE:** Specific to SMI/SED, it is important to:*

- *recognize the human worth of people with SMI/SED and the importance of their integration into society*
- *understand and recognize barriers experienced by those with this diagnosis*
- *understand and recognize prejudices and discrimination impacting those with this diagnosis*
- *understand issues of social justice and equity as they affect persons with SMI/SED*

Understanding of and respect for diversity are crucial for faculty, staff, and residents and must be demonstrated toward those with SMI/SED, their family members and support systems and in a manner that reflects psychology's ethical principles and professional standards. Competence in individual and cultural diversity is especially important given the wide-ranging symptoms and functional deficits that typically accompany an SMI/SED diagnosis, and the complexity of the social and cultural impact on the genesis, maintenance, and amelioration of those symptoms. Cultural factors influence one's response to psychotic symptoms (e.g., interpretation of hallucinations, taking action on delusional thinking) and experts in the field have agreed for years that cultural context colors the experience of illnesses such as schizophrenia.

The DSM-5 Cultural Formulation Interview (American Psychiatric Association, 2013) is recommended for use in training programs in this Specialty to ensure Resident competence in conducting person-centered cultural assessment.

Level 2—Program-Specific or Area-of-Focus Competencies[7]

Per the CoA: "Programs that are accredited in one of the substantive major areas of training (Clinical, Counseling, or School Psychology) or other developed practice areas that provide greater depth of training than that which occurs during the internship training year are required to identify Level 2 competencies emanating from the program's aims that are required of all post-doctoral residents. These may include some or all CoA profession-wide competencies or other competencies identified by the program. Programs that are accredited in a substantive specialty practice area may choose but are not required to identify program-specific or area-of-focus competencies in addition to the required Level 3 competencies." Level 2 competencies that are not APA CoA required but are recommended by the Specialty Council are presented following the Level 3 APA-CoA required competencies.

Level 3—Serious Mental Illness Psychology – Specialty Area Competencies

Per the CoA: "Programs that are accredited in a substantive specialty practice area, as identified in IR C-5P, are required to provide advanced preparation for practice in the competencies and associated elements associated with the specialty practice area. Specialty competencies must be operationalized in terms of multiple elements and must, at a minimum, reflect the bulleted content for each required specialty competency." Programs must also document evaluation of each competency for all residents. The following are the APA CoA required Level 3 competencies for SMI Psychology.

I. Professional Values

Post-doctoral residents are expected to:

[7] In order to become accredited by the APA, post-doctoral training programs must meet all CoA requirements as specified in the Standards of Accreditation (SOA) and in the Implementing Regulations (IR)—see the APA Accreditation website: https://www.accreditation.apa.org/ and https://irp.cdn-website.com/a14f9462/files/uploaded/Section%20C_092421.pdf

- demonstrate up-to-date knowledge of professional practice guidelines and research materials related to the practice of the Serious Mental Illness (SMI) Psychology Specialty.
- demonstrate an emerging professional identity consistent with the SMI Psychology Specialty.

TRAINING NOTE: Mental Health Recovery and the Recovery Movement are key foundational concepts that are intended to shape all aspects of care provision for people with SMI/SED diagnoses.

Assessment Note: *Comprehensive assessment is essential to any recovery plan. Residents should be able to appropriately assess, evaluate, and develop practical interventions for individuals with severe and persistent mental illnesses, including those with complicated mental, substance abuse, and medical co-morbidities, as well as histories of trauma. These assessments should then be used to inform treatment planning, incorporating relevant f practical and evidence-based interventions.*

II. Assessment

Post-doctoral residents are expected to:

- demonstrate knowledge of current diagnostic systems related to Serious Mental Illness, strengths-based and functional capability assessments, and subjective measures of recovery and quality of life; and must provide evidence of the ability to conduct assessments using these specialized measures.
- demonstrate the ability to apply the knowledge of functional and dysfunctional behaviors including context to the assessment and/or diagnostic process as particularly applicable to the Serious Mental Illness population.
- demonstrate the 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 Serious Mental Illness/Serious Emotional Disturbance.
- interpret assessment results, following current research and professional standards and guidelines, to inform case conceptualization, classification, and recommendations (including components related to positive and negative symptoms, strengths, and an individual's ability to make use of resources), while guarding against decision-making biases, distinguishing the aspects of assessment that are subjective from those that are objective.
- demonstrate the ability to recognize and screen for potential cognitive deficits that are core areas of dysfunction for people with Serious Mental Illness/Serious Emotional Disturbance including processing speed, verbal memory, and attention.
- demonstrate knowledge of and ability to assess psychosis, thought disorder, and other conditions associated with Serious Mental Illness/Serious Emotional Disturbance.
- demonstrate knowledge of medication side effects especially those specific to psychotropic medications and ability to assess for medication adherence and barriers to adherence
- demonstrate the ability to assess for capacity to give informed consent.

TRAINING NOTE: ***For SMI Psychologists, it is important to:***

- ***recognize and understand the etiology of co-occurring substance use disorders, as well as the role of trauma in SMI/SED disorders***
- ***assess for family burden in caregivers of individuals diagnosed with an SMI/SED***
- ***assess for the potential risk for suicide, self-harm, or violence towards others***
- ***assess an individual's readiness and desire for PSR interventions, as well as their perceived recovery, life satisfaction/quality of life, and self-stigma***
- ***assess resources (including social skills/deficits and levels of insight) available to the individual and the person's ability to utilize those resources***
- ***assess and address both positive and negative symptoms objectively and subjectively***
- ***assist clients in identifying their values as they develop individualized goals using shared decision-making and person-centered planning approaches***
- ***develop tailored clinical and recovery-oriented interventions that meet the client's identified goals and facilitate action steps for goal achievement***
- ***recognize when modifications to treatment plans are needed to reflect the needs and values of the client and work to determine satisfaction of services provided***
- ***display knowledge of the essentials of each of the schizophrenia PORT evidence-based and promising practices recommendations (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010), and their fidelity criteria where these have been developed***

See Appendix B for Assessment Instruments Recommended for Use with SMI/SED Population

ALSO:
Language and approach regarding medication use are important points in recovery-oriented care. Phrases like "medication compliance" are counter to a recovery approach.

Utilizing assessment and intervention methods based on knowledge of the full range of diversity-related characteristics—including recognition of the importance of environmental, social, and developmental factors as well as health disparities, that might account for illness and functioning in persons with SMI/SED—is critically important.

Intervention Note: *Residents should demonstrate skills in applying and adapting evidence-based psychiatric rehabilitation (PSR) interventions with individuals with SMI/SED. Residents are also expected to manage crisis situations and identify opportunities for transition of services for persons with SMI/SED. Residents are expected to provide appropriate interventions in response to a range of presenting psychosocial problems and treatment concerns and must demonstrate the ability to effectively work with diverse populations, interprofessional providers, and various program specialties. By the completion of their training year, residents with a Major Area of Study in SMI Psychology 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.*

TRAINING NOTE: For SMI/SED Psychologists, it is important to:

- ***assist clients in identifying their values as they develop individualized goals using shared decision-making and person-centered planning approaches***
- ***develop tailored clinical and recovery-oriented interventions that meet the client's identified goals and facilitate action steps for goal achievement***
- ***recognize when modifications to treatment plans are needed to reflect the needs and values of the client and work to determine satisfaction of services provided***
- ***display knowledge of the essentials of each of the schizophrenia PORT evidence-based and promising practices recommendations (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010), and their fidelity criteria where these have been developed***

See Appendix C for Interventions Recommended for Use with SMI/SED Population

III. Intervention

Post-doctoral residents are expected to:

- demonstrate the ability to implement interventions informed by the current Serious Mental Illness/Serious Emotional Disturbance scientific literature, assessment findings, diversity characteristics, and contextual variables.
- demonstrate the ability to implement social skill training and illness management skills.
- demonstrate the ability to implement evidence-based interventions for first and subsequent episodes of psychosis.
- demonstrate the ability to modify and adapt treatment protocols to the specific needs of the SMI population, develop tailored clinical and recovery-oriented interventions that meet the client's identified goals, and develop action steps for goal achievement.
- demonstrate the ability to implement evidence-based interventions and psychoeducation to family members or care partners of persons with Serious Mental Illness/Serious Emotional Disturbance.
- demonstrate the ability to assist clients identify their values as they develop individualized goals using shared decision making and person-centered planning approaches.
- demonstrate the ability to develop tailored clinical and recovery-oriented interventions that meet the client's identified goals and develop action steps for goal achievement

TRAINING NOTE:: ***An SMI Psychologist should be knowledgeable in a number of key interventions. The list below represents highly desired competencies related to various key interventions.***

- ***Cognitive Behavioral Therapy for psychosis (CBTp) and general practice of Cognitive Behavioral Therapy (CBT)—have thorough knowledge of the differences between CBTp and CBT, and demonstrate the ability to competently practice and supervise others in both interventions***
- ***Skills training and illness management skills – demonstrate the ability to apply these interventions with persons with SMI/SED and demonstrate the ability to supervise others across implementation***
- ***Family Intervention/Psychoeducation – understand fidelity criteria and exhibit the ability to implement and supervise others in doing so***
- ***PSR interventions for first episode psychosis (FEP) –demonstrate knowledge of recent research indicating the effectiveness of FEP interventions (e.g., RAISE) and to the ability to implement interventions, participate on teams, and supervise others***
- ***Stigma/self-stigma interventions – exhibit familiarity with and skills in the implementation of interventions aimed at changing biased attitudes and decreasing discriminatory behaviors among health providers and the public at large***
- ***Trauma interventions (trauma informed and trauma specific care) – exhibit the 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***
- ***Assertive Community Treatment (ACT) –display knowledge of fidelity criteria and the ability to implement appropriate interventions, participate on teams, and supervise others***
- ***Supported Employment (SE) – be able to adhere to fidelity criteria, implement interventions, participate on teams, and supervise others***
- ***Social learning programs (e.g., Token Economy) – display knowledge of, appropriate application of, and skills in implementation of interventions, as well as the ability to train and supervise others***
- ***Integrated Dual Diagnosis Treatment (IDDT)/Co-occurring disorders treatment –demonstrate knowledge of fidelity criteria and ability to implement interventions, participate on teams, and supervise others***
- ***Weight management approaches and smoking cessation approaches – be able to competently implement appropriate interventions and supervise others***
- ***Illness self-management including Wellness Recovery Action Planning (WRAP) and behavioral tailoring for medication – demonstrate ability to implement and supervise others***
- ***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 – exhibit knowledge of interventions to help individuals achieve educational goals***
- ***Motivational interviewing (MI) for those with SMI/SED – ability to competently implement motivational interviewing as appropriate and to supervise others in practice***

See Appendix C for Interventions Recommended for Use with SMI/SED Population

Interventions in Special Settings Note: *Special settings (e.g., forensic) and symptom clusters (e.g., Bipolar Disorder) present further opportunities to demonstrate breadth of proficiency in treatment of SMI/SED. See below for related Training notes.*

***TRAINING NOTE:** Specialized Interventions for Forensic/Criminal Justice Populations with SMI/SED - residents should be familiar with relevant interventions (such as those below) and should demonstrate understanding of the factors that impact the success of these interventions for forensic and criminal justice populations with SMI/SED:*

- *Forensic Assertive Community Treatment (FACT) – Residents demonstrate the ability to implement relevant interventions, participate on teams, and supervise others*
- *Cognitive Behavioral Therapy for psychosis (CBTp) and general practice of Cognitive Behavioral Therapy (CBT) – Demonstrate the ability to appropriately tailor these interventions for persons with SMI/SED in criminal justice/forensic settings and to supervise others in practice*
- *IDDT/Co-occurring disorders treatment for those in criminal justice/forensic settings – Residents demonstrate knowledge of the specialized needs of people with SMI/SED in these settings, the ability to provide integrated mental health and substance use services targeted to the population, and the capability to supervise others in practice*
- *Trauma interventions for those in criminal justice/forensic settings (trauma informed and trauma specific care) – Residents demonstrate recognition of trauma as the norm for those with SMI/SED in the forensic and criminal justice systems, the 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 (e.g., services for those at highest risk), as well as the ability to supervise others in provision of services*
- *Comprehensive supported housing interventions for those in criminal justice/forensic settings – enact efforts to assure that supported housing is available for individuals being released into the community*
- *Transition planning and follow-up for criminal justice/forensic settings – Residents demonstrate understanding of the critical nature of this intervention and the 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), residents should be knowledgeable in:

- *Interpersonal and Social Rhythm Therapy (IPSRT) and Family Focused Treatment (FFT) for bipolar disorder – demonstrate ability to implement and to supervise others in practice*
- *Dialectical Behavior Therapy (DBT) and Mindfulness Based Cognitive Therapy - demonstrate ability to implement and to supervise others in practice*

See Appendix B for Assessment Instruments Recommended for Use with SMI/SED Population

***Supervision/Teaching Note:** By the completion of the training year, residents should demonstrate the ability to give presentations in a formal didactic setting, to develop and apply mentoring/teaching skills across work with individuals or small groups, and to communicate knowledge and provide feedback to those they serve, their support networks, other professionals, trainees, paraprofessionals, and/or community partnering agencies. When teaching and providing supervision, residents should demonstrate sensitivity to ethical, legal, and cultural issues, as well as the ability to teach the principles and practices of PSR.*

IV. Supervision/Teaching

Post-doctoral residents are expected to:

- demonstrate the ability to assist supervisees and team members in the management of difficult behaviors that may be exhibited by persons with Serious Mental Illness/Serious Emotional Disturbance.
- demonstrate knowledge of supervision models and practices related to Serious Mental Illness/Serious Emotional Disturbance.
- supervise and teach others by accurately, effectively, and appropriately presenting information related to Serious Mental Illness/Serious Emotional Disturbance.

TRAINING NOTE: ***Residents are able to assist supervisees and team members in the management of difficult behaviors that may be exhibited by persons with SMI/SED. The following are highly desirable competencies related to supervision and teaching:***

- ***demonstrate the capability to competently supervise trainees in the full range of clinical activities, including psychosocial assessments, interventions, and use of fidelity measures where these exist***
- ***demonstrate the ability to impart knowledge on and help others to develop an understanding of the role of principles such as hope, respect, positive regard, and acceptance of one's goals, wishes, and preferences, in the development of the therapeutic relationship (which is key and sometimes difficult to form), as well as the ability to supervise others in fostering these values***
- ***demonstrate the ability to impart an understanding of the pace and non-linear process for recovery, to develop positive expectations for the person's progress, and to recognize the importance of incremental improvements and shaping in goal setting and recovery, despite the combination of social, functional, and cognitive impairments that are commonly observed***
- ***demonstrate the ability to impart knowledge of the phenomenology of the disorders of SMI (e.g., auditory hallucinations, conceptual disorganization, negative symptoms such as diminutions of basic drives, etc.)***
- ***demonstrate the 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***
- ***demonstrate the ability to promote self-reflection and self-examination of fear, stereotypes, pre-conceptualizations of, and biases toward people with SMI/SED, including roles of stigma and self-efficacy***
- ***demonstrate the ability to teach about and supervise trainees in maintaining appropriate boundaries and relevant considerations in work with this population***
- ***demonstrate the ability to use feedback from live or recorded sessions to understand the often complex nuances of work with persons with SMI/SED***
- ***demonstrate the ability to provide education, training, and supervision for a range of other mental health providers (e.g., psychiatrists, peers, nurses, social workers, pharmacists, occupational therapists)***

Consultation and Interprofessional Skills Note: *Within the bounds of confidentiality and privacy, residents must demonstrate the ability to listen to, understand, communicate with, and establish 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 with and proficiency in providing effective consultation and feedback to the person served, family members, clinical programs, interprofessional staff, and community partners.*

V. Consultation and Interprofessional Skills

Post-doctoral residents are expected to:

- apply specialized knowledge and expertise concerning Serious Mental Illness when consulting with other professionals.
- demonstrate the ability to educate and consult with families or care partners about the individual's illness and the role of others in treatment.
- demonstrate the ability to apply specialized knowledge and expertise concerning Serious Mental Illness/Serious Emotional Disturbance symptomatology and diagnosis to problems that arise in professional settings.
- demonstrate comprehensive knowledge of psychosocial functioning and recovery and ability to describe this to team members, other colleagues, and members of the public.

TRAINING NOTE: ***The following are highly desirable competencies related to consultation and interprofessional skills. Residents should be able to:***

- **demonstrate the ability to educate and consult with families about their family member's illness and the role of family in treatment**
- **apply specialized knowledge and expertise concerning SMI/SED symptomatology and diagnosis to problems that arise in professional settings**
- **demonstrate comprehensive knowledge of psychosocial functioning and recovery, as well as the ability to describe relevant concepts to team members, colleagues, and members of the public**
- **demonstrate the ability to integrate information into a case formulation that presents an opportunity for use of PSR interventions designed to promote recovery and attainment of the client's self-identified goals**
- **demonstrate the ability to work with staff in specialized facilities (e.g., supported housing) to help them recognize and respond appropriately to symptoms and problem behaviors in order to help individuals with SMI/SED thrive in their community**
- **demonstrate the ability to educate, train, and supervise staff at all levels of training (from front-line behavioral health staff to highly trained staff, managers, and administrators) in the recovery paradigm, PSR interventions, and effective ways to help people with SMI/SED manage symptoms, set and achieve goals, and access resources. Some examples of potential foci of training include limit-setting, stigma, development of empathy, delusions/hallucinations, and crisis intervention**
- **demonstrate 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)**
- **demonstrate the ability to educate and train staff in facilities and on specialized units for youth, young adults, and older persons where knowledge of and expertise in behavioral health and SMI/SED is lacking.**
- **demonstrate the 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**
- **demonstrate the 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**
- **demonstrate the 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**

Advocacy Note: *Residents should demonstrate 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 other social supports to encourage, promote, and assist persons with SMI/SED to develop social networks, access appropriate health/mental healthcare, access needed social services, and fully participate in their communities.

VI. Advocacy

Post-doctoral residents are expected to:

- demonstrate the ability to work with staff in specialized facilities to help them recognize and respond appropriately to symptoms and to create opportunities for people with Serious Mental Illness/Serious Emotional Disturbance to meet and interact with others with and without Serious Mental Illness/Serious Emotional Disturbance.
- demonstrate knowledge of community resources and ability to work with those resources for the benefit of people with Serious Mental Illness/Serious Emotional Disturbance.
- demonstrate knowledge of laws that affect individuals with Serious Mental Illness/Serious Emotional Disturbance negatively and may lead to human rights violations.

TRAINING NOTE: ***The following are highly desirable competencies related to advocacy. Residents should be able to:***

- **create opportunities for people with SMI/SED to meet and interact with others with and without SMI/SED, as well as to build social capital, promote community wellbeing, overcome social isolation, increase social connectedness, and address social exclusion**
- **demonstrate knowledge of community resources and the ability to reach out to these resources as a means of expanding access to services for people with SMI/SED**
- **demonstrate knowledge of and responsiveness to 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.)**

Management/Administration Note: *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 to persons with SMI/SED. Residents should demonstrate a good understanding of organizational dynamics and systemic issues within programs, as well as the ability to effectively function within various institutional contexts and appreciated how contextual factors impact and influence clinical care (especially for persons with SMI/SED).*

VII. Management/Administration

Post-doctoral residents are expected to:

- demonstrate the ability to evaluate the effectiveness of programs for persons with Serious Mental Illness in achieving benefits for that population.
- demonstrate the ability to design and implement clinical programs that address the specific needs of the Serious Mental Illness population.
- demonstrate knowledge of methods of bringing about organizational change and the ability to make use of those methods.

- demonstrate knowledge of the Americans with Disabilities Act and its amendments and application to individuals with Serious Mental Illness/Serious Emotional Disorder.
- demonstrate knowledge of legal and accreditation requirements applicable to facilities that treat, house, or otherwise provide services for individuals with Serious Mental Illness.

TRAINING NOTE: ***The following are highly desirable competencies related to management and administration. Residents should be able to***

- ***demonstrate knowledge of the complexity of systems change issues, as well as an ability to promote resiliency when resistance is encountered and to effect change across systems***
- ***demonstrate knowledge of various systems of care and recovery oriented care for persons with SMI/SED, as well as the importance of integrative implementation and interprofessional cooperation across care***
- ***demonstrate familiarity with reimbursement structures and with PSR services that are not funded or are partially funded, as well as the ability to secure funding for needed specialized services***
- ***demonstrate knowledge of Commission on Accreditation of Rehabilitation Facilities (CARF) and Joint Commission and Centers for Medicare and Medicaid Services (CMS) requirements for accreditation, as well as the ability to implement policies and procedures needed to secure and maintain accreditation***
- ***demonstrate knowledge of the Americans with Disabilities Act and its amendments, as well as its application to those with SMI/SED***
- ***demonstrate knowledge of implementation and dissemination challenges and opportunities relevant to use of EBPs for those with SMI/SED across multiple, complex, uncoordinated settings***
- ***demonstrate recognition of the importance of conducting program evaluation and/or quality improvement studies, as well as the ability to convince management and team members of the utility of such projects***
- ***demonstrate the ability to develop comprehensive programs across the full continuum of care that incorporate needed interventions (e.g., supported employment)specifically developed for this population***
- ***impart knowledge about PSR assessments and interventions based on a comprehensive knowledge of same; further, they should be able to promote cooperation and implementation of PSR assessments and interventions within teams and within the overall system.***

Level 2 SMI Psychology Recommended Competency Areas

The SMI Psychology Specialty Council has also recommended two additional competency categories (Level 2) that expand upon desired skill sets. These supplemental competencies serve to further emphasize the utility of such skill sets in the practice of SMI Psychology. These are not required by the CoA and it is up to individual SMI Psychology postdoctoral programs to determine if and how they wish to use these recommended competencies to guide and evaluate training. Please see the APA Commission on Accreditation (CoA) website (https://accreditation.apa.org/policies) for the most up to date information about APA accreditation and requirements. The Level 2 SMI Psychology recommended competencies are: Research and Evaluation, and Continuing Professional Development.

The CoA competency areas listed above, as well as other APA requirements of psychologists, often embed the areas of Research and Evaluation and Continuing Professional Development within other guidance. In order to underscore their importance, the Specialty Council recommends post-doctoral residency programs include training and evaluation of these in their programs.

I. Research and Evaluation:

Residents are expected to participate in scholarly inquiry and to apply theoretical and scientific knowledge to work with persons with SMI/SED. They are expected to engage in their own scholarly endeavors which may include research, grant proposal writing, and program development, implementation, and evaluation. Highly desired competencies include**:**

i. Residents have awareness of current literature and demonstrate the ability to search and evaluate literature that is applicable to the SMI/SED population
ii. Residents recognize 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 process includes, but is not limited to, the formulation of hypotheses and study questions, creation of study design, determination of statistical methods, and recruitment of participants
iii. Residents demonstrate recognition and understanding of the needs of vulnerable populations vis a vis their participation in research efforts, including but not limited to their ability to provide informed consent
iv. Residents recognize the importance of and demonstrate the ability to incorporate family members and first-degree relatives into designs (e.g., research into how illness manifests in individuals vs. family members, looking at phenotypes in the individual and their family)
v. Residents demonstrate up-to-date knowledge of the latest assessments and interventions for this population and use this knowledge to guide evaluation and research efforts
vi. Residents are able to utilize research and applicable knowledge to adapt or modify assessments and interventions that have excluded persons with SMI/SED, and do so appropriately recognizing when fidelity to the original practice is essential
vii. Residents are able to identify appropriate program evaluation outcomes – paying consideration to the various factors impacting quality of life, psychosocial functioning, and recovery, while capitalizing on the involvement of multiple stakeholders
viii. Residents are able to inform and educate IRBs about the type of intervention research common with SMI/SED populations, such as PSR interventions
ix. Residents demonstrate understanding of the unique needs of persons with SMI/SED vis a vis study design and apply this knowledge to prevent/minimize dropout rates, as these are typically different for persons with SMI/SED
    a. dropouts tend to be doing worse
    b. severe economic disadvantages impact people with SMI/SED disproportionately
    c. follow-up studies need to include more time (>1 year) due to the nature of the illness
x. Residents demonstrate knowledge of mixed methods research designs and other methods that are best suited to the environments and situations of persons with SMI/SED and seek consultation from experts as needed
xi. Residents demonstrate familiarity with and the ability to use single-case designs, have an understanding of their utility (i.e., disorders may persist over time and multiple baselines provide a clearer picture of the impact of different treatment components and their level of effectiveness), and - seeking relevant consultation from experts as needed
xii. Residents demonstrate knowledge of and, when appropriate, the ability to conduct multifactorial designs of programs with SMI/SED populations. They exhibit understanding of the importance of controls for non-specific factors and the ability to seek consultation from experts as needed

xiii. Residents demonstrate the ability to collaborate with other disciplines (e.g., psychiatry, rehabilitation services, nursing, occupational therapy, etc.) on research projects

II. Continuing Professional Development:

Residents are expected to have competence in, recognize the importance of, and participate in ongoing professional development and life-long learning beyond their Post-doctoral training. Many of these are similar to Post-doctoral competences and are restated here to underscore the importance of maintaining up-to-date knowledge and skills.

Expected ongoing professional development competencies include:

i. demonstrate up-to-date knowledge of professional practice guidelines and research materials related to the practice of the SMI Psychology Specialty
ii. demonstrate ongoing development of a professional identity consistent with the SMI Psychology Specialty

Highly desired ongoing professional development competencies include**:**

i. demonstrate ongoing examination and awareness of personal biases, assumptions, stereotypes, and areas of potential discomfort relevant to their work with individuals with SMI, their families, and supporting team members, particularly those of backgrounds divergent from their own
ii. remain open and responsive to feedback and supervision/peer supervision
iii. maintain affiliation with professional organizations whose mission it is to advance knowledge of and practice in PSR theory
iv. engage in continuing education and life-long learning activities to strengthen existing competencies and to develop new competencies in the assessment and treatment of individuals with SMI/SED

Section III: Training Guidelines

Overview and Philosophy

The goal of treatment for those with SMI/SED is the person's recovery, measured not only as a reduction in symptoms but also as improved functioning, life satisfaction, and participation in environments of one's choice. In order to support this goal, training opportunities for SMI Psychology residents should focus on the provision of psychiatric rehabilitation (PSR) interventions, although residents may also provide treatments such as psychotherapy, illness management, and supportive therapy. Embedded in these Training Guidelines is an interprofessional approach based on a recovery model that empowers persons with SMI/SED to develop personalized goals and to choose from a variety of PSR treatment opportunities (including inpatient and outpatient services) that are designed to help them achieve these self-identified goals. The purpose of services is to improve community functioning and quality of life for persons with SMI/SED. Ensuring an active partnership with persons with SMI/SED and their communities is an essential element of this work.

Each resident's training plan should be individually created to meet the specific training needs of the resident, preferably with **80% of resident's time spent within the clinical and scientific areas specific to SMI Psychology**, including didactic, experiential, supervisory, and other components of the residency (*Major Area of Study;* See Appendix D for example training structure) and should address:

- specialized assessment methods that comprehensively assess strengths and functional capability rather than solely symptomatology and deficits
- evidence-based and promising practices designed specifically for this population
- interventions modified or developed for and researched specifically with this population, as well as for those within the forensic mental health system
- psychiatric rehabilitation approaches
- leadership in settings serving people with SMI/SED
- the practice of SMI Psychology as part of interprofessional teams
- approaches to client-centered, recovery oriented mental health care
- consultation for staff, family members, and organizations working with persons with SMI/SED
- supervision for psychology and non-psychology trainees and staff, as well as multi-disciplinary teamwork
- research and scientific inquiry, including methods adapted for SMI/SED or similar populations
- advocacy and systems transformation methods specific to mental health systems that serve this population
- ethical, legal, and cross-cultural/diversity issues and concerns that impact this population
- supervision and teaching
- program management and administration
- continuing professional development

A core set of required education and training experiences that focus on SMI Psychology are required across all programs. These include:

- Primary clinical placement (20 hours/week, 50% of time)
- Secondary placements and other training experiences (12-20 hours/week, up to 50% of time)
    - Secondary clinical placement(s)
    - Seminars and didactics

- Teaching and presentations
- Supervision

- Resident evaluation and program quality improvement

These are described in detail below. Note that because a focus of PSR is community integration, residents should have at least one ongoing experience in which services are provided in the community (e.g., ACT, home-based interventions, etc.). This can be in the primary or secondary clinical placement.

Note: *Attention should be given to ensure that workload is reasonable, equitable, and trainees' workload should be such to support the well-being of trainees.*

Major Area of Study in SMI Psychology: Required Primary Clinical Placement

I. Settings:

For the duration of the training year, all psychology post-doctoral residents should participate as members of an interprofessional team for approximately 20 hours per week (50% of residents' time) with their primary clinical placement providing services to persons with SMI/SED. Primary placement settings can be designed across the care continuum (e.g., outpatient, residential, inpatient, etc.) and should provide opportunities for residents to learn about recovery-driven systems of care. Ideally, this, and all placements, should include a recovery-oriented approach and use of PSR practices in service provision for those with SMI/SED. Clinical supervision should be provided by a licensed psychologist as per APA training guidelines.

Examples of core components that recovery-oriented PSR units/teams include are:

- Specialized individualized assessment/re-assessment designated for use with the SMI/SED population, including intakes, diagnostic clarifications, cognitive screening, functional assessment, rehabilitation readiness assessment, and recovery/treatment planning

- Evidence-based and promising PSR practices,[8] including:
  - Family psychoeducation
  - Assertive Community Treatment (ACT)
  - Supported education
  - Supported employment (particularly the Individual Placement and Support Model)
  - Concurrent disorders treatment
  - Social cognition and cognitive remediation training
  - Early intervention and PSR treatments for recent onset psychosis
  - Trauma-informed and trauma-specific care
  - Illness management interventions
  - Interventions for those in criminal justice and forensic settings

[8] Detailed information about all evidence-based and promising practices for this Specialty can be found in the practice guidelines referenced above and in the Petition to APA for recognition of this Specialty which is posted on the Specialty Council website.

- Individual or group psychotherapy, including:
  - CBT for psychosis (CBTp)
  - Social skills training
  - Illness management and recovery
  - Anger management
  - Development of relationship skills
  - Family psychoeducation
  - Cognitive behavioral social skills training (CBSST)
  - Cognitive enhancement therapy
  - Interpersonal psychotherapy
  - Health promotion interventions such as diabetes management, exercise promotion and smoking interventions
  - Solution-focused approaches (e.g., WRAP)

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

II. Experiences:

Across all placements, the post-doctoral resident should be the primary psychologist responsible for several individual clients. As residents increase their skill, confidence, and levels of responsibility, they should receive more complex cases and more independent clinical work, as well as the ability to pursue their own training goals and opportunities to take on additional cases (if desired). Given that much PSR work focuses on community integration, programs should consider providing at least one ongoing experience outside of the clinic/within the community (e.g., ACT, home-based interventions, etc.).

Clinical and related experiences should include:

- conducting a range of EBPs and promising practices—preferably specific to persons with SMI/SED—with fidelity to the models (if fidelity criteria exist)
- leading or co-leading of at least one or more skills training group(s)
- conducting several cultural, strengths-based, and functional assessments—and use of those assessments to develop treatment plans or recommendations for clients
- providing psychoeducation to clients and their social supports (e.g., families, friends) to meet client's expressed needs
- offering case presentations that include a cultural case formulation
- conducting screening and providing diagnostic, clinical, and strength-based functional and resource assessments
- working with clients on goal-setting
- helping motivate individuals to engage in PSR treatment
- assisting in data collection, program evaluation, and quality improvement to improve services
- participating in one-to-one (and possibly group) supervision regarding specialized PSR and related clinical activities for an SMI/SED population
- reviewing cases and processing experiences in training with other residents and trainees
- leading clinical rounds, facilitating discussions, and offering supervision and leadership
- conducting supervision of trainees within the training hierarchy (e.g., pre-doctoral interns, practicum students), if possible

Note: The intensity and level of these experiences and activities would be determined in a collaborative nature between trainee, supervisors, and the Director of Training.

Major Area of Study in SMI Psychology: Additional Requirements

During the remaining 12-20 hours of the week (30-50% of residents' time) in their Major Area of Study in SMI Psychology, residents are required to participate in an additional rotation/secondary placement as well as weekly didactic seminars, supervisory sessions, and other experiences designed to round out their understanding and knowledge of SMI/SED service provision.

I. Required Secondary Placements:

For their secondary placement, SMI Psychology post-doctoral residents should participate as members of one or more interprofessional team distinct from their primary placement but still focused on recovery and PSR services for persons with SMI/SED. Within the secondary placement, residents should work closely with a wide range of allied healthcare providers (e.g., nurses, social workers, psychiatrists, occupational therapists, vocational specialists, recreational therapists, medical residents, dietitians, art therapists, peer support specialists, etc.), family members, and other treatment partners. Clinical supervision should be provided by a licensed psychologist.

Examples could include:

- outpatient clinics
- community programs
- forensic settings
- vocational programs
- a short-stay unit where treatment services for acute episodes of psychiatric illness are offered

II. Seminars and Didactics:

In addition to completing required primary and secondary placements, residents are expected to attend seminars and didactic presentations, to have teaching and presenting opportunities, and to engage in supervision sessions focused on issues related to SMI/SED. Contemporary research literature on each topic along with seminal articles should be used to facilitate the scientific and theoretical discussion required for the Specialty with a particular emphasis on SMI/SED.

See Appendix A for examples of topics and concepts relevant to training in SMI/SED psychology. Note that not all topics could be covered in depth in a one- or even two- year post-doctoral residency program. However, residents should be made aware of and provided training on the breadth and distinctiveness of assessments and interventions available. Each residency program must decide which of the assessment instruments and interventions would be required and/or emphasized.

III. Teaching and Presentations:

Residents should demonstrate knowledge of methods of teaching (specific to PSR and the SMI/SED population) in case conferences, seminars, didactics, journal clubs, or other venues. They should be able to effectively translate knowledge of specialized PSR and related clinical activities for the SMI/SED population to interprofessional audiences. Residents may also participate in interprofessional educational activities such as patient-care rounds, case conferences, team meetings, and/or formal educational opportunities.

Residents should be encouraged to teach at least one (60-90 minute) didactic session in an area of interest, and to submit abstracts for talks to be given at relevant conferences (e.g., Psychiatric Rehabilitation Association, Association of Behavioral and Cognitive Therapies, American Psychological Association convention, APA Division seminars, NAMI conferences, and local, state, or regional conferences with an interest in SMI/SED, etc.). If applicable, time is devoted to teaching strategies for giving presentations and to providing participants feedback as they rehearse presentations for larger audiences.

IV. **Supervision:**

Individual and Group Supervision with Training Faculty: Generally, a resident's training will follow a progression from observation of supervisor to increasingly independent service delivery. Supervision may involve live supervision, co-facilitation of groups, and video or audiotaping of sessions. It is recommended that programs incorporate one or more models of supervision into their structure, such as a competency-based approach (Falender & Shafranske, 2004) or an integrative developmental model (Stoltenberg & McNeill, 2010). An evaluation tool adapted specifically for SMI/SED Psychology training and competence evaluation was piloted and is in use at post-doctoral training sites.[9]

At a minimum, two weekly hours of individual supervision must be conducted by doctoral-level licensed psychologists, at least one of whom serves as the resident's primary supervisor. Supervisors are expected to be involved in an ongoing supervisory relationship with the resident and have professional clinical responsibility for the cases on which they provide supervision. Residents should have the opportunity to discuss program matters including administrative needs, educational plans, professional development, systems issues, and other topics of individual interest. 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 psychology supervisor maintains overall responsibility for all supervision, including oversight and integration of supervision provided by other mental health professionals with psychological research and practice.

Consultation Meetings: Consultation meetings provide residents opportunities to learn more about how to work with those with SMI/SED. These meetings may provide a space to process past group or individual sessions, review skills, engage in role play exercises, identify relevant scientific data, conduct research, and practice management activities specific to PSR and the SMI/SED population, as well as to learning more about various theories, tools, and techniques.

Performing Supervision: Residents should demonstrate knowledge of methods for providing clinical supervision to other psychology trainees (e.g., interns, pre-doctoral students, doctoral interns, etc.) that emphasizes skill-building in providing Specialty care. If possible, residents should also take part in workshops or other training opportunities to develop their own supervisory skills. This is especially important if the resident is assisting other trainees and colleagues who do not have Specialty training. Topics of supervision training could include models of supervision, evaluation of clinical competency, goals of supervision, reducing anxiety in supervision, effective use of silence, considerations on countertransference, supervision and ethics, risk management, self-care for the therapist/supervisor, and respect for the full range of human diversity.

[9] The assessment tool was adapted with permission and is entitled *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*

Resident Evaluation and Program Quality Improvement

Resident Evaluation: Residents' competency is continually monitored and formally evaluated throughout the residency. At a minimum, residency programs should provide at least two formal evaluations of performance each training year. These should be focused on measurable goals or behaviors and the extent to which the resident is meeting the performance requirements and expectations of the program. See the Specialty Council website (www.psychtrainingsmi.com) for the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*. Written policies and procedures for continuation in or termination from the program should be made available to each resident.

Each formal evaluation should include a face-to-face meeting and a written report. Evaluations should include performance appraisals by the resident, supervisors, peers and/or colleagues, and the Director of Training. Behavioral observation, structured observation checklist ratings, and ratings based on record or chart review are encouraged as sources for data to inform evaluations. Other options may include oral or written examinations, clinical vignettes, written products (e.g., topic essays or literature reviews), student portfolios with evidence of learning, patient satisfaction ratings, and patient outcome data. Competency evaluations should typically be behaviorally-based. Residents should be evaluated on their knowledge, skills, and abilities related to their understanding and application of didactic and seminar information, their ability to participate in supervision and to supervise others, their aptitude in providing consultation, education, and training, their work across interprofessional and discipline-specific teams, and their conduct in research/evaluation activities.

Feedback should be provided at several times during the rotation with the exact timing dependent on the duration of the rotation. Any deficit areas must be 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 should be reviewed at the mid- and end-points of the rotation to determine appropriateness and status.

Program Quality Improvement: At the end of each rotation, residents should complete evaluations of supervisors and rotations. At the end of the residency, they should complete an evaluation of the residency overall, including feedback on research opportunities, didactics, seminars, and other components. Results should be used to modify, improve, and/or enhance the quality of the residency training and documentation of such improvements should be recorded.

Evaluation Tools: The Specialty Council strongly encourages use of the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED).*[10] This tool includes 4 areas of competence (i.e., General Knowledge, Assessment, Intervention, Consultation) that allow for individual items to be categorized as 1) knowledge base and 2) professional functioning. Individuals and/or supervisors utilize this *Instrument* to rate the level of competency (i.e., novice, intermediate, advanced, proficient, expert). **NOTE:** The APA CoA requires that post-doctoral programs seeking accreditation document evaluation of each required competency for all residents.

The *Instrument* was developed by the Specialty Council which requested and received permission to modify an evaluation instrument developed by the Council of Professional Geropsychology Training programs (i.e., Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel, et al., 2012).

[10] Instrument is available on the Specialty Council website (www.psychtrainingsmi.com)

The *Instrument* is intended to serve three main functions for professional development:

1) to allow individuals to identify personal competency areas in need of improvement via continued professional development and education;
2) to provide aggregate data on the areas around which there is the greatest need for additional training to inform the development of CE opportunities; and
3) to provide a holistic structure from which to develop and evaluate available training and professional development offerings. This evaluation *Instrument* is intended to measure competency over time and is highly recommended for use by programs in this Specialty.

Available Training-Related Resources

The *Recovery to Practice Curriculum*[11] (American Psychological Association & Jansen, 2014) is a practice guideline developed by APA and designed specifically for psychologists practicing in the SMI/SED Specialty area. The *Curriculum* is a comprehensive guideline for training psychologists to work with persons with SMI/SED and includes readings, exercises, assessments, and other materials. It is currently in use at sites across the United States.

The *Clinical Practice Guideline Toolkit for Psychologists Working with Persons with Serious Mental Illness/Severe Emotional Disturbance*[12] is a short clinical practice guideline tool developed for psychologists working in the Specialty. The *Toolkit* provides an easy-to-use mechanism for conceptualization, identification, and assessment of issues and related intervention planning and execution. The *Toolkit* consists of a flowchart depicting the stages of psychological practice and is designed as a quick reference guide for use by frontline psychologists, program managers, or administrators working with the SMI/SED population. The *Toolkit* can be used together with the *Curriculum*. Note that the *Toolkit* was prepared with the expectation that those using it would already have specialized training with the SMI/SED population, and is not meant as a substitute for comprehensive training in psychological assessment and treatment for those with SMI/SED. Instead, it is meant as a handy guide to help psychologists make certain that they have covered the essential steps when working with this specialized population.

The National Institute for Health and Care Excellence (NICE) guideline entitled *Psychosis and Schizophrenia in Adults: Prevention and Management* (National Institute for Health and Care Excellence, 2014) [NICE][13] is the pre-eminent and most comprehensive interprofessional practice guideline for working with people with SMI. The NICE guidelines are continuously reviewed and updated. Furthermore, in 2016, NICE introduced a new guideline based on the emerging science around early intervention for those experiencing a first episode of psychosis entitled: *Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance*. With respect to SED, NICE provides the guideline entitled *Psychosis and Schizophrenia in Children and Young People: Recognition and Management*. There are also NICE guidelines for practice with patients diagnosed with bipolar disorder and for assessment and treatment of co-morbid psychosis and substance use disorders. Other important resources include the reports from the NIMH PORT study (Kreyenbuhl, Buchanan, Dickerson & Dixon, 2010), the NIMH RAISE trial (Kane, et al., 2016), the SAMHSA evidence-based toolkits [14], and the SAMHSA statement on Cognitive Behavioral Therapy for Psychosis as the Standard of Care for Individuals Seeking Treatment for Psychosis [15]

[11] *Recovery to Practice Curriculum can be found on the Training page at* www.psychtrainingsmi.com or at www.apa.org/pi/rtp
[12] *Clinical Practice Guideline Toolkit for Psychologists Working with Persons with Serious Mental Illness/Severe Emotional Disturbance* is located here www.psychtrainingsmi.com
[13] The NICE Practice Guideline, *Psychosis and Schizophrenia in Adults: Prevention and Management* is located here https://www.nice.org.uk/guidance/cg178
[14] SAMHSA evidence-based toolkits are located here https://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs
[15] SAMHSA guide located for download at this link https://store.samhsa.gov/product/cognitive-behavioral-therapy-for-psychosis/PEP20-03-09-001

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Appendix A: Topics & Concepts Relevant to Training in SMI Psychology

Note: Topics below are described in seminar format; however, topics may be covered in seminars, workshops, or any other training venues.

Principles of Psychosocial Rehabilitation (PSR): This weekly didactic seminar should mirror the training philosophy of the scientist-practitioner model and be designed to provide participants with a broad and thorough understanding of PSR interventions, principles, theories, and current research in clinical and community psychology. Sessions should focus on the specialized assessments and evidence-based or promising PSR practices that have been designed, developed, and empirically validated for persons with SMI/SED, as well as other topics relevant to the Specialty (e.g., stigma, ethics, and boundaries). Care should also be taken to distinguish how relevant considerations may differ between general clinical settings and those focused on persons with SMI/SED.

Research/Program Evaluation and Dissemination Seminar: Residents should gain experience in identifying, reviewing, and contributing to the scientific literature and knowledge-base for SMI Psychology. Each resident should be expected to design, develop, and implement a research or program evaluation project, or an educational dissemination project that can be presented at a relevant national, regional, or local conference. The purpose of this undertaking is to become proficient with the nuances of conducting research/evaluation with persons with SMI/SED or the program/systems that treat this population. This seminar may also be designed to assist in the formulation and execution of an education dissemination 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. 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.

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 conducted 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 client and treatment team. Residents would be assigned at least one case (preferably two or more) as part of the interprofessional team.

Systems Change Seminar: Training should include a didactic seminar comprised of discussions about leadership, management styles, and professional development. Residents should meet with various leaders and managers, who facilitate discussions on topics ranging from mentoring, decision-making, workforce development, career paths, negotiation styles, politics in organizations, and leadership in education/community organizations - specifically with an emphasis on effecting systems change to reflect mental health policies for recovery and rehabilitation for persons with SMI/SED. This seminar

draws heavily from the research literature on change management, organizational development, and systems design. Readings on organizational behavior and culture highlight both historical and modern perspectives. Contemporary re-design models that place the person at the center of any change initiative are also highlighted, along with the link between these human-centered initiatives and the SMI Psychology Specialty's focus on person-centeredness.

Diversity Seminar: When working with the SMI/SED population, diversity training is primarily practical and applied, with cultural competence defined as a foundational competency. While topics and speakers will likely cover a broad range, those that are particularly pertinent to persons with SMI/SED should be highlighted. Seminar should provide training on ethical issues, informational content, clinical considerations, and interventions relevant 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, and discuss various identity factors (e.g., age, sex, gender, ability/disability/illness, culture, ethnicity, race, language/culture of origin, sexual orientation, socioeconomic status, religious/spiritual beliefs), as well as the intersectionality of identities and strategies to provide culturally informed care.

Note that the interpretation of hallucinations, response to psychotic symptoms, and taking action on delusional thinking are all shaped by cultural influences and experts in the field have agreed for years that cultural context shapes the experience of illnesses such as schizophrenia (Sartorius, et al., 1974) and has continued to be affirmed more recently (Dein, 2017; Katz, et al., Laroi, 2014; Luhrmann, 2007; Versola-Russo, 2006). Furthermore, the DSM-5 highlights culturally-relevant diagnostic issues, noting that cultural and religious background must be considered when determining if an individual's experiences rise to the level of psychosis, or if instead they are part of culturally-sanctioned response patterns or cultural activities (American Psychiatric Association, 2013). This is an aspect of symptom presentation that is imperative to understand when working with persons with SMI/SED and a critical aspect of Specialty training in SMI Psychology.

Important topics include: the poor attention often given by healthcare providers to physical health complaints of persons with SMI/SED, misattributions of legitimate health concerns to psychotic symptoms, discriminatory practices (e.g., failure to follow treatment guidelines when providing care to people of color and diverse cultural backgrounds), and need for attention to language barriers, traditional beliefs about mental illness, and religious/cultural issues. The exploration of power differentials, interpersonal dynamics, and privilege should be at the core of understanding issues of diversity, social structures, and institutionalized forms of discrimination that may influence one'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. Therefore, these factors must be considered as psychologists engage in assessment, case conceptualization/formulation, and intervention.

In addition to participation in the diversity seminar described above, fellows should receive clinical training in at least one (and preferably more) clinical setting that serves a substantial proportion of non-majority SMI/SED consumers and where clinical supervisors are from diverse cultural groups. All clinical supervisors are encouraged to address diversity issues routinely in supervision with fellows.

Laws and Ethics Seminar: Mental health recovery for persons with SMI/SED raises important ethical issues regarding competence, safety, self-determination, and autonomy. Although the APA Code of Ethics (American Psychological Association, 2017) is relevant for all clinical practice, attention must be paid to issues of competency, capacity, and legal requirements. This seminar should 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. The intersection of these issues with SMI/SED should be particularly highlighted. A specific code of ethics for Psychiatric Rehabilitation Practitioners has been developed to guide recovery-oriented care (Certification Commission for Psychiatric Rehabilitation, 2012). Training in ethical decision-making and application of this knowledge for persons with SMI/SED is critical.

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 focused on how to implement EBPs for SMI/SED, best practices in PSR 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 (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.

Other Content Specific to SMI/SED

Note: These topics can be incorporated into seminars, workshops, or any other training venues.

Etiology/Epidemiology

- Stress-vulnerability Model of SMI/SED
- Neurobiologically/neurophysiologically/neurocognitive phenomena
- Biopsychosocial Model
  - Premorbid/Prodromal, First-episode
  - Untreated psychosis
  - Older adult/aging
  - Physical health/common health problems/health behaviors

Psychopharmacology for SMI/SED

- Medications and side effects /iatrogenic effects of treatment, treatment adherence, psychopharmacology, pharmacokinetics, and pharmacodynamics

History/Community Advocacy/Ethics/Diversity/Other Issues

- History of Treatment of Persons with SMI/SED, including deinstitutionalization, history of coercion, clubhouse model, empowerment movement, and systems of care/settings for care provision
- Advocacy groups/community resources
- Ethical treatment of persons with SMI/SED
- Violence and Aggression – by persons with SMI/SED and against persons with SMI/SED

Appendix B: Assessment Instruments Recommended for SMI/SED

NOTE: For a scholarly review of the assessments developed for SMI/SED, see the chapter by Glynn and Mueser (2018; in References above) which presents a comprehensive review along with information about the psychometric properties of each instrument. Additionally, a short presentation is offered in *Recovery to Practice Curriculum*[16] (American Psychological Association & Jansen, 2014)

Assessments

- Culturally informed assessment[17]
  - The DSM 5 Cultural Formulation Interview (American Psychiatric Association, 2013).
- Symptom assessment/diagnostic assessment
  - The Brief Psychiatric Rating Scale (BPRS) (Ventura, Lukoff, Nuechterlein, Liberman, Green, & Shaner, 1993).
  - The Positive and Negative Syndrome Scale (PANSS) (Kay, Fiszbein, & Opler, 1987).
  - Scale for the Assessment of Negative Symptoms and Positive Symptoms (SANS-SAPS) (Andreasen, Flaum, Swayze, et al., 1990).
  - Clinician Administered PTSD Scale (Schizophrenia) (CAPS-S) (Gearon, Bellack, & Tenhula, 2004).
  - Clinician-Rated Dimensions of Psychosis Symptom Severity (American Psychiatric Association, 2013).
  - Structured Clinical Interview for DSM-5 Disorders – Clinician Version (SCID-5-CV) (First, Williams, Karg, & Spitzer, 2016).
  - Clinical Assessment Interview for Negative Symptoms (CAINS) (Kring, Gur, Blanchard, Horan, & Reise, 2013).
  - Brief Negative Symptoms Scale (BNSS) Kirkpatrick, et al., 2011).
  - Structured Interview for Psychosis-Risk Syndromes (SIPS) (McGlashan, Walsh, & Woods, 2014).
  - Communication Disturbances Index (CDI) (Docherty, et al., 1996)
  - Scale for the Assessment of Thought, Language and Communication (TLC) (Andreason, 1986)
  - Comprehensive Assessment of At-Risk Mental States (CAARMS) (Yung, et al., 2005).
  - Bipolar Prodrome Symptom Scale (BPSS) (Correll, et al., 2014).
  - Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) (Kaufman, et al., 1997).
  - Peters et al., Delusions Inventory - 21 (PDL - 21) (Peters, Joseph, Day, Garety, 2004).
  - Beck Cognitive Insight Scale (BCIS) (Beck, Baruch, Balter, Steer, Warman, 2004).
- Recovery attitudes, self-stigma, and distress from symptoms
  - Mental Health Recovery Measure (MHRM) (Young & Bullock, 2005).
  - Recovery Assessment Scale (RAS) (Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995; Ralph, Kidder, & Phillips, 2000).
  - Illness Management and Recovery (IMR) Scales, (Mueser, et al., 2004)
  - Behavior and Symptom Identification Scale (BASIS-24; Cameron et al., 2007)
  - Self-Stigma of Mental Illness Scale (SSMI) (Corrigan, Watson, & Barr, 2006).
  - Internalized Stigma of Mental Illness Scale (ISMI) (Ritsher et al., 2003).

[16] *Recovery to Practice Curriculum can be found here*www.psychtrainingsmi.com or at www.apa.org/pi/rtp

[17] see Criterion VI of the Petition to APA for comprehensive list and detailed information about the wide array of culturally informed assessment instruments

- Stigma Scale (SS) (King et al., 2007).
- Psychotic Symptom Rating Scale (PSYRATS) (Haddock, McCarron, Tarrier, & Faragher, 1999).

- Assessment of family attitudes and burden among caregivers
  - Camberwell Family Interview (Leff & Vaughn, 1985).
  - Patient Rejection Scale (Kreisman et al., 1988).
  - Zarit Burden Scale (Zarit, Reever, & Bach-Peterson, 1980).
  - Family Experiences Interview Schedule (Tessler & Gamache, 1996).
  - Burden Assessment Scale (Reinhard, Gubman, Horwitz, & Minsky, 1994.
- Cognitive screening/evaluations
  - Brief Assessment of Cognition in Schizophrenia (BACS) (Keefe, Goldberg, Harvey, Gold, Poe, & Coughenour, 2004).
  - Brief Cognitive Assessment Tool for Schizophrenia (B-CATS) (Hurford, Marder, Keefe, Reise, & Bilder, 2009)
  - Hinting Task (Corcoran, Mercer, & Frith, 1995).
  - Penn Emotion Recognition Test (Penn, Corrigan, Bentall, Racenstein, & Newman, 1997).
  - Cognitive Assessment Inventory (CAI) (Ventura, Reise, Keefe, Hurford, Wood, & Bilder, 2013).
  - Repeatable Battery for the Assessment of Neuropsychological Symptoms (RBANS) (norms specific for persons with Schizophrenia) (Wilk, et al., 2004).
  - The MATRICS Consensus Cognitive Battery (MCCB) (Nuechterlein & Green, 2008).
- Decision making capability/capacity
  - Aid to Capacity Evaluation (ACE) (Joint Centre for Bioethics, undated).
  - MacArthur Competency Assessment Tool for Treatment (MacCAT-T) (Grisso, Appelbaum, & Hill-Fotouhi, 1997).
- Strength based assessment
  - The Self-reported Quality of Life Measure for People with Schizophrenia (SQLS) (Wilkinson, Hesdon, Wild, Cookson, Farina, Sharma, Fitzpatrick, & Jenkinson, 2000).
  - The Client's Assessment of Strength, Interests, and Goals (CASIG) (Wallace, Lecomte, Wilde, & Liberman, 2001).
  - The Psychosocial Rehabilitation Services Toolkit (The Research Committee of the International Association of Psychosocial Rehabilitation Services, 1995).
- Readiness assessment
  - Psychiatric Rehabilitation Training Technology - Readiness Assessment (Farkas, Sullivan-Soydan, & Gagne, 2000).
- Functional assessment
  - The University of California San Diego Performance-based Skills Assessment (UPSA) (Patterson, Goldman, Mckibbin, & Hughs, & Jeste, 2001).
  - The DSM-IV Social and Occupational Functioning Assessment Scale (SOFAS) (Rybarczyk, 2018).
  - Specific Levels of Functioning (SLOF) (Schneider & Struening, 1983).
  - The Multidimensional Scale of Independent Functioning (MSIF) (Jaeger, Berns, & Czobor, 2003).
  - The Maryland Assessment of Social Competence (MASC) (Bellack, Brown, & Thomas-Lorhman, 2006).
  - Camberwell Assessment of Need (CAN) (Phelan, et al., 1995).
  - Social Adjustment Scale-II (SAS-II) (Schooler, Hogarty, & Weissman, 1979).
  - MIRECC-GAF (Niv, Cohen, Sullivan, & Young, 2007).
  - Psychiatric Rehabilitation Training Technology - Functional Assessment (Cohen, Farkas, & Cohen, 2007).
  - The Social Performance Survey Schedule (SPSS) (Lowe & Cautela, 1978).

- The Social Functioning Scale (SFS) (Birchwood, Smith, Cochrane, Wetton, & Copestake, 1990).
- The Social-Adaptive Functioning Evaluation (SAFE) (Harvey, Davidson, Mueser, Parrella, White, & Powchik, 1997).
- The Independent Living Skills Inventory (ILSI) (Menditto, Wallace, Liberman, Vander Wal, Tuomi Jones, & Stuve, 1999).
- Global Functioning-Social (GF-Social) (Auther, Smith, & Cornblatt, 2006).
- Global Functioning-Role (GF-Role) (Niendam, Bearden, Johnson, & Cannon, 2006).

- Risk assessment[18]
  - Hare Psychopathy Checklist-Revised (PCL-R) (Hare, 1991).
  - Historical, Clinical, Risk Management-20 V3 (HCR-20) (Douglas, Hart, Webster, & Belfrage, 2013).
- Recovery based assessment of systems
  - Recovery Self-Assessment (RSA) (Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995)
  - Recovery Assessment Scale (RAS) (Ralph, Kidder, & Phillips, 2000).
  - Recovery Oriented Systems Indicators (ROSI) (Onken, Dumont, Ridgway, Dornan, & Ralph, 2007).
  - Recovery Oriented Practices Index (ROPI) (Mancini & Finnerty, 2005).
  - Recovery Promotion Fidelity Scale (RPFS) (Armstrong & Steffen, 2009).

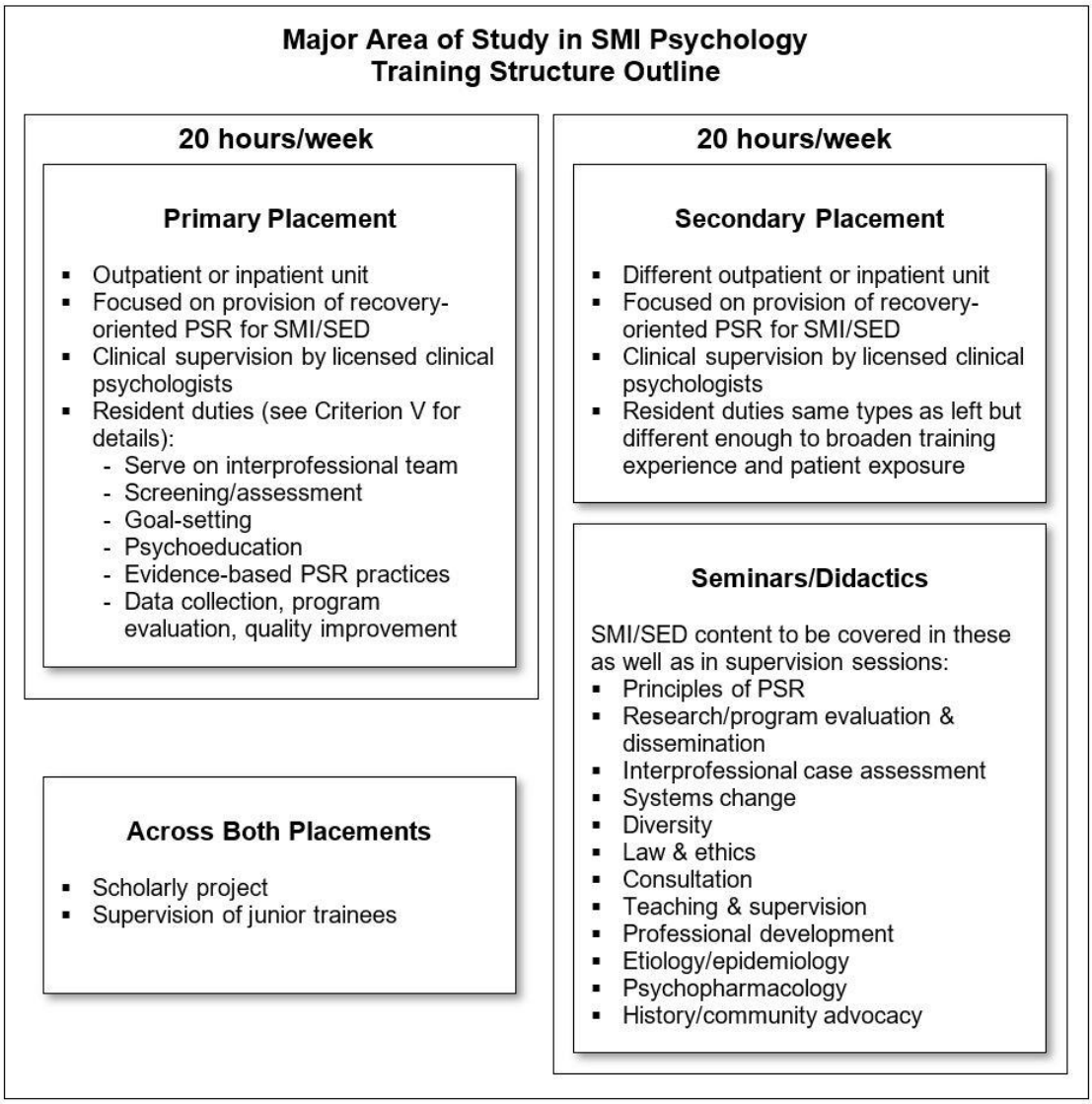
[18] Note: the predictive accuracy of instruments in this category "remains a source of considerable uncertainty" (Fazel, Singh, Doll, & Grann, 2012).

Appendix C: Interventions Recommended for Persons with SMI/SED

- Assertive Community Treatment (ACT)
- Family Psychoeducation
- 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
- PSR Interventions for Weight Management
- PSR Interventions for Stopping Smoking
- Integrated Dual Diagnosis Treatment for Co-morbid Substance Use Disorders
- PSR treatments for recent onset schizophrenia (RAISE/NAVIGATE protocol)
- Trauma Specific Interventions for Psychosis, (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, self-stigma, social isolation, and community exclusion
- Interventions for suicide prevention
- Implementation and Dissemination Strategies Specific to SMI/SED Interventions

Appendix D: Graphic Illustrating Training Structure for SMI Psychology

Example of Post-doctoral Training Structure in SMI Psychology



Source: Dimitri Perivoliotis, Ph.D., UCSD San Diego / VA San Diego Healthcare System Post-doctoral Residency.

In addition, a sample curriculum and sample sequence of training can be found in the Petition for Recognition of a Post-Doctoral Specialty in Serious Mental Illness Psychology (SMI Psychology) located here - www.psychtrainingsmi.com.