

**PETITION FOR THE RECOGNITION OF A
SPECIALTY IN PROFESSIONAL PSYCHOLOGY**

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

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

AMERICAN PSYCHOLOGICAL ASSOCIATION
750 First Street, NE
Washington, D.C. 20002-4242
(202) 336-5500

PETITION PACKAGE

Petition for Recognition of Post-Doctoral Specialty in Serious Mental Illness Psychology (SMI Psychology)

Table of Contents

Preamble.....	iii
Criterion I. Administrative Organizations	1
Criterion II. Public Need for Specialty Practice	16
Criterion III. Diversity	64
Criterion IV. Distinctiveness	88
Criterion V. Advanced Scientific and Theoretical Preparation	153
Criterion VI. Advanced Preparation in the Parameters of Practice	196
Criterion VII. Structures and Models of Education and Training in the Specialty	313
Criterion VIII. Continuing Professional Development and Continuing Education	388
Criterion IX. Effectiveness.....	392
Criterion X. Quality Improvement	403
Criterion XI. Guidelines for Specialty Service Delivery	414
Criterion XII. Provider Identification and Evaluation	418
Public Description	424
Appendix I: Serious Mental Illness (SMI) Psychology Education and Training Guidelines	426
Appendix II: Clinical Practice Guideline Toolkit	464
Appendix III: SMI/SED Evaluation Instrument	490
Appendix IV: Minneapolis VA Post-Doctoral Residency in SMI Brochure	511
Appendix V: MIRECC Post-Doctoral Fellowship in Mental Illness Research & Treatment Brochure.....	520
Appendix VI: UCSD/VA Post-Doctoral Fellowship in PSR Brochure	535
Appendix VII: VA CT/Yale University Post-Doctoral Residency in PSR Brochure.....	549

Preamble

This petition seeks recognition of the post-doctoral Specialty in **Serious Mental Illness Psychology (SMI Psychology) [the Specialty]** previously called Psychological Assessment and Treatment of Persons with Serious Mental Illness and Severe Emotional Disturbance. In addition to simplifying the name of the Specialty, we also wish to clarify that the terms psychosocial rehabilitation and/or psychiatric rehabilitation (PSR) are interchangeable. These practices are specific to the population under consideration in this Specialty. In other words, the identified evidence-based PSR practices are those that have been developed and found effective specifically for the population of persons with SMI/SED. In order to implement these practices efficaciously, specialized training at the post-doctoral level with a Major Area of Study is needed. We have endeavored to use the acronym PSR throughout the petition wherever possible. In some cases this has not been possible, e.g., where the term is used in the name or quote from a publication, or otherwise used by an institution, etc.

The petition will highlight the Specialty as a post-doctoral Major Area of Study (American Psychological Association (APA), 2012) that provides specialized health services to a defined population based on a defined set of competencies that highlight the distinctiveness of the Specialty.

The petitioners understand that knowledge and practice competencies in psychology have expanded and become increasingly differentiated over the past 50 years. Historically, the APA acknowledged four professional specialties in psychology: clinical, counseling, school, and industrial/organizational psychology. It is important to note that these specialties first gained de facto recognition through a process of historical evolution (APA, 2011). The APA accreditation guidelines also reference clinical, counseling, and school psychology as specialties (APA, 2015). Since that first recognition of specialties, APA, has come to recognize 16 specialties with overlapping core competencies based on broad and general education and training but with distinct education and training in the specialty based on the specialty's recommendation for a Major Area of Study at the graduate, internship, and/or post-doctoral level of education.

The petitioners recognize that in Health Service Psychology (Health Service Psychology Collaborative, 2013) there exists a shared core of scientific and professional competencies – knowledge, skills, and attitudes – common to all Health Service Psychology's professional specialties. This shared core has been recognized in several conference reports on the future of professional psychology including the reports of groups and conferences of the National Council of Schools and Programs of Professional Psychology, the Joint Council on Professional Education in Psychology, and the National Conference on Scientist-Practitioner Education and Training for the Professional Practice of Psychology (Hatcher, et al., 2013; Kaslow, 2004; Kenkel & Peterson, 2009; Rodolfa, et al., 2013). We note that nothing in this petition precludes a health service psychologist from using the methods or working with the populations of this or any recognized specialty, except insofar as they do so “within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience” (APA Ethical Principles of Psychologists and Code of Conduct, 2002).

The public will continue to require the services of general practice specialists, such as those offered by clinical, counseling, school and industrial/organizational psychologists. However, in order to meet the services needs of the evolving health care system, and patient expectations for specialized care, the emergence of new specialties to provide needed psychological services must be recognized and validated. The petitioners look forward to establishing the distinctiveness and need for the post-doctoral **Specialty in Serious Mental Illness Psychology (SMI Psychology)**. As such, the petitioners recognize and will utilize the APA definition of specialty (APA, 2011):

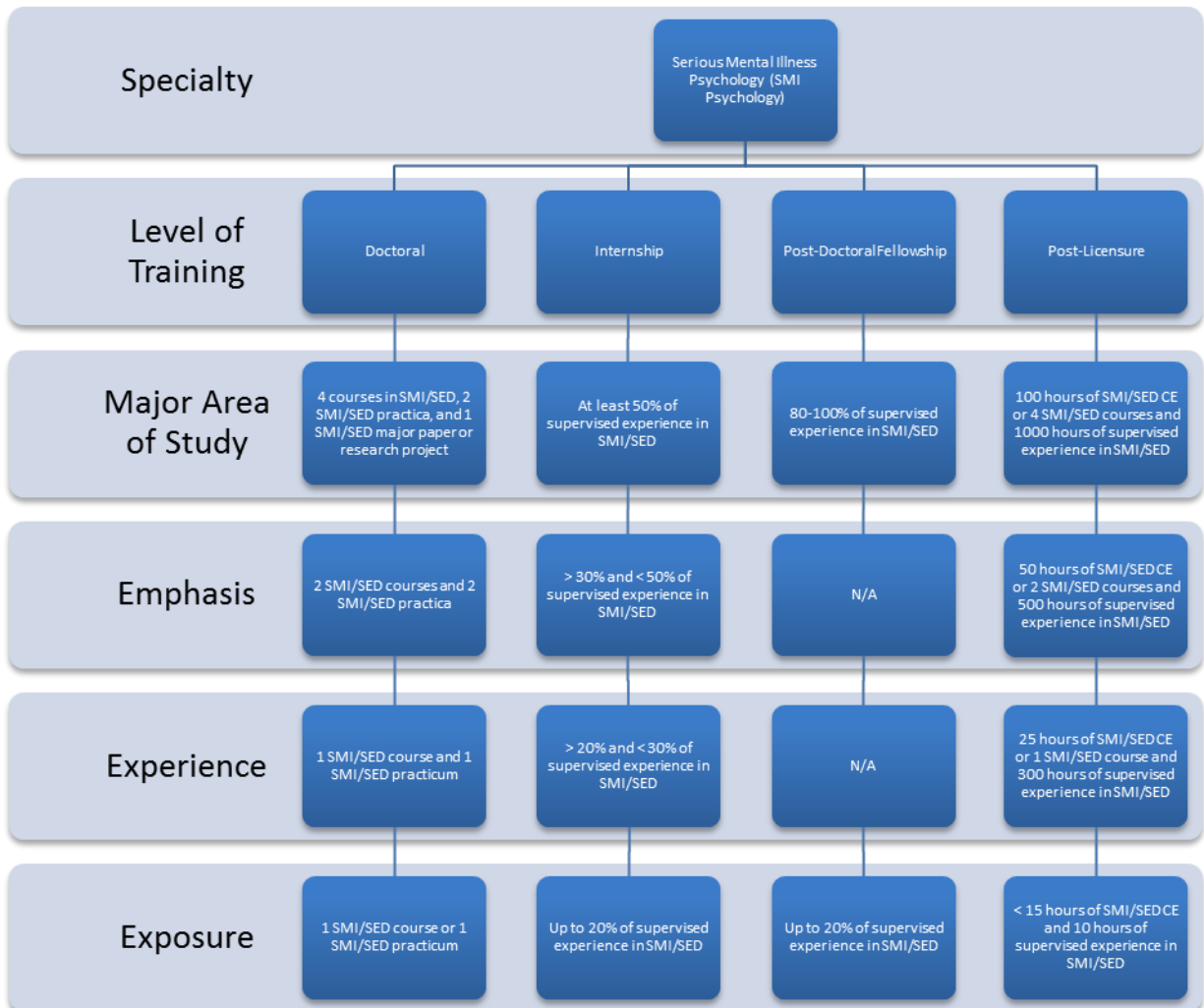
A specialty is a defined area of professional psychology practice characterized by a distinctive configuration of competent services for specified problems and populations. Practice in a specialty requires advanced knowledge and skills acquired through an organized sequence of

education and training in addition to the broad and general education and core scientific and professional foundations acquired through an APA or CPA accredited doctoral program.* Specialty training may be acquired either at the doctoral or postdoctoral level as defined by the specialty.

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

It is the intent of the petitioners to make clear that The Specialty has evolved from its original recognition as a proficiency and now meets the criteria of a distinctive Specialty. We understand that a specialty is distinguished from a proficiency, which is a **circumscribed activity** in the general practice of professional psychology or one or more of its specialties that is represented by a distinct procedure, technique, or applied skill set used in psychological assessment, treatment and/or intervention within which one develops competence. We will make clear that the post-doctoral Specialty in **SMI Psychology** is now “ ... a **defined area of professional psychology practice** characterized by a distinctive configuration of competent services for specified problems and populations.” In support of the evolution of the Specialty, we note that the SMI Psychology Specialty has a comprehensive and fully developed practice guideline, the *Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment* (American Psychological Association & Jansen, 2014) (available on the Specialty Council website (www.psychtrainingsmi.com)), a complete set of functional competencies for all domains of practice (presented in Criterion VII of this petition and available in our Training Guidelines (which are Appendix I of this petition and on the Specialty Council website), and a comprehensive evaluation instrument for use by trainees, supervisors, and clinicians; the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*, which is included in our Training Guidelines, is included in this petition as Appendix III, and is also on our website. The Taxonomy for SMI Psychology (below) makes clear that this Specialty requires a Major Area of Study at the post-doctoral level; the SMI Psychology Taxonomy is included below and is also included in Criterion X and in our Training Guidelines.

Taxonomy for Education and Training in Serious Mental Illness Psychology (SMI Psychology)



SMI/SED Course – Each course must have predominant content specific to the recovery paradigm and/or psychosocial rehabilitation for persons with SMI/SED and be taken for at least 3 hours of credit.

SMI/SED Practicum – Minimum experience of 9 months of applied, clinical supervised experience for at least 10 hours per week working with persons with SMI/SED.

Applied, Clinical Supervised Experience – Must include at least 80% clinical contact with persons with SMI/SED and pertain to assessment, treatment, and/or consultation. If offered, seminar attendance, interdisciplinary team participation, readings, and research may count as part of the supervised experience for interns and postdoctoral fellows. Supervision must be provided by a psychologist meeting requirements for Major Area of Study in SMI/SED at the post-licensure stage.

CE coursework – Must be approved by the American Psychological Association and have content specific to SMI/SED.

Post-doctoral specialization in SMI/SED is intended to follow broad and general training in clinical, counseling or school psychology.

References

American Psychological Association (2002). *Ethical Principles of Psychologists and Code of Conduct*. Retrieved from <http://www.apa.org/ethics/code/>

American Psychological Association (2011). *Principles for the Recognition of Specialties in Professional Psychology*. Retrieved from <http://www.apa.org/ed/graduate/specialize/index.aspx>

American Psychological Association (2012). *Education and training guidelines: A taxonomy for education and training in professional psychology health service specialties*. Retrieved from <https://www.apa.org/ed/graduate/specialize/taxonomy.pdf>

American Psychological Association. (2015). *Standards of Accreditation for Health Service Psychology*. Retrieved from <http://www.apa.org/ed/accreditation/>

American Psychological Association & Jansen, M. A. (2014). *Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders*. Washington, DC: American Psychological Association.

Hatcher, R. L., Fouad, N. A., Grus, C. L., Campbell, L. F., McCutcheon, S. R., Leahy, K. L. (2013). Competency benchmarks: Practical steps toward a culture of competence. *Training and Education in Professional Psychology*, 7(2), 84-91.

Health Service Psychology Education Collaborative. (2013). Professional psychology in health care services: A blueprint for education and training. *American Psychologist*, 68(6), 411-426.

Kaslow, N. (2004). Competencies in Professional Psychology. *American Psychologist*, 59(8), 774-781.

Kenkel, M. B., & Peterson, R. L. (2009). *Competency-Based Education for Professional Psychology*. Washington, D. C.: American Psychological Association.

Rodolfa, E., Greenberg, S., Hunsley, J., Smith-Zoeller, M., Cox, D., Sammons, M., ... Spivak, H. (2013). A competency model for the practice of psychology. *Training and Education in Professional Psychology*, 7(2), 71-83.

Name of Proposed Specialty: Serious Mental Illness Psychology (SMI Psychology)

Please check one:

- X Petition for Initial Recognition
 Petition for Renewal of Recognition

Criterion I. Administrative Organizations

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

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

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

Name of organization or specialty council:

Council for Psychological Training in Serious Mental Illness Psychology (SMI Psychology).

Address: 8A – 1500 Alberni St.

City/State/Zip: Vancouver, BC V6G 3C9

Phone: 604 488-8854 FAX: NA

E-mail address: jansenm@shaw.ca

Website of organization: PsychTrainingSMI.com

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

Name: Mary A. Jansen, Ph.D. APA membership status: Fellow

Address: 8A – 1500 Alberni St.

City/State/Zip: Vancouver, BC V6G 3C9

Phone: 604 488-8854 FAX: NA

E-mail address: jansenm@shaw.ca

Please Note: In the event that the primary representative (Dr. Jansen) is not available, the current leaders of the Specialty Council organizations should be contacted.

3. Please provide the following information for the organization or specialty council submitting the petition: Council for Serious Mental Illness (SMI) Psychology

Year founded? 2013 Incorporated? Yes___ No X State incorporated _____

Describe the purpose and objectives of the administrative organization or specialty council submitting the petition.

This specialty petition is submitted by the Council for Serious Mental Illness Psychology (SMI Psychology). The Council is comprised of four primary organizations, all of which have an interest in promoting specialized training and competency development for psychologists who provide high quality services to individuals who have, or are at risk of developing, serious mental health disorders. The Council's member organizations are actively involved in initiatives of the American Psychological Association and in collaborating with other organizations interested in education, research and quality health care related to the SMI/SED populations.

The Council consists of the following organizational members:

- (1) the APA Task Force on Serious Mental Illness/Severe Emotional Disturbance (<http://www.apa.org/practice/leadership/serious-mental-illness/default.aspx>),
- (2) APA's Division of Psychologists in Public Service (Division 18) in its role as supporting psychologists in public service with a focus on health service practice, research, training and policy formulation,
- (3) Division 18's Section on Serious Mental Illness and Severe Emotional Disturbance, and
- (4) The Special Interest Group (SIG) on Schizophrenia & Other Serious Mental Disorders of the Association for Behavioral and Cognitive Therapies (ABCT).

History of the Organizational Members of the Council

Task Force on SMI/SED

The Task Force on SMI/SED was created 25 years ago by the APA Council of Representatives. It is a semi-permanent quasi-governance entity that serves APA by providing expertise in the areas of serious mental illness and severe emotional disturbance (SMI/SED). The Task Force reported to the Committee for the Advancement of Professional Practice from its inception until 2015 when it was moved to the Board of Professional Affairs.

The Task Force has made many substantial contributions to psychological practice and has been continuously supported by its parent governance body. Some of the work undertaken by the Task Force includes two mini-conventions presented at APA conventions (1999 and 2000), three resolutions adopted by the Council of Representatives (Stigma and Discrimination, 1999; Outpatient Civil Commitment, 2004; APA Endorsement of the Concept of Recovery, 2009), testimony presented to the President's New Freedom Commission on Mental Health, provision of input and assistance to APA staff on multiple legislative initiatives, including the current federal Interdepartmental Severe Mental Illness Coordinating Committee (ISMICC), presentation of several continuing education symposia, workshops, and webinars, and support for, and contribution to the petition for recognition of the post-doctoral specialty in SMI/SED.

These and the many other activities undertaken by the Task Force have substantially strengthened the professional practice of psychology and have enhanced the public's awareness of psychology's contributions to the well-being of those with SMI and SED thereby increasing the esteem in which the public holds psychologists.

A letter from Dr. Dan Abrahamson, Associate Executive Director, APA Practice Directorate, who has been the Task Force staff liaison to CAPP and the BPA since 2003 is included at the end of this criterion.

A letter from Dr. Lisa Kearney, Chair of BPA is also included at the end of this criterion.

Division 18

Division 18, the Division of Psychologists in Public Service, is comprised of psychologists in a wide range of public service settings, from community organizations through to medical center and hospital settings (including the largest integrated and coordinated health service delivery system in the U.S. – the VA), and includes psychologists working with defined populations such as persons in Indian country, persons with criminal justice issues, veterans, and persons with SMI/SED. These settings and populations form the seven sections of the Division and include a student membership portal.

During the course of developing the petition for Specialty recognition, the Division has taken several steps to directly support the work of the Specialty Council and this petition. These include support for a meeting to develop the competencies for this specialty (support was also provided by BEA); support for development of the Specialty Council website; support for research, writing, and multiple reviews of the petition; support for consultants to review and suggest revisions to the petition; and research, writing, review and editing support to respond to CRSPPP's concerns. These concrete demonstrations of the Division's support and commitment to the Specialty are in addition to the overall commitment of the Division to this Specialty.

A letter from Dr. Nadine Kaslow, President of Division 18 is included at the end of this criterion.

Division 18 Section on SMI/SED

The Section on SMI/SED of Division 18 was formed in 2012 because of the recognized need for greater attention to the unique and specific needs of persons with SMI/SED. The Section evolved from a Divisional workgroup which was formed to investigate the interest in and feasibility of a new section. Interest in the prospect of the Section supported its feasibility; the Section was formed with the second largest membership – second only to the VA Section.

When the section was proposed, it received unanimous support from the Division's Executive Committee and from all of the other sections of the Division and was voted as a new section with no dissenting votes. The reason for this high level of support is the cross cutting nature of the population within public service psychology. The other sections and their leadership recognized the importance of SMI/SED as a societal issue and recognized the need for greater attention to this population within psychology. The Division and its sections place great importance on the population and the problems they face; as we all recognize, persons with SMI/SED are not limited to any one segment of society or treatment setting.

The focus of this Section is on promoting optimal functioning in adults living with serious psychiatric disorders and youth diagnosed with severe emotional disorders. Members work in a variety of settings (e.g., state hospitals, community agencies, private practice, VA facilities, residential programs and criminal justice systems) and share a commitment to supporting the recovery and resilience of persons experiencing disorders such as schizophrenia and other disorders on the psychotic spectrum, mood disorders and co-occurring Axis II diagnoses. Members are involved in mental health administration, direct clinical care, research, public policy development and patient advocacy.

Membership in the Section has remained strong, as has its commitment to and support for this petition for specialty recognition. The Section's membership includes members of each of the other sections of the Division. Several members of the Section have contributed to the petition's research, writing, and editing and look forward to its recognition.

A letter from Dr. Marcia Hunt and Dr. Meghan Stacy, the Chair and Chair-elect of the Division 18 Section on SMI/SED is included at the end of this criterion.

Special Interest Group (SIG) on Schizophrenia & Other Serious Mental Disorders of the Association for Behavioral and Cognitive Therapies (ABCT)

The SIG on Schizophrenia & Other Serious Mental Disorders was founded to facilitate high-quality research on the best assessment and treatment practices for people with SMI, and expedite the dissemination of that research to providers. SIG members are researchers, clinicians, program directors, and/or administrators pursuing the development, dissemination, and implementation of evidence-based cognitive-behavioral interventions (e.g., social skills training, cognitive therapy, cognitive remediation, illness management, behavioral family therapy) for people with serious mental disorders. In addition to those already in professional careers, the SIG also has many student members who are preparing for careers in the above mentioned careers.

At the annual ABCT conference, SIG members are prominent speakers, organizers, and award winners. Students are particularly encouraged to attend and participate, and a student research award is presented each year. The SIG's website contains pages for students and an Information For the Public page that provides information about schizophrenia and other serious mental illnesses, treatment, information, information about finding a provider, along with information about stigma, and violence. The website of the Specialty Council is featured prominently on the SIG website along with information about the SMI Psychology Specialty.

The SIG and its members have long been supporters of the Specialty Council's efforts to establish the Specialty in SMI Psychology. Many members of the SIG are also APA members and several have worked with the Council on development of the petition. These members have contributed research and practice literature, have contributed to the writing and review of the petition, have participated in CE symposia and CE workshops developed by the Council, serve as program directors at several of the post-doctoral programs listed in the petition, and several are past chairpersons of the APA Task Force on SMI/SED. In 2018, the SIG initiated formal discussions about joining the Council and ultimately joined the Council in mid 2018.

A letter from Dr. Jerome Yoman, President of the ABCT Special Interest Group on Schizophrenia and Other Serious Mental Disorders is included at the end of this criterion.

Each of the organizational members of the Specialty Council has two representatives who sit on the national Council and who represent all members of the Specialty.

Present a rationale that describes how your organization or specialty council provides systems and structures which make a significant contribution to the organized development of the specialty.

As we noted in the Preamble, the SMI Psychology Specialty has evolved from its original recognition as a proficiency and is now a distinctive Specialty. The SMI Psychology Specialty meets the APA definition of a specialty and is "... a defined area of professional psychology practice characterized by a distinctive configuration of competent services for specified problems and populations." As we will articulate throughout this petition, under the direction of the Specialty Council, the SMI Psychology Specialty has developed a comprehensive and fully developed practice guideline, the *Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment* (American Psychological Association & Jansen, 2014) (available from APA and linked on the Specialty Council website) (www.psychtrainingsmi.com), a complete set of functional competencies for all domains of practice (presented in Criterion VII of this petition and available in our Training Guidelines (Appendix I of this petition and on the Specialty Council website), and a comprehensive evaluation instrument for use by trainees, supervisors, and clinicians; the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*, which is included in our Training Guidelines, is included in this petition as Appendix III, and is also on our website. These and several other structures provided by the Council are detailed below:

- (1) The Council is seeking a seat on the Council of Specialties (CoS) but presently is only able to

formally join CoS after APA recognition (CoS bylaws prohibit a specialty council from joining CoS prior to APA recognition of the specialty). We are working with the CoS informally prior to recognition and have attended the November, 2018 CoS board meeting in an observer capacity. This contact was initiated in order to assure that the Specialty will be well positioned to join CoS and be represented on the CoS to collaborate with other recognized specialties in psychology with interests in research and interventions related to health issues to enhance public welfare. The Council's intent is to join with other recognized specialties, to describe the components of education and training programs in the Specialty and define the Major Area of Study, Emphasis, Experience and Exposure experiences at the graduate, internship, post-doctoral, and life-long learning levels of education.

- (2) The Council, acting to assure the recognition and growth of the Specialty, is also working with the American Board of Professional Psychology (ABPP) to ensure that the requirements and examination procedures for Board Certification in SMI Psychology are developed and ready for implementation once the Specialty receives APA recognition. The Specialty Council participated in a conference call with the ABPP Executive Director and the President in order to facilitate these efforts and continues to develop its certification requirements in concert with ABPP.
- (3) The Council, functioning in its role as a training council, has developed Training Guidelines that are presented in Appendix I of this petition, and are available on the Council website (<http://www.psychtrainingsmi.com>). These Guidelines were developed with the participation and input of several groups of interested psychologists. These groups include the APA Task Force on Serious Mental Illness/Severe Emotional Disturbance, APA's Division 18, Psychologists in Public Service, the Division 18 Section on Serious Mental Illness/Severe Emotional Disturbance, the Association for Behavioral and Cognitive Therapies Special Interest Group on Schizophrenia and Other Serious Mental Disorders, the Training Directors and Program Leaders of post-doctoral programs offering this specialized training, and participants at a meeting sponsored by the above groups and convened following the APA 2016 Convention in Denver, CO. This meeting was funded by grants from the APA Board of Educational Affairs, Division 18, and its Section on Serious Mental Illness/Severe Emotional Disturbance and included representatives from the groups mentioned above and a representative from the APA Board of Professional Affairs. Following development of a draft of these Training Guidelines, they were sent for review and comment to members of interested groups, revised based on feedback received, and finalized.
- (4) As the Specialty Council was beginning its work, APA secured funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a curriculum to train psychologists in the concepts of recovery from serious mental illness and the interventions to assist people to achieve that recovery and reach their full potential; these interventions are known as psychosocial or psychiatric rehabilitation (PSR) interventions. A member of the Council assisted in developing the APA proposal to SAMHSA for this funding, served on the curriculum steering committee, and wrote the text and accompanying power point slides. Released by APA in 2014 (American Psychological Association & Jansen, 2014), the full curriculum and accompanying slides are available from APA (<http://www.apa.org/pi/mfp/psychology/recovery-to-practice/training.aspx>) and a link to the curriculum is provided on the Council website (<http://www.psychtrainingsmi.com>).
- (5) Following the meeting mentioned in number 3 above, the Council developed the competencies needed by psychologists practicing in the SMI Psychology Specialty. Funding for the meeting was secured by the Council from APA's BEA and Division 18 (a member of the Council) and produced the Training Guidelines and competencies. These are included in this petition at Criterion VII and also in the Training Guidelines (Appendix I) and are included in the Training Guidelines which are also posted on the Council's website (www.psychtrainingsmi.com).
- (6) Another outcome of the meeting sponsored by the Specialty Council is the *Instrument to Assess*

Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED) which is a comprehensive evaluation instrument in use at post-doctoral residency programs in SMI Psychology. Following development of the competencies, the Council sought and received permission from the Council of Professional Geropsychology Training Programs to modify the *Pikes Peak Geropsychology Knowledge and Skill Assessment Tool* (Karel et al., 2012) The *Instrument* was subsequently pilot tested and is now in use and is recommended for SMI Psychology post-doctoral programs in the Specialty. The Instrument is included in this petition as Appendix III and is also available on the Council website (www.psychtrainingsmi.com).

- (7) For more than 14 consecutive years, the Specialty has coordinated several APA convention CE offerings including five full day CE workshops and several symposia offered for CE credit. Beginning in 2004, and continuing to the present, members of the Council have offered symposia on SMI/SED. Interest in these offerings has been substantial, garnering between 100 and 150 attendees each year, with some of the symposia attendance topping 200 attendees. Beginning in 2012, the SMI/SED Section of Division 18 also began sponsoring symposia; more recently, other divisions have followed suit and as a result, the number of convention offerings on SMI/SED topics has increased considerably. Feedback has consistently indicated that training is needed to help psychologists work more competently with persons with SMI/SED and these symposia have sought to meet this need. In addition to the many symposia offered by members of the Specialty Council, beginning in 2010 and continuing through 2018, the Specialty Council has presented five full day CE workshops; these have also been highly rated, receiving ratings above 4.5 each time workshops were presented. The workshops are:
- New Interventions and Perspectives for Practitioners Treating Those with Serious Mental Illnesses, August, 2010.
 - Treating Adults and Adolescents with Serious Mental Illness: Using EBPs in Clinical Practice, August, 2011.
 - New and Emerging Clinical Practices for Treating People with Serious Mental Illness, August, 2012.
 - Recent Advances in Evidence Based Practices to Help People Recover from Serious Mental Illnesses August, 2014.
 - Evidence Based Interventions for First Episode Psychosis - RAISE-ETP & Beyond, August, 2018.
- (8) Members of the Council also routinely present at other national and international research and training conferences such as the Association of Behavioral and Cognitive Therapies (ABCT), the Psychiatric Rehabilitation Association (PRA), the International Congress on Schizophrenia Research of the Schizophrenia International Research Society (SIRS), among others.
- (9) Additionally, the APA Task Force and the APA Office of Continuing Education collaborated on the development of a four part CE series on SMI/SED entitled “APA CE Webinar Series on Serious Mental Illness and Severe Emotional Disturbance”; this four part CE webinar was presented by Council members. Each of the four parts can be taken for CE credit individually or the full series can be taken for CE credit. As listed on the APA CE website, the four titles are:
- Webinar I: Assessment, Engagement, and Ethical Considerations
 - Webinar II: Clinical Interventions and Ethical Issues
 - Webinar III: Interventions for Special Populations - Specialized Training for Ethical Practice

- Webinar IV: Interventions for Management & Policy Positions – Ethical Responsibilities, Training the Next Generation of Psychologists

Thus, the Council identifies issues important for the organized development and implementation of The Specialty and provides a mechanism for information exchange and coordination. The Council is the organizational home for Specialized psychological training for psychologists and other mental health professionals who are interested in working with people with serious mental health disorders (SMI) and those with emerging severe emotional disturbances (SED). The Council oversees the development of curriculum materials, establishment of competencies to work with these populations, evaluation mechanisms to ensure competency of professional psychologists for this work, conducts training, and encourages research and publications in this area.

The Council also ensures that Training Guidelines for The Specialty remain current and the Council disseminates updates on training. The Council oversees or conducts CE opportunities, scientific sessions at national and international conventions and will conduct regular training for program directors and for site visitors to facilitate accreditation of post-doctoral residency programs in this Specialty.

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

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

Please see Specialty Council website (<http://www.PsychTrainingSMI.com>) for the Council bylaws.

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

An annual meeting is held at the APA Convention and a virtual meeting\conference call is held at least once each year. Council business is conducted primarily via e-mail and virtual meetings.

Name of Organization	Council for Serious Mental Illness Psychology (SMI Psychology)
Frequency of Meetings	Quarterly
Number of Meetings per year	4
Membership size	4 organizational members representing psychologists in each organization
Functions Performed	Oversight of committees and recruitment of leadership with particular attention to ECP and diversity psychologists; Development of curriculum materials, establishment of competencies to work with individuals with SMI/SED, evaluation mechanisms to ensure competency of professional psychologists for this work, encouragement of research and publications in this area, conduct of training about SMI/SED and for potential accreditation site visitors, and promotion of understanding regarding the etiology, nature, impact, and amelioration of SMI/SED among psychologists and the general public.
How are decisions made	Representatives from each organization speak for their members during meeting discussions, convention meeting and via e mail regarding shared documents
Types of committees	Executive, Research, Training and Evaluation, Accreditation, Practice,

	Marketing and Communications
Dues Structure	None
Names of Publications	<p>1) Two APA scientific journals that specialize in SMI/SED and publish works of Specialty Council members: a) Psychiatric Rehabilitation (Editor: Sandra Resnick, Ph.D., APA TF on SMI/SED representative to the Specialty Council), b) Psychological Services (Division 18 journal with most recent special issue on Early Intervention Services in Serious Mental Illness, edited by Shirley Glynn, Ph.D., Division 18 past president and representative to the Specialty Council)</p> <p>2) Members of the Specialty Council also regularly publish in non-APA journals dedicated to SMI/SED. Some of these include: Schizophrenia Bulletin, Psychiatric Services, Early Intervention in Psychiatry, World Psychiatry, among many others.</p> <p>3) Division 18 Newsletter (short articles, news, updates, etc.).</p>
Website	http://www.PsychTrainingSMI.com

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

Name: Mary A. Jansen, Ph.D. Title: Executive Officer Date: December 31, 2018
Mary A. Jansen, Ph.D.

References

- American Psychological Association & Jansen, M. A. (2014). Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders. Washington, DC: American Psychological Association.
- Karel, M. J., Holley, C., Whitbourne, S. K., Segal, D. L., Tazeau, Y., Emery, E., Molinari, V., Yang, J., & Zweig, R. (2012). Preliminary validation of a tool to assess knowledge and skills for professional geropsychology practice. *Professional Psychology: Research & Practice*, 43(2), 110-117.

List of Letters Included with this Criterion

- Letter from Dr. Dan Abrahamson, APA Staff for APA Task Force on SMI/SED and for BPA
 Letter from Dr. Lisa Kearney, Chair of BPA
 Letter from Dr. Nadine Kaslow, President of Division 18
 Letter from Dr. Marcia Hunt & Dr. Meghan Stacy, Chair & Chair-elect of Division 18 Section SMI/SED
 Letter from Dr. Jerome Yoman, President of the Association of Behavioral and Cognitive Therapies Special Interest Group on Schizophrenia & Other Serious Mental Disorders



July 12, 2018

Dr. Pamela Remer, Chair
Commission for the Recognition of Specialties and
Proficiencies in Professional Psychology (CRSPPP)

Dear Dr. Remer:

I have been informed of CRSPPP's request for additional information from the Specialty Council for the Psychological Assessment and Treatment of Serious Mental Illness and Severe Emotional Disturbance (SMI/SED) on their petition for recognition of a post-doctoral specialty. I am writing regarding CRSPPP's concern about the continued viability of the APA Task Force on Serious Mental Illness and Severe Emotional Disturbance and to assure you that I fully support their work and continuation.

The Task Force was created 25 years ago by the APA Council of Representatives. It is a semi-permanent quasi-governance entity that serves APA by providing expertise in the areas of serious mental illness and severe emotional disturbance. It previously reported to the Committee for the Advancement of Professional Practice and currently reports to the Board of Professional Affairs.

For the past 13 years I have been the lead staff person with liaison and budget responsibilities for the Task Force. I know first-hand of the dedication, commitment, and hard work of the members of the Task Force which has led to substantial contributions to psychological practice. Some of the work undertaken by the Task Force includes two mini-conventions presented at APA conventions (1999 and 2000), three resolutions adopted by the Council of Representatives (Stigma and Discrimination, 1999; Outpatient Civil Commitment, 2004; APA Endorsement of the Concept of Recovery, 2009), testimony presented to the President's New Freedom Commission on Mental Health, provision of input and assistance to APA staff on multiple legislative initiatives, including the current federal Interdepartmental Severe Mental Illness Coordinating Committee (ISMICC), presentation of several continuing education symposia, workshops, and webinars, and support for, and contribution to the petition for recognition of the post-doctoral specialty in SMI/SED. These and the many other activities undertaken by the Task Force have substantially strengthened the professional practice of psychology and have enhanced the public's awareness of psychology's contributions to the well-being of those with SMI and SED thereby increasing the esteem in which the public holds psychologists. Although the full body of work of the Task Force is exemplary, the specialty petition stands as one of the most important to date. Most psychologists receive limited or no preparation for working with this population; work which requires the specialized training presented in the Specialty Council petition.

Because of the many and sustained contributions of the Task Force and the ongoing support it receives from its parent Board at APA, the task force is expected to continue its work on behalf of APA into the foreseeable future.

Thank you for your continued dedication to ensuring excellent education and training for psychologists in all areas of specialization.

Sincerely,

Daniel J Abrahamson

Daniel J. Abrahamson, Ph.D.
Associate Executive Director
APA Practice Directorate

MEMORANDUM

TO: Sandra G. Resnick PhD, Chair
Task Force on Serious Mental Illness / Severe Emotional Disturbance (TF SMI/SED)

FROM: Lisa K. Kearney, PhD, ABPP, Chair
Board of Professional Affairs

RE: Clarification of the status of the Task Force on Serious Mental Illness / Severe Emotional Disturbance (TF SMI/SED)

DATE: Monday, July 23, 2018

This Memorandum intends to clarify the status of the Task Force on Serious Mental Illness / Severe Emotional Disturbance (TF SMI/SED), including its continuation as a Task Force of the American Psychological Association.

The Board of Professional Affairs (BPA) supports the work of the Task Force and does not anticipate any change in its status. In addition, BPA does not intend to advance any recommendation or governance item that would adversely impact the status of the Task Force. On the contrary, in light of the exemplary contributions of the Task Force, BPA strongly supports the work of the Task Force, and does so without reservation. **BPA is confident that the Task Force will remain a viable and important component of the APA governance structure for many years to come.**

It may be that the Task Force would wish to share this Memorandum in support of its efforts to seek recognition of specialty status. If that is the case, BPA would have no objection for the Task Force doing so. In addition, BPA would welcome the opportunity to engage in dialogue to further expand on its strong support for the work of this group.

Background

For background, the Board of Professional Affairs (BPA) is a standing board of the Association, established in accordance with the Association Rules, and responsible for developing recommendations for and monitoring the implementation of APA policy, standards and guidelines for the profession of psychology, maintaining relationships with other professional organizations and groups appropriate to its mission, recognizing contributions to the profession of psychology through awards and honors, proposing to the Association ways to enhance the profession of psychology, and fostering the application of psychological knowledge in order to promote public welfare. In this regard, BPA has several groups reporting to the APA Board of Directors and Council through it, or to it (as an ad hoc group), and otherwise informing its work, as well as several subcommittees, committees, and working groups. Several of these linkages have shifted over time depending upon the strategic priorities of BPA and needs of the Association.

Council voted to approve in principle sun-setting the 501(c)(3) responsibilities of CAPP effective December 31, 2014, and requested that the amendments to the APA Association Rules and APAP0 Bylaws needed for implementing this change be brought to Council for action at its August 2014 meeting (Council Minutes, dated February 21-23, 2014). Once approved, CAPP began a process whereby it appropriately triaged its 501(c)(3) responsibilities, including a new determination on reporting groups.

BPA assumed several of these 501(c)(3) responsibilities and additional reporting groups including the Task Force. In response, BPA reached out to these new reporting groups to share information on issues and matters of strategic importance. A liaison has been assigned to each, in accordance with BPA's policies and procedures, to ensure optimal interface and ongoing dialogue. In addition, BPA requests summary notes and reports from each group for sharing with members at each of its meetings and as needed. Reporting groups have also been invited to submit items for consideration and review by BPA. Chairs have been invited to join BPA for some or all of its regular meetings.

BPA very much appreciates the additional capacity and insights afforded by virtual of linkages with the Task Force and other reporting groups. Specifically, regarding the work of the Task Force, BPA believes that there is growing public need for psychologists who are specially trained to work with people with serious mental illness and those with severe emotional disturbances; this work is particularly important as the Association promotes greater access to quality and relevant health care and services. There is also considerable interest by early career and seasoned psychologists for more resources in working with these populations to help individuals recover from the effects of their illness and reach their goals and full potential. This includes supporting the Task Force's efforts to promote the establishment of work with SMI/SED populations as an area for specialization within the field of psychology. The work of the Task Force informs this vital work of the Association.

About the Task Force

The Task Force was formed in 1994 when it was established by the Council of Representatives as a semi-permanent entity providing input and expertise on matters related to serious mental illness and severe emotional disturbance. Since its inception, the Task Force has distinguished itself by undertaking projects that have enhanced the profession of psychology. These projects include, but are not limited to scholarly publications (including a special section in *Professional Psychology: Research and Practice* [1997, 28]), continuing education (CE) symposia, workshops, and webinars, resolutions submitted to and approved by the Council of Representatives, provision of input and assistance to APA staff regarding legislative efforts and other advocacy of importance to psychology, the public, and those with SMI/SED, to name but a few of the initiatives undertaken by the Task Force. BPA supports this work and looks forward to continued dialogue and collaboration on the same.



**DIVISION OF PSYCHOLOGISTS IN PUBLIC SERVICE (18)
AMERICAN PSYCHOLOGICAL ASSOCIATION**

September 3, 2018

Pamela P. Remer, PhD

Chair, Commission for the Recognition of Specialties and Proficiencies in Professional Psychology

Dear Dr. Remer:

I am writing to you in my role as President of APA Division 18 (Psychologists on Public Service). On behalf of the division, I would like to thank you and your colleagues for sharing CRSPPP's thoughtful and detailed feedback on the petition for recognition of the specialty in Psychological Assessment and Treatment of Serious Mental Illness and Severe Emotional Disturbance (SMI/SED). While we were keenly disappointed by CRSPPP's concerns, we feel confident that the Specialty Council will satisfactorily address each of them in a revised petition. I am writing to assure you and CRSPPP of Division 18's support for this petition and for the Specialty Council's continued work to promote the specialty.

As you may know, Division 18 formed the section on SMI/SED several years ago. When the section was proposed, it received unanimous support from the Division's Executive Committee and from all of the other sections of the Division and was voted as a new section with no dissenting votes. The reason for this high level of support is the cross cutting nature of the population within public service psychology. All of the other sections and their leadership recognized the importance of SMI/SED as a societal issue and recognized the need for greater attention to this population within psychology. The Division and its sections place great importance on the population and the problems they face; as we all recognize, persons with SMI/SED are not limited to any one segment of society or treatment setting.

In addition to the Division's general support of the petition, I want to highlight some of the specific actions the Division has taken to support the work of the Specialty Council and this petition. These include provision of support for a meeting to develop the competencies for this specialty (support was also provided by BEA); provision of support for development of the Specialty Council website; provision of support for research, writing, and multiple reviews of the petition; provision of support for consultants to review and suggest revisions to the petition; and research, writing, review and editing support to respond to CRSPPP's concerns. These concrete demonstrations of the Division's support and commitment to the Specialty are in addition to the overall commitment of the Division to this specialty.

I want to assure you that Division 18 is fully committed to doing all we can to support the work needed to promote the post-doctoral specialty in Psychological Assessment and Treatment of Serious Mental Illness and Severe Emotional Disturbance (SMI/SED).

Thank you for your consideration of this letter. Please let me know if there is any further information you need. I can be reached at nkaslow@emory.edu or 404-547-1957.

Best Regards,

Nadine J. Kaslow, PhD, ABPP
President, APA Division 18
Past President (2014), American Psychological Association

July 1, 2018

Dr. Pamela Remer, Chair

APA Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP)

Dear Dr. Remer:

The Serious Mental Illness/Severe Emotional Disturbance (SMI/SED) Section of Division 18 is one of the three organizational members of the Psychological Assessment and Treatment of Persons with Serious Mental Illness and Severe Emotional Disturbance Specialty Council. As such, we are deeply invested in the outcome of the Specialty Application, and would like to address the concern raised by CRSPPP that the Specialty may not be fully supported by the members of the Specialty Council.

The SMI/SED Section of Division 18 was formed in 2012 due to a recognized need for greater attention to the unique and specific challenges in the lives of persons with serious mental illnesses and serious emotional disturbance. The SMI/SED Section evolved from a Divisional workgroup tasked to investigate the interest in and feasibility of a new Section with a focus on SMI/SED. High levels of interest in the prospect of the potential new Section supported its feasibility. The SMI/SED Section was unanimously supported by the Division's Executive Committee and all of the other five sections of the Division. The SMI/SED Section was approved as a new Section with no dissenting votes. The reason for this high level of support is the cross-cutting impact and needs of the SMI/SED population within public service psychology. For example, people with these diagnoses are served in Veterans Affairs Medical Centers, state hospitals, community mental health centers, and the Indian Health Service; they are found in jails and prisons and regularly interact with law enforcement. Thus, the other sections and their leadership recognized the importance of SMI/SED as a larger societal issue and recognized the need for greater attention to this population within psychology as a whole. The Division and its sections place great importance on the population and the problems they face; as we all recognize, persons with SMI/SED are not limited to any one segment of society or treatment setting and psychologists need appropriate training to help them recover. Ultimately, the SMI/SED Section was formed with the second largest membership – second only to the VA Section.

Since its inception, membership in the SMI/SED Section has remained strong and is growing. We are a large group of psychologists dedicated to promoting optimal functioning in adults living with serious mental illnesses and children diagnosed with severe emotional disorders. Members work in a variety of settings (e.g., state hospitals, community agencies, criminal justice systems) and share a commitment to supporting the recovery and resilience of persons experiencing disorders, such as schizophrenia, bipolar disorder, and other SMI diagnoses that severely impact their social and occupational functioning. Given the cognitive, functional, and social limitations of individuals experiencing these disorders, our Section recognizes the need for advanced, specialized training in community re-integration, psychosocial rehabilitation, and other recovery-oriented interventions. We also recognize the need for psychologists with this advanced training and expertise to be involved in mental health administration, direct clinical care, teaching, research, public policy, and patient advocacy.

As such, this Section is deeply committed to supporting the petition for Specialty recognition. To illustrate the depth and breadth of the support, the Section's membership includes members of

each of the other sections of the Division. Several members of the Section have contributed to the petition's research, writing, and editing, and time is allotted on each of its monthly calls to discuss the status and progress of this petition. In short, we look forward to its recognition.

We hope this clarifies the SMI/SED Section's unwavering commitment to the SMI/SED Specialty Council and support for the Council's petition for recognition of the post-doctoral specialty in Psychological Assessment and Treatment of Persons with Serious Mental illness and Severe Emotional Disturbance.

Marcia Hunt, Ph.D., Chair, Division 18 SMI/SED Section

Meaghan Stacy, Ph.D., Chair-Elect, Division 18 SMI/SED Section



December 2, 2018

Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP)
 American Psychological Association
 750 First Street NE
 Washington, DC 20002

Dear CRSPPP:

I am writing to express the strong support of the Association for Behavioral and Cognitive Therapies (ABCT) Special Interest Group (SIG) on Schizophrenia and Other Serious Mental Disorders (SOSMD-SIG) for the application of specialty recognition of a post-doctoral specialty in SMI Psychology. The SIG is honored to join the SMI Psychology Specialty Council in promoting this much-needed post-doctoral specialty training.

SOSMD-SIG is comprised primarily of psychologists and psychologists in training. We are clinicians, researchers, training program directors, and administrators who specialize in research, training, and clinical services for those with schizophrenia and other serious mental disorders. Our mission is to promote "...the development, dissemination, and implementation of evidence-based interventions and behavioral assessments for persons experiencing, or at risk for, psychosis and problems on the schizophrenia spectrum".

Although we are a new organizational member of the Specialty Council, our members have contributed to the development of this important work for the past several years. I, and many of our members, belong to APA divisions, and several of our members are past members of the APA Task Force on SMI/SED. Their contributions to developing the petition for APA range from writing and reviewing sections of the petition to attending open meetings of the Specialty Council. Organizationally, the SIG has supported this work by posting information and updates about the Specialty Council and the petition on our website (<https://psychology.unl.edu/schizsig/resources-links>) and by including information about the specialty during SIG sessions at the annual ABCT annual convention.

I would like to stress how important and needed we believe this specialty is for training competent psychologists for work with people with serious mental disorders. As psychologists, we have an obligation to provide the most up to date training available for clinicians, researchers, and administrators. The specialty in SMI Psychology is well developed and positioned to do that. Without such specialty training, psychologists are not equipped to provide the empirically supported treatments persons with these complex and challenging disorders deserve. These treatments have been shown to enable individuals to recover and re-gain their functional capability. The specialty in SMI Psychology will highlight for the public and the mental health community psychology's important leadership role in developing and delivering effective services for this underserved population.

Thank you for considering our input on this important advance for psychology.

Sincerely,

Jerome Yoman, Ph.D., ABPP
 Clinical Psychologist (OR Lic. #1894)
 Board Certified in Cognitive & Behavioral Psychology
 Fellow, Association for Cognitive & Behavioral Therapies
 Leader, Schizophrenia and Other Serious Mental Disorders Special Interest Group, ABCT

Criterion II. Public Need for Specialty Practice

The services of the specialty are responsive to identifiable public needs

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

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

Definitions

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

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

For SMI:

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

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

For SED:

Children with SED are defined as persons:

From birth up to age 18, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities....these disorders include any mental disorder (including those of biological etiology) listed in DSM-III-R or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-III-R `V' codes, substance use, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance....Functional impairment is defined as

difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in their environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition (Federal Register, Volume 58, Number 96. Pages 29422-29425).

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

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

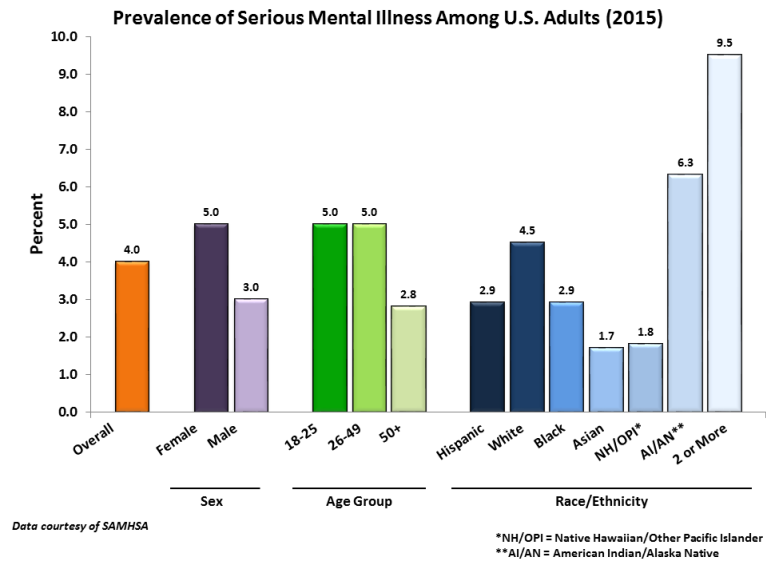
Those with SMI/SED are distinct from others with mental health disorders primarily because of the differences in symptomatology, the severity of their illnesses, the resultant functional limitations, and the debilitating societal stigma and self-stigma that they confront. The incidence and prevalence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

SMI Prevalence

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

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

Results further indicate that only about 6.4 million of those with SMI or 65.3 percent received mental health services for their illness in the past year. The reasons that approximately 35% do not receive mental health services are complicated and include one or more of the following: stigma, poverty, lack of insurance, provider lack of knowledge of appropriate treatments, fear of treatment including hospitalization or medication, distrust of providers or the mental health system, and perceived lack of treatment (Corrigan, Druss, & Perlick, 2014; Kessler et al., 2001; Kreyenbuhl, Nossel, & Dixon, 2009; Torrey et al., 2001). Globally, the proportion of people with mental health disorders is highly similar throughout the world and most do not receive treatment (World Health Organization, 2001).



Source: NIMH Website, downloaded February 15, 2017

With respect to co-morbid substance use disorders (SUD), “Among the 19.6 million adults aged 18 or older in 2015 who had a past year SUD, 2.3 million (11.9 percent) also had SMI in the past year. The 2.3 million adults with SMI who met the criteria for an SUD in the past year represent 23.8 percent of the 9.8 million adults with SMI” (Center for Behavioral Health Statistics and Quality, 2016).

SED Prevalence

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

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

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

In the Great Smoky Mountain Study participants (ages 9-21 years of age) were followed and interviewed up to nine times (Copeland, Shanahan, Costello, & Angold, 2011). Cumulative prevalence of

psychiatric disorders was striking, as by age 21, 61.1% of participants met diagnostic criteria for a well specified disorder, and an additional 21.4% for a “not otherwise specified” disorder. The researchers concluded that although at any given time a small percentage of children/youth meet criteria for a DSM disorder, by young adulthood, the majority do, making the experience nearly universal. (This study included substance disorders, which were the most common disorder.) An additional longitudinal study showed similar results (Jafee, Harrington, Cohen, & Moffit, 2005).

Impact of SED on Development

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

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

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

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

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

There are an abundance of risk factors that put children and adolescents at a greater risk for SED and declining quality of care. Youth in foster homes, abuse victims, those living in poverty, and/or

experiencing high life stress are all at greater risk for developing SED or SMI (Fontanella, Gupta, Hiance-Steelsmith, & Valentine, 2014; Subica, 2013; Willard, Long, & Phipps, 2016).

Public Health Needs

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

Schizophrenia in late life is emerging as a major public health concern worldwide and impacts on persons affected, their families and caregivers, public health systems, and the public as costs escalate (Folsom, et al., 2006). Older adults with schizophrenia have been a largely neglected population, and only since 1990 has any systematic effort been made to study them. Clinical care for this ever-increasing segment of our population requires special consideration of the unique characteristics of older persons with schizophrenia. There are different symptoms and unique challenges associated with SMI in all age groups and for older adults, the central issue is that of age-related changes in the clinical features of schizophrenia, which include delusions, hallucinations, emotional changes, cognitive impairments, and adaptive life skills (Harvey, 2005). In 2005, it was estimated that over 9% of nursing home residents had SMI (Becker & Mehra, 2005) and estimates are that by 2030, the number of persons aged 65 who have a serious mental illness and over will double (Cohen, 2000) and be the same as the number of persons aged 30 – 44 with a similar disorder (Jeste & Liebowitz, 1997).

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

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

We discuss the following public needs below:

- Greater morbidity, mortality of individuals with SMI/SED and years of life lost through premature death from serious health problems along with the attendant increased health care costs incurred by these factors
 - a. Stigma

- b. Lack of appropriate mental health treatment
 - c. Lack of insurance
 - d. Racial and cultural Issues, e.g., stigma, poor adherence to guideline based treatment, use of inappropriate treatment settings, practitioner bias
- Additional implications of inadequate access to treatment for those with SMI/SED including psychological and social problems of those with SMI/SED, and impact on public health needs.
 - Greater incarceration and forensic hospital utilization with attendant increased costs in the justice and forensic sectors noting the additional factors associated with SMI/SED and the justice and forensic systems. These include:
 - a) Racial/cultural issues
 - b) Immigrant and refugee issues.
 - Greater burden on families and caregivers with increased health care costs for these individual caregivers.
 - Economic burden due to greater health-care costs, lost productivity, tax revenue, and decreased economic growth, and on family care givers, and social systems such as housing, criminal justice and forensic systems.

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

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

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

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

suicide, which tend to occur more often in early than late adulthood” (Thorncroft, 2011, p. 441).

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

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

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

Smoking

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

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

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

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

Obesity

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

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

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

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

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

Unnatural Causes

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

Suicide

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

People are most at risk immediately following discharge from the hospital, and within ninety days of discharge (Olfson, et al., 2016), especially for those discharged from a first admission (Appleby, et al., 1999; Bakst, et al., 2010; Lee & Lin, 2009; Pompili, et al., 2011). The risk is greater for those without a previous admission during the year, compared to those hospitalized more than three times in the previous year (Geddes & Juszczak, 1995; Goldacre, Seagroatt, & Hawton, 1993; Heila, et al., 1997; Lee & Lin, 2009). Pompili et al., (2007) report that the suicide risk is three times higher for adolescents or young adults with schizophrenia than for adults with this disorder. Risks for both suicide and violence are greater during the first episode of psychosis and for those who have not received treatment. Given that this appears to be a critical period for these events and that onset of SMI typically occurs during adolescence or young adulthood, it is particularly important to monitor young people closely especially following discharge from hospital.

Violence

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

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

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

As a whole, a large body of research indicates that “risk of violence is modestly elevated for people with mental disorder, particularly those who misuse substances” (Silver, 2006, p. 685). Still, most people with mental illness are not violent, most violent offenders are not mentally ill, and the strongest risk factors for violence (e.g., past violence) are shared by those with- and without- mental illness (see Link & Stueve, 1995; Monahan et al., 2001; Mulvey, 1994; Walsh, Buchanan, & Fahy, 2002). ... Based on a meta-analysis of 204 diverse studies and samples,

Douglas, Guy, and Hart (2009) found a small correlation between psychosis and violence ($r = .16$ or $OR = 1.53$). However, there was no meaningful correlation for offenders with mental illness ($r = .00$ or $OR = 0.91$) and general offenders ($r = .01$ or $OR = 1.27$). ... In a meta-analysis of 58 prospective studies of offenders with mental illness (70% with schizophrenia), Bonta et al. (1998) found that clinical variables (e.g., diagnoses, treatment history) did not meaningfully predict a new general offense ($r = -.02$) or a new violent offense ($r = -.03$). Instead, the strongest predictors of a new violent offense ($r = .20$) were antisocial personality, juvenile delinquency, criminal history, and employment problems. (p. 117).

In summary, people with SMI/SED have high levels of medical co-morbidities which impact their level of general functioning (Briskman, Bar, Boaz, & Shargorodsky, 2012). Reasons for the poorer health status of people with SMI/SED range from the cognitive deficits seen in this population to medication side effects, but also include such social factors as social disadvantage, racial bias among providers, language or other cultural barriers, physician bias leading to somatic complaints not taken seriously, and self-stigma, leading to individuals' embarrassment and reluctance to make and keep general medical appointments (de Hert, et al., 2011; Dickerson, et al, 2003; Howard, et al., 2010; Mechanic & Bilder, 2004; U.S. Department of Health and Human Services, 2001). We look at each of these and other factors, separately below.

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

Stigma and health care issues

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

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

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

professionals.

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

Lack of appropriate mental health treatment

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

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

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

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

According to the NIMH “Research on psychiatric epidemiology shows that mental disorders are common throughout the US, affecting tens of millions of people each year, and that only a fraction of those affected receive treatment” (NIMH webpage, 2014), exemplifying the underlying public need for services for this population. Additionally, NIMH indicates that “While mental disorders are common in the United States, their burden of illness is particularly concentrated among those who experience disability due to serious mental illness (SMI).” (NIMH website, retrieved from

<http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-adults.shtml> on February 22, 2016) Despite recognition of this need, psychologists and other mental health providers remain ill prepared to provide the kinds of services needed to help individuals recover from the effects of their illness.

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

Lack of insurance

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

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

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

Stigma, health care, and racial/cultural issues

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

Following publication of the Surgeon General's 1999 Report (U.S. Department of Health and

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

The Supplement summed the situation up concisely:

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

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

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

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

Racial/cultural issues in health care: guideline based treatment

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

Racial/cultural issues in health care: treatment settings

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

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

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

Racial/cultural issues in health care: practitioner bias

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

Additional Implications of Inadequate Access to Treatment for Those with SMI/SED: Psychological and Social Problems of Those with SMI/SED and Impact on Public Health Needs

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

There are several challenges presented by people with SMI/SED. Individuals may have had negative past experiences with providers, which can contribute to suspicions of mental health professionals, and they may not want to be involved with the mental health system. The pervasive effects

of stigma and the vulnerability of individuals who are ill can make it difficult for them to seek help (Mazi-Kotwal & Upadhyay, 2011; Thornicroft, 2011), or they may miss appointments or drop out of treatment (Atdjan & Vega, 2005). Individuals can sometimes be perceived as hostile, fearful and uncooperative. These behaviors can reinforce a provider's biases and can negatively influence interactions. These factors can make it challenging for mental health providers to know how to be of assistance (Phelan, Stradins & Morrison, 2001). When racial and ethnic differences or language barriers are added, the result can be less than optimal and potentially damaging for the person who needs assistance, ultimately leading to the observed disparities in treatment and dire consequences that we discussed in this and the previous section.

Neuropsychological functioning

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

Trauma

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

Severe depression and despair

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

Stigma

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

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

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

The prevalence of people with SMI/SED in justice-related settings is higher than their overall prevalence in the population with incarceration rates estimated to be about 20% (American Psychiatric Association, 2000). As with the public health system, the failure to provide timely and appropriate treatment results in overuse of the criminal justice and forensic systems and increases the burden on these already under-resourced systems.

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

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

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

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

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

Racial/cultural issues

Similarly to the non-forensic health-care system, there are clear differences in the way that people of color are perceived and treated by criminal justice authorities and the forensic system in the US. These differences are confounded with social determinants of health, education, employment, housing, socio-economic status, and other aspects of life in the US. (Primm, et al., 2010; Thompson, 2011). African

Americans are frequently labeled as criminals when they are actually suffering from SMI/SED, which may account for their overrepresentation in the system (Foulks, 2004).

Immigrants and Refugees

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

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

Family and caregiver burden

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

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

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

Individuals with SMI/SED constitute the largest and fastest-growing group of Social Security disability beneficiaries (Danziger, Frank, & Meara, 2009; McAlpine & Warner, 2000). As we indicated, there are substantial impacts on many public health sectors (Millier, 2014). Referring specifically to schizophrenia, Millier et al. (2014) stated: "The costs of the disease's management remain large for individuals and society" (p. 85). The tremendous economic burden reported by Cloutier et al. (2016) for the US that we cited at the beginning of this section, is not just a U.S. issue. Similar results have been found worldwide. For example, a systematic review conducted of economic burden studies from several

countries found that the enormous burden documented by Cloutier et al., mirrors similar findings from countries all over the world (Chong, et al., 2016). Researchers have found similar results in individual country-level studies in Australia (Neil, Carr, Mihalopoulos, Mackinnon, & Morgan, 2014), China (Montgomery, et al., 2013; Xu, Wang, Wimo, & Qiu, 2016), Germany (Frey, 2014), India (Singh & Goyal, 2017), Japan (Sado, et al., 2013), and Norway (Evensen, et al., 2016), among others.

As we indicate in our responses to subsequent sections of this Criterion, psychological interventions, namely those that, based on rigorous empirical research, have been designated as evidence-based and promising practices for this population, and are known as psychosocial rehabilitation (PSR) interventions, have been shown to improve outcomes and can improve the course of SMI/SED, with the potential to alleviate the public burdens documented above.

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

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

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

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

An example from the homeless literature exemplifies this point. People with SMI/SED are often either homeless or at risk of becoming homeless (Padgett, 2007). Being homeless or at risk of being homeless has far reaching impacts that go beyond simply not having a place to live. The daily struggles for basic necessities such as food, safety, and shelter from the elements means that little time or energy is left for health care, even when serious illness or disease is present (Koh & O’Connell, 2016). The state of being homeless is traumatic in and of itself and puts individuals at risk of victimization, physical and sexual abuse/assault, and criminal activity. Homelessness may pose unique challenges for older adults who are homeless (Molinari, et al., 2013). When added to the already difficult circumstances that people with SMI/SED experience, homelessness is a serious complicating and additive factor (Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011; Hopper, Bassuk, & Olivet, 2010), further increasing the economic impact on several public health sectors including health, social services, and potentially the criminal justice and forensic sectors.

With specific reference to the question in this Criterion, we should note that there are far reaching

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

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

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

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

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

There are several federal, state and local surveys designed to monitor developments related to children's health and these are useful for gathering information about SED. The federal surveys and surveillance systems that collect data on mental disorders among children include the following: *National Health and Nutrition Examination Survey* (NHANES), *National Health Interview Survey* (NHIS), *National Survey of Children's Health* (NSCH), *National Survey on Drug Use and Health* (NSDUH), *National Violent Death Reporting System* (NVDRS), *National Vital Statistics System* (NVSS), *National Youth Risk Behavior Survey* (YRBS), and the *School-Associated Violent Death Study* (SAVD). These are available at the relevant national organization websites. However, childhood-onset schizophrenia is not included in ongoing U.S. national surveillance, in part because of its low frequency, and because of the challenges in identifying it through surveys or nonclinical interviews (Perou et al., 2013). *The London Child Health and*

Development Study is a community based study that is prospective and longitudinal, and began by sampling children from 9-11 years old who presented premorbid risk markers for schizophrenia (Laurens & Cullen, 2016), and will identify targets for preventive intervention.

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

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

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

3. Describe how the specialty attends to public need.

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

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

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

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

Cost Effectiveness of Psychosocial Rehabilitation (PSR) Interventions

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

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

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

Researchers have documented the cost effectiveness of providing SE (Bond & Drake, 2014; Knapp, et al., 2013; Salkever, 2010) and shown that SE IPS can reduce social security costs (Drake, Skinner, Bond, & Goldman, 2009). Several have also demonstrated that employment leads to decreased

mental health costs (Bond et al., 1995; Bush, Drake, Xie, McHugo, & Haslett, 2009; Clark 1998; Drake, Xie, Bond, McHugo, & Caton, 2013; Henry, Lucca, Banks, Simon, & Page, 2004; Latimer 2001; Perkins, Born, Raines, & Galka, 2005; Rogers, Sciarappa, MacDonald-Wilson, & Danley, 1995; Schneider et al., 2009), and the six-country EQOLISE study (Knapp, et al., 2013), found better employment outcomes and lower costs for the SE IPS model, leading some to conclude that long-term cost reductions may be even greater than those measured by existing studies (Bush et al., 2009).

Due to the heightened interest in determining the effects of intervening early in the course of SMI/SED, several investigators sought to determine if providing a range of evidence-based and promising PSR services to those with first episode psychosis would demonstrate cost savings. The combination of interventions often includes intensive case management, supported housing, CBT, family psychoeducation, and supported employment combined with low-dose medication regimens. Studies of this nature have been conducted in several countries and have found health, social and economic benefits (Hastrup, et al., 2013; McCrone, Craig, Power, & Garety, 2010; Mihalopoulos, Harris, Henry, Harrigan, & McGorry, 2009; Mihalopoulos, McGorry, & Carter, 1999). In the UK, Park, McCrone and Knapp (2016) found that providing early intervention services saved the equivalent in U.S. dollars of more than \$2,600 per person over three years. Similarly in the US, Breitborde, et al. (2015) found that provision of early intervention services resulted in significant savings over the six months of the study, leading them to conclude “that for every \$1 spent on EPICENTER care, \$2.79 dollars were saved during the first 6 months of treatment” (p. 7). Further, Rosenheck, et al. (2016) used results from the NIMH RAISE trial of early intervention services to link early intervention treatment to quality of life adjusted years and found that the estimated benefits exceeded costs compared to usual community care evidencing a cost benefit for the early intervention services.

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

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

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

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

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

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

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

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

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

and prefer to work with individuals they feel prepared to help achieve success (Bernheim, 1990; Buck, Romeo, Olbert, & Penn, 2014).

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

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

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

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

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

References

- Adair, C. E., Streiner, D. L., Barnhart, R., Kopp, B., Veldhuizen, S., Patterson, M. ... Goering, P. (2016). Outcome trajectories among homeless individuals with mental disorders in a multisite randomised controlled trial of housing first. *The Canadian Journal of Psychiatry*, 61, 1, 30-39.
- Agency for Healthcare Research and Quality. (2009). *Mental Health Research Findings*. Rockville, MD: AHRQ Pub. No. 09-P011.
- Ahn, W., Proctor, C. & Flanagan, E. H. (2009). Mental health clinicians' beliefs about the biological, psychological and environmental bases of mental disorders. *Cognitive Science*, 33, 147-182.

- Akutsu, P. D., Snowden, L. R., & Organista, K. C. (1996). Referral patterns in ethnic-specific and mainstream programs for ethnic minorities and Whites. *Journal of Counseling Psychology*, 43(1), 56.
- Alegria, M., Canino, G., Ríos, R., Vera, M., Calderón, J., Rusch, D., & Ortega, A. N. (2002). Mental health care for Latinos: Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino Whites. *Psychiatric Services*, 53, 12, 1547-1555.
- Alexandre, P. K., Martins, S. S. & Richard, P. (2009). Disparities in adequate mental health care for past-year major depressive episodes among Caucasian and Hispanic youths. *Psychiatric Services*, 60, 10, 1365–1371.
- Allison, D. B., Newcomer, J. W., Dunn, A. L., Blumenthal, J. A., Fabricatore, A. N., Daumit, G. L., ... Alpert, J. E. (2009). Obesity among those with mental disorders: A National Institute of Mental Health meeting report. *American Journal of Preventive Medicine*, 36, 4, 341-350.
- American Psychiatric Association. (2000). Task Force Report: Psychiatric Services in Jails and Prisons 2nd ed. Washington, DC: American Psychiatric Association Press.
- Anderson, K. K. & Kurdyak, P. (2016). Factors associated with timely physician follow-up after a first diagnosis of psychotic disorder. *The Canadian Journal of Psychiatry*, doi: 10.1177/0706743716673322.
- Andrew, A. (2014). Family therapy. In M. Knapp, A. Andrew, D. McDaid, V. Lemmi, P. McCrone, A-L Park, ... G. Shepherd (Eds), *Investing in recovery: Making the business case for effective interventions for people with schizophrenia and psychosis* (12-13). London, UK: London School of Economics and Political Science.
- Appleby, L., Dennehy, J. A., Thomas, C. S., Faragher, E. B., & Lewis, G. (1999). Aftercare and clinical characteristics of people with mental illness who commit suicide: A case-control study. *The Lancet*, 353, 1397–1400.
- Armando, M., Pontillo, M. & Vicari, S. (2015). Psychosocial interventions for very early and early-onset schizophrenia: A review of treatment efficacy. *Current Opinions in Psychiatry*, 28, 312-323.
- Aron, L., Honberg, R., Duckworth, K., et al. (2009). *Grading the States 2009: A report on America's health care system for adults with serious mental illness*. Arlington, VA: National Alliance on Mental Illness.
- Atdjian, S. & Vega, W. A. (2005). Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services*, 56, 12, 1600–1602.
- Aubry, T., Nelson, G., & Tsemberis, S. (2015). Housing first for people with severe mental illness who are homeless: A review of the research and findings from the At Home-Chez Soi demonstration project. *Canadian Journal of Psychiatry*, 60, 11, 467–474.
- Baker, D. W., Hayes, R., & Fortier, J. P. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical care*, 36, 10, 1461-1470.

- Bakst, S., Rabinowitz, J. & Bromet, E. J. (2010). Antecedents and patterns of suicide behavior in first-admission psychosis. *Schizophrenia Bulletin*, 36, 4, 880–889.
- Barry, C. L., Huskamp, H. A., & Goldman, H. H. (2010). A political history of federal mental health and addiction insurance parity. *Milbank Quarterly*, 88, 404–433.
- Becker, M. & Mehra, S. (2005). *Serious Mental Illness in Florida nursing homes: A study of resident, facility, cost, and quality of care characteristics (Report to Agency for Health Care Administration)*, Tampa, FL: University of South Florida.
- Bergland, A., Meaas, I., Debesay, J., Brovold, T., Jacobsen, E. L., Antypas, K., & Bye, A. (2016). Associations of social networks with quality of life, health and physical functioning. *European Journal of Physiotherapy*, 18, 2, 78-88.
- Bernheim, K. P. (1990). Additional comments to Key issues in training in psychology for service to the seriously mentally ill. In H. P. Lefley. (Ed.). *Clinical Training in Serious Mental Illness*. Washington, DC: National Institute of Mental Health, DHHS Pub No (ADM) 90-1679.
- Birmaher, B., Brent, D., and the AACAP Work Group on Quality Issues. (2007). Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 1503-1526.
- Birman, D., Ho, J., Pulley, E., Batia, K., Everson, M. L., Ellis, H. ... Gonzalez, A. (2005). *Mental Health Interventions for Refugee Children in Resettlement*. [White Paper II]. Chicago, IL: National Child Traumatic Stress Network, Refugee Trauma Task Force.
http://www.nctsn.net/nctsn_assets/pdfs/materials_for_applicants/MH_Interventions_for_Refugee_Children.pdf.
- Blazer, D. G., Hybels, C. F., Simonsick, E. M. & Hanlon, J. T. (2000). Marked differences in antidepressant use by race in an elderly community sample: 1986–1996. *American Journal of Psychiatry*, 157, 1089–1094.
- Bond, G. R., Dietzen, L. L., Vogler, K. M., Katuin, C. H., McGrew, J. H., & Miller, L. D. (1995). Toward a framework for evaluating costs and benefits of psychiatric rehabilitation: Three case examples. *Journal of Vocational Rehabilitation*, 5, 75–88.
- Bond, G. R. & Drake, R. E. (2014). Making the case for IPS supported employment. *Administration and Policy in Mental Health*, 39, 6, 69-73.
- Bond, G. R., Drake, R. E., Mueser, K. T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on consumers. *Disease Management and Health Outcomes*, 9, 3, 141-159.
- Bossarte, R. M., Simon, T. R. & Barker, L. (2006). Characteristics of homicide followed by suicide incidents in multiple states, 2003–04. *Injury Prevention*, 12, (supplement 2), ii33–ii38.
- Breitborde, N. J. K., Bell, E. K., Dawley, D., Woolverton, C., Ceaser, A., Waters, A. C., ... Harrison-Monroe, P. (2015). The Early Psychosis Intervention Center (EPICENTER): Development and six-month outcomes of an American first-episode psychosis clinical service. *BMC Psychiatry*, 15, 266.

- Brekke, J. S., Prindle, C., Bae, S. W. & Long, J. D. (2001). Risks for individuals with schizophrenia who are living in the community. *Psychiatric Services*, 52, 1358-1366.
- Briskman, I., Bar, G., Boaz, M. & Shargorodsky, M. (2012). Impact of co-morbid mental illness on the diagnosis and management of patients hospitalized for medical conditions in a general hospital. *The International Journal of Psychiatry in Medicine*, 43, 4, 339-348.
- Brown, S., Kim, M., Mitchell, C. & Inskip, H. (2010). Twenty-five year mortality of a community cohort with schizophrenia. *The British Journal of Psychiatry*, 196, 116–121.
- Buck, B., Romeo, K. H., Olbert, C. M., & Penn, D. L. (2014). Self-reported comfort treating severe mental illnesses among pre-doctoral graduate students in clinical psychology. *Journal of Mental Health*, 23, 6, 297-302.
- Burgess, D., van Ryn, M., Dovidio, J. & Saha, S. (2007). Reducing racial bias among health care providers: Lessons from social-cognitive psychology. *Journal of General Internal Medicine*, 22, 882–887.
- Burns, T., Fioritti, A., Holloway, F., Malm, U., & Rössler, W. (2001). Case management and assertive community treatment in Europe. *Psychiatric Services*, 52, 5, 631-636.
- Burns, B. J., & Santos, A. B. (1995). Assertive community treatment: an update of randomized trials. *Psychiatric Services*, 46, 7, 669-675.
- Bush, P. W., Drake, R. E., Xie, H., McHugo, G. J., & Haslett, W. R. (2009). The long-term impact of employment on mental health service use and costs. *Psychiatric Services*, 60, 1024–1031.
- Cacioppo, J. T. & Hawkley, L. C. (2003). Social isolation and health, with an emphasis on underlying mechanisms. *Perspectives in Biology and Medicine*, 46, 3, S39-S52.
- Canadian Mental Health Association & Wellesley Institute. (2009). *Focus on Equity: Response to Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy*. Ontario, CA: Authors.
- Carmen, E., Rieker, P. P. & Mills, T. (1984). Victims of violence and psychiatric illness. *American Journal of Psychiatry*, 141, 378-383.
- Carr, E. R., Bhagwat, R., Miller, R., & Ponce, A. N. (2014). Training in mental health recovery and social justice in the public sector. *The Counseling Psychologist*, 42, 8, 1108-1135.
- Cattell, V. (2001). Poor people, poor places, and poor health: The mediating role of social networks and social capital. *Social Science & Medicine*, 52, 10, 1501-1516.
- Center for Behavioral Health Statistics and Quality. (2016). Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health (HHS Publication No. SMA 16-4984, NSDUH Series H-51).
- Center for Behavioral Health Statistics and Quality (2016). 2014 National Survey on Drug Use and Health: DSM-5 Changes: Implications for Child Serious Emotional Disturbance. (unpublished internal documentation). Substance Abuse and Mental Health Services Administration.

Rockville, MD. Retrieved: <http://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactChildSED-2016.pdf> on 9/18/2016.

- Chan, J. Y., Hirai, H. W., & Tsoi, K. K. (2015). Can computer-assisted cognitive remediation improve employment and productivity outcomes of patients with severe mental illness? A meta-analysis of prospective controlled trials. *Journal of Psychiatric Research*, 68, 293-300.
- Chiu, C. C., Chen, C. H., Chen, B. Y., Yu, S. H., & Lu, M. L. (2010). The time-dependent change of insulin secretion in schizophrenic patients treated with Olanzapine. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, 34, 6, 866-870.
- Choe, J. Y., Teplin, L. A. & Abram, K. M. (2008). Perpetration of violence, violent victimization, and severe mental illness: Balancing public health concerns. *Psychiatric Services*, 59, 153–164.
- Chong, H. Y., Teoh, S. L., Wu, D. B.-C., Kotirum, S., Chiou, C.-F., & Chaiyakunapruk, N. (2016). Global economic burden of schizophrenia: a systematic review. *Neuropsychiatric Disease and Treatment*, 12, 357–373.
- Chu, J. P., Emmons, L, Wong, J., Goldblum, P., Reiser, R., Barrera, A. Z., & Byrd-Olmstead, J. (2012). The public psychology doctoral training model: Training clinical psychologists in community mental health competencies and leadership. *Training and Education in Professional Psychology*, 6, 2, 76–83.
- Chung, H., Mahler, J. C. & Kakuma, T. (1995). Racial differences in treatment of psychiatric inpatients. *Psychiatric Services*, 46, 581–591.
- Clark, R. E. (1998). Supported employment and managed care: Can they coexist? *Psychiatric Rehabilitation Journal*, 22, 1, 62–68.
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., ... Thornicroft, G. (2014). What is the impact of mental health-related stigma on helpseeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, 45, 1, 1-17.
- Clemmensen, L., Vernal, D. L., Steinhausen, H. (2012). A systematic review of the long-term outcome of early onset schizophrenia. *BMC Psychiatry*, 12, 150. doi:10.1186/1471-244X-12-150.
- Cloutier, M., Aigbogun, M. S., Guerin, A., Nitulescu, R., Ramanakumar, A. V., Kamat, S. A., ... Wu, E. (2016). The economic burden of schizophrenia in the United States in 2013. *Journal of Clinical Psychiatry*, 77, 6, 764–771.
- Cohen, C. I. (2000). Directions for Research and Policy on Schizophrenia and Older Adults: Summary of the GAP Committee Report. *Psychiatric Services*, 51, 3, 299-302.
- Compton, M. T., Ramsay, C. E., Shim, R. S., Goulding, S. M., Gordon, T. L., Weiss, P. S., Druss, B. (2009). Health services determinants of the duration of untreated psychosis among African-American first-episode patients. *Psychiatric Services*, 60, 11, 1489–1494.
- Copeland, W., Shanahan, L., Costello, E. J., Angold, A. (2011). Cumulative prevalence of psychiatric disorders by young adulthood: A prospective cohort analysis from the Great Smoky

- Mountains study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50, 3, 252-261.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, 7, 614-625.
- Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, 15, 2, 37-70.
- Corrigan, P. W., Mittal, D., Reaves, C. M., Haynes, T. F., Han, X., Morris, S., & Sullivan, G. (2015). Mental health stigma and primary health care decisions. *Psychiatry Research*, 218, 35-38.
- Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsck, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services*, 63, 963-973.
- Corrigan, P. W., & Shapiro, J. R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review*, 30, 8, 907-922.
- Corrigan, P. W., Steiner, L., McCracken, S. G., Blaser, B., & Barr, M. (2001). Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. *Psychiatric Services*, 52, 12, 1598-1606.
- Costello, E. J. (2016): Early Detection and Prevention of Mental Health Problems: Developmental epidemiology and systems of support. *Journal of Clinical Child & Adolescent Psychology*, DOI: 10.1080/15374416.2016.1236728
- Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry*, 60, 837-44.
- Council of State Governments. (2005). *Criminal Justice/Mental Health Consensus Project*. New York, NY: Council of State Governments/Eastern Regional Conference.
- Couture, S. M., Penn, D. L., & Roberts, D. L. (2006). The functional significance of social cognition in schizophrenia: A review. *Schizophrenia Bulletin*, 32, S1, S44-S63.
- Crump, C., Sundquist, K., Winkleby, M. A. & Sundquist, J. (2013). Mental disorders and vulnerability to homicidal death: Swedish nationwide cohort study. *British Medical Journal*, 346:f557.
- Cuijpers, P., & Smit, F. (2002). Excess mortality in depression: A meta-analysis of community studies. *Journal of Affective Disorders*, 72, 227-236.
- Danziger, S., Frank, R. G., & Meara, E. (2009). Mental illness, work, and income support programs. *American Journal of Psychiatry*, 166, 398-404.
- David, R. A., & Rhee, M. (1998). The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *Mount Sinai Journal of Medicine*, 65, 393-397.

- de Hert, M., Correll, C. U., Bobes, J., Cetkovich-Pakmas, M., Cohen, D., Asai, I. ... Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, 10, 1, 52–77.
- de Leon, J., & Diaz, F. J. (2005). A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. *Schizophrenia Research*, 76 2, 135-157.
- Desai, H. D, Seabolt, J., & Jann, M. W. (2001). Smoking in patients receiving psychotropic medications: A pharmacokinetic perspective. *CNS Drugs*, 15, 6, 469-494.
- Dickerson, F. B., Brown, C. H., Kreyenbuhl, J. A., Fang, L., Goldberg, R. W., Wohlheiter, K., & Dixon, L. B. (2006). Obesity among individuals with serious mental illness. *Acta Psychiatrica Scandinavica*, 113, 4, 306-313.
- Dickerson, F. B. & Lehman, A. F. (2006). Evidence-based psychotherapy for schizophrenia. *Journal of Nervous and Mental Disease*, 194, 1, 3-9.
- Dickerson, F. B., McNary, S. W., Brown, C. H., Kreyenbuhl, J., Goldberg, R. W., & Dixon, L. B. (2003). Somatic healthcare utilization among adults with serious mental illness who are receiving community psychiatric services. *Medical care*, 41, 4, 560-570.
- Dixon, L. (2000). Assertive community treatment: Twenty-five years of gold. *Psychiatric Services*, 51, 6, 759-765.
- Dixon, L. B. & Schwarz, E. C. (2014). Fifty years of progress in community mental health in US: The growth of evidence-based practices. *Epidemiology and Psychiatric Sciences*, 23, 5-9.
- Douglas, K., Guy, L., & Hart, S. (2009). Psychosis as a risk factor for violence to others: A meta analysis. *Psychological Bulletin*, 135, 679-706.
- Draine, J., Salzer, M. S., Culhane, D. P., & Hadley, T. R. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*, 53, 5, 565-673.
- Drake, R. E., Skinner, J. S., Bond, G. R., & Goldman, H. H. (2009). Social Security and mental illness: Reducing disability with supported employment. *Health Affairs*, 28, 761–770.
- Drake, R. E., Xie, H., Bond, G. R., McHugo, G. J., Caton, C. L. M. (2013). Early psychosis and employment. *Schizophrenia Research*, 146, 1, 111-117.
- Druss, B. G., Bradford, D. W., Rosenheck, R. A., Radford, M. J., & Krumholz, H. M. (2000). Mental disorders and use of cardiovascular procedures after myocardial infarction. *Journal of the American Medical Association*, 283, 506–511.
- Druss, B. G., Marcus, S. C., Rosenheck, R. A., Olfson, M., Tanielian, T., & Pincus, H. A. (2000). Understanding disability in mental and general medical conditions. *American Journal of Psychiatry* 157, 9, 1485–1491.

- Dusetzina, S. B., Farley, J. F., Weinberger, M., Gaynes, B. N., Sleath, B., & Hansen, R. A. (2012). Treatment use and costs among privately insured youths with diagnoses of bipolar disorder. *Psychiatric Services, 63*, 10, 1019-1025.
- Ellingrod, V. L., Taylor, S. F., Dalack, G., Grove, T. B., Bly, M. J., Brook, R. D., ... Pop-Busui, R. (2012). Risk factors associated with metabolic syndrome in bipolar and schizophrenia subjects treated with antipsychotics: The role of folate pharmacogenetics. *Journal of Clinical Psychopharmacology, 32*, 2, 261.
- Ellis, B. H., Lincoln, A., Charney, M., Ford-Paz, R., Benson, M., & Strunin, L. (2010). Mental health service utilization of Somali adolescents: Religion, community, and school as gateways to healing. *Journal of Transcultural Psychiatry, 47*, 5, 789–811.
- Evensen, S., Wisløff, T., Lystad, J. U., Bull, H., Ueland, T., & Falkum, E. (2016). Prevalence, employment rate, and cost of schizophrenia in a high-income welfare society: A population-based study using comprehensive health and welfare registers. *Schizophrenia Bulletin, 42*, 2, 476-483.
- Fazel, S., Wolf, A., Palm, C. & Lichtenstein, P. (2014). Violent crime, suicide, and premature mortality in patients with schizophrenia and related disorders: a 38-year total population study in Sweden. *The Lancet Psychiatry, 1*, 1, 44-54.
- Fellner, J. (2006). A Conundrum for corrections, a tragedy for prisoners: Prisons as facilities for the mentally ill. *Washington University Journal of Law & Policy, 22*, 1, 1-11.
- Fernando, S. M., Deane, F. P., McLeod, H. J., & Davis, E. L. (2017). A carer burden and stigma in schizophrenia and affective disorders: Experiences from Sri Lanka. *Asian Journal of Psychiatry, 26*, 77-81.
- Folsom, D. P., Lebowitz, B. D., Lindamer, L. A., Palmer, B. W., Patterson, T. L., & Jeste, D. V. (2006). Schizophrenia in late life: emerging issues. *Dialogues in Clinical Neuroscience, 8*, 1, 45–52.
- Fontanella, C. A., Gupta, L., Hiance-Steelesmith, D. L., & Valentine, S. (2014). Continuity of care for youth in foster care with emotional disturbances. *Children and Youth Services Review, 50*, 38-43.
- Foulks, E. F. (2004). Commentary: Racial bias in diagnosis and medication of mentally ill minorities in prisons and communities. *The Journal of the American Academy of Psychiatry and the Law, 32*, 34–35.
- Fristad, M. A., & MacPherson, H. A. (2013). Evidence-based psychosocial treatments for child and adolescent bipolar spectrum disorders. *Journal of Clinical Child & Adolescent Psychology, 43*, 339-355.
- Frey, S. (2014). The economic burden of schizophrenia in Germany: A population-based retrospective cohort study using genetic matching. *European Psychiatry, 29*, 8, 479-489.
- Gater, A., Rofail, D., Tolley, C., Marshall, C., Abetz-Webb, L., Zarit, S. H., & Berardo, C. G. (2014). “Sometimes It’s Difficult to Have a Normal Life”: Results from a qualitative study exploring

- caregiver burden in schizophrenia. *Schizophrenia Research and Treatment*, Article ID 368215.
- Geddes, J. R. & Juszczak, E. (1995). Period trends in rate of suicide in first 28 days after discharge from psychiatric hospital in Scotland, 1968-92. *British Medical Journal*, 311, 357–360.
- George, T. P., Termine, A., Sacco, K. A., Allen, T. M., Reutenauer, E., Vessicchio, J., C., & Duncan, E. J. (2006). A preliminary study of the effects of cigarette smoking on impulse inhibition in schizophrenia: Involvement of nicotinic receptor mechanisms. *Schizophrenia Research*, 87, 1, 307–315.
- Gill, K. J., & Murphy, A. A. (2013). Psychiatric/psychosocial rehabilitation (PSR) education: Academic and professional. *Current Psychiatry Reviews*, 9, 3, 260-269.
- Gilmer, T. P., Stefancic, A., Tsemberis, S., & Ettner, S. L. (2014). Full-service partnerships among adults with serious mental illness in California: Impact on utilization and costs. *Psychiatric Services*, 65, 9, 1120-1125.
- Glied, S. & Cuellar A. E. (2003). Trends and issues in child and adolescent mental health. *Health Affairs*, 22, 5, 39-50.
- Goldacre, M., Seagroatt, V. & Hawton, K. (1993). Suicide after discharge from psychiatric inpatient care. *The Lancet*, 342, 283–286.
- Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S. D., Swartz, M., Essock, S. M. ... 5 Site Health and Risk Study Research Committee. (2001). Recent victimization in women and men with severe mental illness: Prevalence and correlates. *Journal of Traumatic Stress*, 14, 615-632.
- Graham, H. (2007). *Unequal Lives: Health and Socioeconomic Inequalities*. Maidenhead, UK: Open University Press.
- Grant, B. F., Hasin, D. S., Chou, S. P., Stinson, F. S., & Dawson, D. A. (2004). Nicotine dependence and psychiatric disorders in the united states: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry*, 61, 11, 1107-1115.
- Greenberg, G. A. & Rosenheck, R. A. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services*, 59, 170–177.
- Greenfield, S. F., Strakowski, S. M., Tohen, M., Batson, S. C., & Kolbrener, M. L. (1994). Childhood abuse in first episode psychosis. *British Journal of Psychiatry*, 164, 831-834.
- Grubaugh, A. L., Zinzow, H. M., Paul, L., Egede, L. E., & Frueh, B. C. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review*, 31, 6, 883–899.
- Hargrove, D. S. (1990). Key issues in training in psychology for service to the seriously mentally ill. In Lefley, H. P. (Ed.). *Clinical Training in Serious Mental Illness*. Washington, DC: National Institute of Mental Health, DHHS Pub No (ADM) 90-1679.

- Harris, E. C. & Barraclough, B. (1997). Suicide as an outcome for mental disorders. A meta-analysis. *British Journal of Psychiatry*, 170, 205–228.
- Harris, E. C. & Barraclough, B. (1998). Excess mortality of mental disorder. *British Journal of Psychiatry*, 173, 11-53.
- Harvey, P. D. (2005). *Schizophrenia in late life; Aging effects on symptoms and course of illness*. Washington DC: American Psychological Association.
- Harvey, P. D. & Strassnig, M. (2012). Predicting the severity of everyday functional disability in people with schizophrenia: Cognitive deficits, functional capacity, symptoms, and health status. *World Psychiatry*, 11, 73-79.
- Hastrup, L. H., Kronborg, C., Bertelson, M., Jeppesen, P., Jorgensen, L., Thorup, A., ... Nordentoft, M. (2013). Cost-effectiveness of early intervention in first-episode psychosis: Economic evaluation of a randomised controlled trial (the OPUS study). *The British Journal of Psychiatry*, 202, 35–41.
- Hawton, K., Sutton, L., Haw, C., Sinclair, J. & Deeks, J. J. (2005). Schizophrenia and suicide: Systematic review of risk factors. *British Journal of Psychiatry*, 187, 9-20.
- Hayden, E. P. & Mash, E. J. (2014). Child psychopathology: A developmental-systems perspective. In E. J. Mash & R. Barkley (Eds.). *Child Psychopathology*. Third Edition. (pp. 3-72). New York: Guilford.
- Hayes, L., Hawthorne, G., Farhall, J., O'Hanlon, & Harvey, C. (2015). Quality of life and social isolation among caregivers of adults with schizophrenia: Policy and outcomes. *Community Mental Health Journal*, 51, 5, 591-597.
- Heila, H., Isometsa, E. T., Henriksson, M. M., Heikkinen, M. E., Marttunen, M. J., & Lönnqvist, J. K. (1997). Suicide and schizophrenia: A nationwide psychological autopsy study on age- and sex specific clinical characteristics of 92 suicide victims with schizophrenia. *American Journal of Psychiatry*, 154, 1235–1242.
- Henry, A. D., Lucca, A. M., Banks, S., Simon, L., & Page, S. (2004). Inpatient hospitalizations and emergency service visits among participants in an Individual Placement and Support (IPS) model program. *Mental Health Services Research*, 6, 227–237.
- Hiroeh, U., Appleby, L., Mortensen, P. B. & Dunn, G. (2001). Death by homicide, suicide, and other unnatural causes in people with mental illness: A population-based study. *The Lancet*, 358, 9299, 2110–2112.
- Hiroeh, U., Kapur, N., Webb, R., Dunn, G., Mortensen, P. B., & Appleby, L. (2007). Deaths from natural causes in people with mental illness: A cohort study. *Journal of Psychosomatic Research*, 64, 275-283.
- Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality a meta-analytic review. *Perspectives on Psychological Science*, 10, 2, 227-237.

- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Med*, 7, 7, e1000316.
- Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, 3, 80-100.
- Horvitz-Lennon, M., Kilbourne, A. M., & Pincus, H. A. (2006). From silos to bridges: Meeting the general health care needs of adults with severe mental illnesses. *Health Affairs*, 25, 3, 659-669.
- Howard, L. M., Barley, E. A., Davies, E., Rigg, A., Lempp, H., Rose, D., ... Thornicroft G. (2010). Cancer diagnosis in people with severe mental illness: Practical and ethical issues. *The Lancet Oncology*, 11, 8, 797–804.
- Hurford, I. M., Kalkstein, S. & Hurford, M. O. (2011) Cognitive rehabilitation in schizophrenia. *Psychiatric Times*, March 15.
- Insel, T. R. (2008). Assessing the economic costs of serious mental illness. *American Journal of Psychiatry*. 165, 6, 703-711.
- Jaffee, S., Harrington, H., Cohen, P., & Moffit, T. E. (2005). Cumulative prevalence of psychiatric disorder in youths. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44, 406-407.
- Jeste, D. V., Lebowitz, B. D. (1997). Coming of age. *The Leifer Report*, Special Edition, 39–40.
- Johnson, D. L. (1990). Response to Key issues in training in psychology for service to the seriously mentally ill. In H. P. Lefley. (Ed.). *Clinical Training in Serious Mental Illness*. Washington, DC: National Institute of Mental Health, DHHS Pub No (ADM) 90-1679.
- Jolley, S., Garety, P., Peters, E., Fornells-Ambrojo, M., Onwumere, J., Harris, V., ... Johns, L. (2015). Opportunities and challenges in Improving Access to Psychological Therapies for People with Severe Mental Illness (IAPT-SMI): Evaluating the first operational year of the South London and Maudsley (SLaM) demonstration site for psychosis. *Behaviour Research and Therapy*, 64, 24-30.
- Joukamaa, M., Heliövaara, M., Knekt, P., Aromaa, A., Raitasalo, R., & Lehtinen, V. (2001). Mental disorders and cause-specific mortality. *British Journal of Psychiatry*, 179, 498-502.
- Joy, M., Clement, T., & Sisti, D. (2016). The ethics of behavioral health information technology: Frequent flyer icons and implicit bias. *JAMA*, published online September 08, 2016. doi:10.1001/jama.2016.12534.
- Kan, C. K., Ho, T. P, Dong, J. Y. & Dunn, E, L. (2007). Risk factors for suicide in the immediate post-discharge period. *Social Psychiatry and Psychiatric Epidemiology*, 42, 208–214.
- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... Heinssen, R. K. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173, 4, 362-372.

- Kataoka, S. L., Zhang, L. & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159, 1548–1555.
- Kessler, R. C., Avenevoli, S., Costello, J., Green, J. G., Gruber, M. J., McLaughlin, K. A. ... Merikangas, K. R. (2012). Severity of 12-month DSM-IV disorders in the national Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, 69, 381-389.
- Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., ... Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health services research*, 36, 6 Pt 1, 987–1007.
- Kessler, R. C., Heeringa, S., Lakoma, M. D., Petukhova, M., Rupp, A. E., Schoenbaum, M. ... Zaslavsky, A. M. (2008). Individual and societal effects of mental disorders on earnings in the United States: results from the national comorbidity survey replication. *American Journal of Psychiatry*, 165, 6, 703-711.
- Khalsa, H. M. K, Salvatore, P., Hennen, J., Baethge, Tohen, M, & Baldessarini, R. J. (2008). Suicidal events and accidents in 216 first-episode bipolar I disorder patients: Predictive factors. *Journal of Affective Disorders*, 106, 1, 179–184.
- Kilbourne, A. M., Switzer, G., Hyman, K., Crowley-Matoka, M., & Fine, M. J. (2006). Advancing health disparities research within the health care system: A conceptual framework. *American Journal of Public Health*, 96, 12, 2113–2121.
- King, E. A., Baldwin, D. S., Sinclair, J. M., Baker, N. G., Campbell, M. J., & Thompson, C. (2001). The Wessex Recent In-Patient Suicide Study, 1. Case-control study of 234 recently discharged psychiatric patient suicides. *British Journal of Psychiatry*, 178, 531–536.
- Kisely, S., Smith, M., Lawrence, D., Cox, M., Campbell, L. A., & Maaten, S. (2007). Inequitable access for mentally ill patients to some medically necessary procedures. *Canadian Medical Association Journal*, 176, 779-784.
- Klee, A., Adams, L., Beesley, N., Fisk, D., Hunt, M. G., Kalaczniak, M., Steinberg, H., & Harkness, L. (2016). Clinical competence for outreach and for special populations. In Jacobs, S. C. & Steiner, J. L. (Eds.). *Yale Textbook of Public Psychiatry*. New York, NY: Oxford University Press.
- Knapp, M., Andrew, A., McDaid, D., Lemmi, V., McCrone, P., Park, A-L., ... Shepherd, G. (Eds). (2014). *Investing in recovery: Making the business case for effective interventions for people with schizophrenia and psychosis*. London, UK: London School of Economics and Political Science.
- Knapp, M., McCrone, P. & McDaid, D. (2014). Cognitive behavioural therapy. In M. Knapp, A. Andrew, D. McDaid, V. Lemmi, P. McCrone, A-L Park, ... G. Shepherd (Eds), *Investing in recovery: Making the business case for effective interventions for people with schizophrenia and psychosis* (pp. 20-22). London, UK: London School of Economics and Political Science.
- Knapp, M., Patel, A., Curran, C., Latimer, E., Catty, J., Becker, T., ... Burns, T. (2013). Supported employment: Cost-effectiveness across six European sites. *World Psychiatry*, 12, 60, 60-68.

- Knitzer, J. (1982). *Unclaimed Children*. Washington, DC: Children's Defense Fund.
- Koh, H. K. & O'Connell, J. J. (November, 2016). Improving Health Care for Homeless People. *The JAMA Forum, JAMA*.
- Koroukian, S. M., Bakaki, P. M., Golchin, N., Tyler, C., & Loue, S. (2012). Mental illness and use of screening mammography among Medicaid beneficiaries. *American Journal of Preventive Medicine, 42*, 606–609.
- Kreyenbuhl, J., Buchanan, R.W., Dickerson, F. B. & Dixon, L. B. (2010). The Schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2009. *Schizophrenia Bulletin, 36*, 1, 94-103.
- Kreyenbuhl, J., Nossel, I. R., & Dixon, L. B. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *Schizophrenia Bulletin, 35*, 4, 696-703.
- Kung, W. W. (2004). Cultural and practical barriers to seeking mental health treatment for Chinese Americans. *Journal of Community Psychology, 32*, 1, 27-43.
- Kuno, E. & Rothbard, A. B. (1997). Racial disparities in antipsychotic prescription patterns for patients with schizophrenia. *American Journal of Psychiatry, 159*, 567–572.
- Lasser, K., Boyd, J. W., Woolhandler, S., Himmelstein, D. U., McCormick, D., & Bor, D. H. (2000). Smoking and mental illness: A population-based prevalence study. *Journal of the American Medical Association, 284*, 20, 2606-2610.
- Latimer, E. A. (1999). Economic impacts of assertive community treatment: A review of the literature. *Canadian Journal of Psychiatry, 44*, 443-454.
- Latimer, E. (2001). Economic impacts of supported employment for the severely mentally ill. *Canadian Journal of Psychiatry, 46*, 496–505.
- Lawrence, D., Hancock, K. J., & Kisely, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: Retrospective analysis of population based registers. *The BMJ, 346*, 2539.
- Lawrence, D., Holman, C. D. J., & Jablensky, A. V. (2001). *Duty to care: Preventable physical illness in people with mental illness*. Perth, Australia: University of Western Australia.
- Lawrence, D. & Kisely, S. (2010). Inequalities in healthcare provision for people with severe mental illness. *Journal of Psychopharmacology, 24*, 4 (supplement), 61–68.
- Lawrence, D., Mitrou, F., & Zubrick, S. R. (2009). Smoking and mental illness: Results from population surveys in Australia and the United States. *BMC Public Health, 2009* 9, 285, 1-14.
- Lawrence, D., Hancock, K. J., & Kisely, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: Retrospective analysis of population based registers. *The BMJ, 346*, 2539.

- Lawson, W. B. (1999). The art and science of ethnopsychopharmacotherapy. In J. Herrera, W. B. Lawson & J. J. Sramek, J. (Eds.). *Cross Cultural Psychiatry*. New York, NY: John Wiley & Sons Inc.
- Laurens, K. R., & Cullen, A. E. (2016). Toward earlier identification and preventative intervention in schizophrenia: Evidence from the London Child Health and Development Study. *Social Psychiatry and Psychiatric Epidemiology*, 51, 475-491.
- Lee, H. & Lin, H. (2009). Are psychiatrist characteristics associated with post discharge suicide of schizophrenia patients? *Schizophrenia Bulletin*, 35, 4, 760–765.
- Lee, R. S. C., Redoblado-Hodge, M. A., Naismith, S. L., Hermens, D. F., Porter, M. A. & Hickie, B. (2013a). Cognitive remediation improves memory and psychosocial functioning in first-episode psychiatric out-patients. *Psychological Medicine*, 43, 1161–1173.
- Lee, M. Y., Teater B., Hsu, K., Greene, G. J, Fraser, J. S., Solovey, A. D., & Grove, D. (2013b). Systems collaboration with schools and treatment of severely emotionally disturbed children or adolescents. *Children & Schools*, 35, 155-168. Doi: 10.1093/cs/cdt013
- Leonard, S. & Adams, C. E. (2006). Smoking cessation and schizophrenia. *American Journal of Psychiatry*, 163, 11, 1877.
- Leonard, S., Adler, L. E., Benhammou, K., Berger, R., Breese, C. R., Drebbling, C., ... Freedman, R. (2001). Smoking and mental illness. *Pharmacology, Biochemistry & Behavior*, 70, 561–570.
- Leong, F. T., & Lau, A. S. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research*, 3, 4, 201-214.
- Li, F., Green, J. G., Kessler, R. C. & Zaslavsky, A. M. (2010). Estimating prevalence of serious emotional disturbance in schools using a brief screening scale. *International Journal of Methods in Psychiatric Research*, 19, 88-98.
- Lindsey, K. & Paul, G. (1989). Involuntary commitment in institutions: Issues involving the overrepresentation of Blacks and the assessment of relevant functioning. *Psychological Bulletin*, 106, 171–183.
- Link, B., & Stueve, A. (1995). Evidence bearing on mental illness as a possible cause of violent behavior. *Epidemiologic Reviews*, 17, 172–181.
- Lipschitz, D. S., Kaplan, M. L., Sorkenn, J. B., Faedda, G. L., Chorney, P., & Asnis, G. M. (1996). Prevalence and characteristics of physical and sexual abuse among psychiatric outpatients. *Psychiatric Services*, 47, 189–191.
- Livingston, J. D. & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, 71, 2150-2161.
- Loebach Wetherell, J. & Jeste, D. V. (2004). Older adults with schizophrenia. *Elder Care*, 3. 2. 8-11.
- Ly, A. & Latimer, E. (2015). Housing First impact on costs and associated cost offsets: A review of the literature. *Canadian Journal of Psychiatry*, 60, 11, 475–487.

- Mabe, A., Ahmed, A. O., Duncan, G. N., Fenley, G., & Buckley, P. F. (2014). Project GREAT: Immersing physicians and doctorally-trained psychologists in recovery-oriented care. *Professional Psychology: Research and Practice*, 45, 5, 347–356.
- Magliano, L., Fiorillo, A., De Rosa, C., Malangone, C., & Maj, M. (2004). Beliefs about schizophrenia in Italy: A comparative nationwide survey of the general public, mental health professionals, and patients' relatives. *Canadian Journal of Psychiatry/La Revue Canadienne De Psychiatrie*, 49, 323–331.
- Mallinger, J. B., Fisher, S. G., Brown, T. & Lamberti, S. (2006). Racial disparities in the use of second-generation antipsychotics for the treatment of schizophrenia. *Psychiatric Services*, 57, 33–136.
- Manu, P. (2011). Medical complications of treatment with antipsychotic drugs. *Romanian Medical Reviews & Research*, 1, 1.
- Martin, L. F. & Freedman, R. (2007). Schizophrenia and the alpha-7 nicotinic acetylcholine receptor. *International Review of Neurobiology*, 78, 225–246.
- Mazi-Kotwal, N. & Upadhyay, B. (2011). Physical health in schizophrenia. *Cutting Edge Psychiatry in Practice*, 1, 3, 74–77.
- McAlpine, D. D. & Warner, L. (2000). Barriers to employment among persons with mental illness: A review of the literature. New Brunswick, NJ: Center for Research on the Organization and Financing of Care for the Severely Mentally Ill, Institute for Health, Health Care Policy and Aging Research, Rutgers, The State University.
- McClellan, J., Stock, S., and the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter for the assessment and treatment of children and adolescents with schizophrenia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 976-990.
- McCrone, P., Craig, T. K. J., Power, P., Garety, P. A. (2010). Cost-effectiveness of an early intervention service for people with psychosis. *British Journal of Psychiatry*; 196, 377–382.
- McCrone, P., Killaspy, H., Bebbington, P., Johnson, S., Nolan, F., Pilling, S., & King, M. (2009). The REACT study: cost-effectiveness analysis of assertive community treatment in north London. *Psychiatric Services*, 60, 7, 908-913.
- McCrone, P., Park, A., & Knapp, M. (2011). Early detection for psychosis. In M. Knapp, D. McDaid, & M. Parsonage (Eds.), *Mental Health Promotion and Mental Illness Prevention: The Economic Case*. London, UK: Department of Health. <http://www.lse.ac.uk/>
- McEvoy, J. P., Meyer, J. M., Goff, D. C., Nasrallah, H. A., Davis, S. M., Sullivan, L., ... Lieberman, J. A. (2005). Prevalence of the metabolic syndrome in patients with schizophrenia: Baseline results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. *Schizophrenia Research*, 80, 1, 19-32.

- McGurk, S. R., Mueser, K. T., Xie, H., Welsh, J., Kaiser, S., Drake, R. E., ... McHugo, G. J. (2015). Cognitive enhancement treatment for people with mental illness who do not respond to supported employment: A randomized controlled trial. *American Journal of Psychiatry*, 172, 9, 852-861.
- McKenzie, W. & Wurr, C. (2001). Early suicide following discharge from a psychiatric hospital. *Suicide and Life Threatening Behavior*, 31, 358–363.
- Mechanic, D. & Bilder, S. (2004). Treatment of people with mental illness: A decade-long perspective. *Health Affairs*, 23, 4, 84–95).
- Melfi, C., Croghan, T., Hanna, M. & Robinson, R. (2000). Racial variation in antidepressant treatment in a Medicaid population. *Journal of Clinical Psychiatry*, 61, 16–21.
- Merikangas, K. R., He, J. P., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., ... Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 49, 980-989.
- Mihalopoulos, C., Harris, M., Henry, L., Harrigan, S., McGorry, P. (2009). Is early intervention in psychosis cost-effective over the long term? *Schizophrenia Bulletin*, 35, 909–18.
- Mihalopoulos, C., McGorry, P. D., Carter, R. C. (1999). Is phase-specific, community oriented treatment of early psychosis an economically viable method of improving outcome? *Acta Psychiatrica Scandinavia*, 100, 47–55.
- Miles, J., Espiritu, R. C., Horen, N. M., Sebian, J., Waetzig, E. (2010). A public health approach to children's mental health: A conceptual framework. Expanded executive summary. Georgetown University Center for Child and Human Development.
- Millier, A., Schmidt, U., Angermeyer, M. C., Chauhan, D., Murthy, V., Toumi, M., & Cadi-Soussi, N. (2014). Humanistic burden in schizophrenia: A literature review. *Journal of Psychiatric Research*, 54, 85-93.
- Miller, E. C., Li, J., & Kabell, D. R. (2015). Using the Minnesota Multiphasic Personality Inventory (Adolescent Version) to identify secondary students with emotional disturbance. *Best Practices in Mental Health*, 11, 2, 35-46.
- Mitchell, A. J., Delaffon, V., & Lord, O. (2012). Let's get physical: Improving the medical care of people with severe mental illness. *Advances in psychiatric treatment*, 18, 216–225.
- Mitchell, A. J., Vancampfort, D., Sweers, K., van Winkel, R., Yu, W. & de Hert, M. (2013). Prevalence of metabolic syndrome and metabolic abnormalities in schizophrenia and related disorders—A systematic review and meta-analysis. *Schizophrenia Bulletin*, 39, 2, 306-318.
- Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., ... Kessler, R. C. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey Replication. *Psychological Medicine*, 41, 1751–1761.

- Molinari, V., Brown, L. M., Frahm, K., Schinka, J., & Casey, R. (2013). Factors that influence homelessness in older homeless veterans. *Journal of Health Care for the Poor and Underserved*, 24, 487-498.
- Monahan, J., Steadman, H., Appelbaum, P., Grisso, T., Mulvey, E., Silver, E., & Bank, S. (2001). *Risk assessment: Violence and mental disorder*. Oxford, UK: Oxford University Press.
- Montgomery, W., Liu, L., Stensland, M. D., Xue, H. B., Treuer, T., & Ascher-Svanum, H. (2013). The personal, societal, and economic burden of schizophrenia in the People's Republic of China: Implications for antipsychotic therapy. *Clinicoeconomics and Outcomes Research*, 5, 1, 407-418.
- Morrissey, J. P., Meyer, P. S. & Cuddeback, G. S. (2007). Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal*, 43, 527–544.
- Moy, E., Dayton, E. & Clancy, C. M. (2005). Compiling the evidence: The national health care disparities reports. *Health Affairs*, 24, 2, 376–387.
- Mueller, B., Nordt, C., Lauber, C., Rueesch, P., Meyer, P. C. & Roessler, W. (2006). Social support modifies perceived stigmatization in the first years of mental illness: A longitudinal approach. *Social Science Medicine*, 62, 39–49.
- Mueser, K. T., Goodman, L. A., Trumbetta, S. L., Rosenberg, S. D., Osher, F. C., Vidaver, R., ... Foy, D. W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 66, 3, 493-499.
- Mueser, K. T., Salyers, M. P., Rosenberg, S. D., Goodman, L. A., Essock, S. M., Osher, F. C. ... 5 Site Health and Risk Study Research Committee. (2004). Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: Demographic, clinical, and health correlates. *Schizophrenia Bulletin*, 30, 1, 45–57.
- Mueser, K. T., Silverstein, S. M., & Farkas, M. D. (2013). Should the training of clinical psychologists require competence in the treatment and rehabilitation of individuals with a serious mental illness?. *Psychiatric Rehabilitation Journal*, 36, 1, 54-59.
- Muhuri, P. K. (2014). *Serious Psychological Distress and Mortality among Adults in the U.S. Household Population: Highlights*. The CBHSQ Report: August 7, 2014. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
- Mulvey, E. (1994). Assessing the evidence for a link between mental illness and violence. *Hospital and Community Psychiatry*, 45, 663–668.
- Nasrallah, H. A., Keefe, R. S., & Javitt, D. C. (2014). Cognitive deficits and poor functional outcomes in schizophrenia: Clinical and neurobiological progress. *Current Psychiatry*, 13, 6, S2.
- Nasrallah, H. A., Harvey, P. D., Casey, D., Csoboth, C. T., Hudson, J. I., Julian, L., ... Skale, T. G. (2015). *The Management of Schizophrenia in Clinical Practice (MOSAIC) Registry: A focus*

- on patients, caregivers, illness severity, functional status, disease burden and healthcare utilization. *Schizophrenia Research*, 166, 1, 69-79.
- National Collaborating Centre for Mental Health (2014). *Psychosis and Schizophrenia in Adults: The NICE Guideline on Treatment and Management in Adults (update)*. CG 178. London, UK: National Institute for Health and Care Excellence.
- National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: Treatment and management (CG178)*. London, UK: National Institute for Health and Care Excellence.
- National Institute of Mental Health. (1990). *Clinical Training in Serious Mental Illness*. (1990). Lefley, H. P. (Ed). DHHS Pub. No. (ADM) 90-1679. Washington, DC: Supt. of Docs., U.S. Govt. Printing Office. Available from <http://babel.hathitrust.org/cgi/pt?id=mdp.39015050781247;view=1up;seq=3>
- National Institute of Mental Health. (2009). *Expert panel addresses high rates of smoking in people with psychiatric disorders*. Washington, DC: Author.
- National Institute of Mental Health. (2012). *Improving health and reducing premature mortality in people with severe mental illness*. Washington, DC: Author.
- Neil, A. L., Carr, V. J., Mihalopoulos, C., Mackinnon, A., & Morgan, V. A. (2014). Costs of psychosis in 2010: Findings from the second Australian National Survey of Psychosis. *Australian & New Zealand Journal of Psychiatry*, 48, 2, 169-182.
- Nielssen, O. & Large, M. (2010). Rates of homicide during the first episode of psychosis and after treatment: A systematic review and meta-analysis. *Schizophrenia Bulletin*, 36, 4, 702–712.
- Ösby, U., Correia, N., Brandt, L., Ekblom, A., & Sparen, P. (2000). Mortality and causes of death in schizophrenia in Stockholm County, Sweden. *Schizophrenia Research*, 45, 1, 21–28.
- Osborn, D. P. J. (2001). The poor physical health of people with mental illness. *The Western Journal of Medicine*, 175, 329–332.
- Olfson, M., Gerhard, T., Huang, C., Crystal, S. & Stroup, T. S. (2015). Premature mortality among adults with schizophrenia in the United States. *JAMA Psychiatry*, 72, 12, 1172-81.
- Olfson, M., Wall, M., Wang, S., Crystal, S., Liu, S-M, Gerhard, T., Blanco, C. (2016). Short-term suicide risk after psychiatric hospital discharge. *JAMA Psychiatry*. Published online September 21, 2016. doi:10.1001/jamapsychiatry.2016.2035.
- Padgett, D. K. (2007). There's no place like (a) home: Ontological security among persons with serious mental illness in the United States. *Social Science Medicine*, 64, 9, 1925–1936.
- Painter, K. (2012). Outcomes for youth with severe emotional disturbance: A repeated measures longitudinal study of a wraparound approach of service delivery in systems of care. *Child Youth Care Forum*, 41, 407-425. Doi: 10.1007/s10566-011-9167-1
- Park, A. L., McCrone, P., & Knapp, M. (2016). Early intervention for first-episode psychosis: Broadening the scope of economic estimates. *Early Intervention in Psychiatry*, 10, 2, 144-151.

- Parks, J., Svendsen, D., Singer, P. & Foti, M. E. (Eds.). (2006). *Morbidity and Mortality in People with Serious Mental Illnesses*. Technical Report 13. Alexandria, VA: National Association of State Mental Health Program Directors Council.
- Pearlmutter, M. D., Dwyer, K. H., Burke, L. G., Rathlev, N., Maranda, L., & Volturo, G. (2017). Analysis of emergency department length of stay for mental health patients at ten Massachusetts emergency departments. *Annals of Emergency Medicine*, DOI: <http://dx.doi.org/10.1016/j.annemergmed.2016.10.005>.
- Peele, P. B., Xu, Y., & Kupfer, D. J. (2003). Insurance expenditures on bipolar disorder: Clinical and parity concerns. *American Journal of Psychiatry*, 160, 1286–1290.
- Perkins, D. V., Born, D. L., Raines, J. A., & Galka, S. W. (2005). Program evaluation from an ecological perspective: Supported employment services for persons with serious psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 28, 217–224.
- Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., ... Centers for Disease Control and Prevention (CDC). (2013, May 17) Mental health surveillance among children – United States, 2005-2011, *Morbidity and Mortality Weekly Report*, 62, 02, 1-35. Accessed http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid=su6202a1_w
- Phelan, M., Stradins, L. & Morrison, S. (2001). Physical health of people with severe mental illness. *British Medical Journal*, 322, 443-444.
- Phillips, S. D., Burns, B. J., Edgar, E. R., Mueser, K. T., Linkins, K. W., Rosenheck, R. A., ... & McDonel Herr, E. C. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services*, 52, 6, 771-779.
- Pickett, K. E. & Wilkinson, R. G. (2015). Income inequality and health: A causal review. *Social Science & Medicine*, 128, 316-326.
- Pompili, M., Amador, X. F., Girardi, P., Harkavy-Friedman, J., Harrow, M., Kaplan, K., ... Tatarelli, R. (2007). Suicide risk in schizophrenia: Learning from the past to change the future. *Annals of General Psychiatry*, 6, 10.
- Pompili, M., Serafini, G., Innamorati, M., Lester, D., Shrivastava, A., Girardi, P., & Nordentoft, M. (2011). Suicide risk in first episode psychosis: A selective review of the current literature. *Schizophrenia Research*, 129, 1, 1-11.
- Primm, A. B., Vasquez, M. J. T., Mays, R. A., Sammons-Posey, D., McKnight, L. R., Presley-Cantrell, L. R., ... Perry, G. S. (2010). The role of public health in addressing racial and ethnic disparities in mental health and mental illness. *Preventing Chronic Disease Public Health Research, Practice, and Policy*, 7, 1, A20, 1–7.
- Puyat, J. H., Daw, J. R., Cunningham, C. M., Law, M. R., Wong, S. T., Greyson, D. L. & Morgan, S. G. (2013). Racial and ethnic disparities in the use of antipsychotic medication: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*, 48, 12, 1861–1872.

- Reeder, C., Harris, V., Pickles, A., Patel, A., Cella, M., & Wykes, T. (2014). Does change in cognitive function predict change in costs of care for people with a schizophrenia diagnosis following cognitive remediation therapy? *Schizophrenia Bulletin*, 40, 6, 1472–1481.
- Reeves, W. C., Strine, T. W., Pratt, L. A., Thompson, W., Ahluwalia, I., Dhingra, S. S., ... & Morrow, B. (2011). Mental illness surveillance among adults in the United States. *MMWR Surveillance Summary*, 60, (Suppl 3), 1-29.
- Roehrig, C. (2016). Mental disorders top the list of the most costly conditions in the United States: \$201 Billion. *Health Affairs*, 35, 6, 1130-1135.
- Rogers, E. S., Sciarappa, K., MacDonald-Wilson, K., & Danley, K. (1995). A benefit-cost analysis of a supported employment model for persons with psychiatric disabilities. *Evaluation and Program Planning*, 18, 105–115.
- Rosen, A., Mueser, K. T., & Teeson, M. (2007). Assertive community treatment – Issues from scientific and clinical literature with implications for practice. *Journal of Rehabilitation Research and Development*, 44, 6, 813-826.
- Rosenberg, S. D., Mueser, K. T., Friedman, M. J., Gorman, P. G., Drake, R. E., Vidaver, R. M., ... Jankowski, M. K. (2001). Developing effective treatments for posttraumatic disorders among people with severe mental illness. *Psychiatric Services*, 52, 11, 1453-1461.
- Rosenhan, A. (1984). Race differences in involuntary hospitalization: Psychiatric vs. labeling perspectives. *Journal of Health and Social Behavior*, 25, 14–23.
- Rosenheck, R., Leslie, D., Sint, K., Lin, H., Robinson, D. G.,...Kane, J. (2016). Cost-effectiveness of comprehensive, integrated care for first episode psychosis in the NIMH RAISE early treatment program. *Schizophrenia Bulletin*, 42, 896-906.
- Rost, K., Hsieh, Y., Xu, S., Menachemi, N. & Young, A. S. (2011). Potential disparities in the management of schizophrenia in the United States. *Psychiatric Services*, 62, 6, 613–618.
- Rözer, J., Kraaykamp, G., & Huijts, T. (2016). National income inequality and self-rated health: The differing impact of individual social trust across 89 countries. *European Societies*, 18, 3, 245-263.
- Rummel-Kluge, C., Komossa, K., Schwarz, S., Hunger, H., Schmid, F., Lobos, C. A., ... Leucht, S. (2010). Head-to-head comparisons of metabolic side effects of second generation antipsychotics in the treatment of schizophrenia: A systematic review and meta-analysis. *Schizophrenia Research*, 123, 2, 225-233.
- Sacco, K. A., Bannon, K. L. & George, T. P. (2004). Nicotinic receptor mechanisms and cognition in normal states and neuropsychiatric disorders. *Journal of Psychopharmacology*, 18, 4, 457–474.
- Sado, M., Inagaki, A., Koreki, A., Knapp, M. R. J., Kissane, L. A., Mimura, M. & Yoshimura, K. (2013) The cost of schizophrenia in Japan. *Neuropsychiatric Disease and Treatment*, 9, 787-798.
- Salkever, D. (2010). *Toward a Social Cost-Effectiveness Analysis of Programs to Expand Supported Employment Services: An Interpretive Review of the Literature*. Washington, DC: U.S.

Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

- Schneider, J., Boyce, M., Johnson, R., Secker, J., Slade, J., Grove, B., et al. (2009). Impact of supported employment on service costs and income of people with mental health needs. *Journal of Mental Health, 18*, 533–542.
- Schroeder, S. A. & Morris, C. D. (2010). Confronting a neglected epidemic: Tobacco cessation for persons with mental illnesses and substance abuse problems. *Annual Review of Public Health, 31*, 297–314.
- Sciar, D. A., Robinson, L. M., Skaer, T. L. & Galin, R. S. (1999). Ethnicity and the prescribing of antipsychotic pharmacotherapy: 1992–1995. *Harvard Review of Psychiatry, 7*, 29–36.
- Silver, E. (2006). Understanding the relationship between mental disorder and violence: The need for a criminological perspective. *Law and Human Behavior, 30*, 685–706.
- Sinclair, J. M. A., Mullee, M. A., King, E. A. & Baldwin, D. S. (2004). Suicide in schizophrenia: A retrospective case-control study of 51 suicides. *Schizophrenia Bulletin, 30*, 4, 803–811.
- Singh, N. K., & Goyal, N. (2017). Perceived social support and burden of care of male and female caregivers of patient with schizophrenia. *Indian Journal of Psychiatric Social Work, 8*, 1, 10-3.
- Skeem, J. L., Manchak, S., & Peterson, J. K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior, 35*, 110-126.
- Society for Research in Child Development. (2009). Report of Healthy development: A summit on young children's mental health: Partnering with communication scientists, collaborating across disciplines and leveraging impact to promote children's mental health. Washington, DC: Author.
- Smith, P. H., Homish, G. G., Giovino, G. A., & Kozlowski, L. T. (2014). Cigarette smoking and mental illness: A study of nicotine withdrawal. *American Journal of Public Health, 104*, e127-33.
- Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health, 93*, 2, 239-243.
- Snowden, L. R., Hu, T. W. & Jerrell, J. M. (1999). Emergency care avoidance: Ethnic matching and participation in minority serving programs. *Community Mental Health Journal, 31*, 463–473.
- Snowden, L. & Pingatore, D. (2002). Frequency and scope of mental health service delivery to African Americans in primary care. *Mental Health Services Research, 4*, 123–130.
- Stafford, M. R., Jackson, H., Mayo-Wilson, E., Morrison, A. P., & Kendall, J. (2013). Early interventions to prevent psychosis: Systematic review and meta-analysis. *BMJ, 346*, f185.
- Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B. & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*, 761–765.

- Stroul, B. A., & Friedman, R. M. (1986). *A System of Care for Severely emotionally Disturbed Children & Youth*. CASSP Technical Assistance Center, Washington, DC: Georgetown University Child Development Center.
- Subica, A. M. (2013). Psychiatric and physical sequelae and childhood physical and sexual abuse and forced sexual trauma among individuals with serious mental illness. *Journal of Traumatic Stress, 26*, 588-596.
- Substance Abuse and Mental Health Services Administration. (1993, May 20). Definition of mental illness and emotional disturbance in children. *Federal Register, 58*, 96, 29422-29422.
- Substance Abuse and Mental Health Services Administration. (2005). *Transforming mental health care in America. Federal Action Agenda: First Steps*. (DHHS Pub No. SMA-O5-0460). Rockville, MD: U. S. Department of Health and Human Services.
- Sullivan, G., Han, X., Moore, S., & Kotrla, K. (2006). Disparities in hospitalization for diabetes among persons with and without co-occurring mental disorders. *Psychiatric Services, 57*, 1126–1131.
- Szreter, S., & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology, 33*, 4, 650-667.
- Takeuchi, D. T., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health, 85*, 5, 638-643.
- Teplin, L. (1984). Criminalizing mental disorder: The comparative arrest rate of the mentally ill. *American Psychologist, 39*, 794–803.
- Teplin, L. A. (2000). Keeping the peace: Police discretion and mentally ill persons. *National Institute of Justice Journal, July*, 8-15.
- Teplin, L. A., McClelland, G. M., Abram, K. M. & Weiner, D. A. (2005). Crime victimization in adults with severe mental illness: Comparison with the National Crime Victimization Survey. *Archives of General Psychiatry, 62*, 911–921.
- Thompson, M. (2011). Gender, race, and mental illness in the criminal justice system. *Corrections & Mental Health, 1*, 1, 1–8.
- Thornicroft, G. (2011). Physical health disparities and mental illness: the scandal of premature mortality. *The British Journal of Psychiatry, 199*, 6, 441-442.
- Thornicroft, G. (2013). Premature death among people with mental illness. *British Medical Journal, 346*, Article F2969.
- Tiffin, P. A. & Welsh, P. (2013). Practitioner review: Schizophrenia spectrum disorders and the at-risk mental state for psychosis in children and adolescents – evidence-based management approaches. *Journal of Child Psychology and Psychiatry, 54*, 1155-1175.
- Torrey, W. C., Drake, R. E., Dixon, L., Burns, B. J., Flynn, L., A. J. Rush, ... Klatzker, D. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services, 52*, 1, 45-50.

- Toussaint, L., Shields, G. S., Dorn, G., & Slavich, G. M. (2016). Effects of lifetime stress exposure on mental and physical health in young adulthood: How stress degrades and forgiveness protects health. *Journal of Health Psychology, 21*, 6, 1004-1014.
- U. S. Department of Health and Human Services. (1999). *Mental health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health and Human Services. (2011). *Social Determinants of Health: Education and Income — United States, 2005 and 2009*. *MMWR Supplement 60*, pps. 11–17. Atlanta, GA: Centers for Disease Control and Prevention.
- U.S. Government Accountability Office. (2007). *Poverty in America: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions as well as the Economic Growth Rate*. Washington, DC: Author.
- VanMeerten, N. J., Harris, J. I., Nienow, T. M., Hegeman, B. M., Sherburne, A., Winskowski, A. M., ... Sponheim, S. R. (2013). Inpatient utilization before and after implementation of psychosocial rehabilitation programs: Analysis of cost reductions. *Psychological Services, 10*, 4, 420–427.
- Veling, W., Selten, J. P., Susser, E., Laan, W., Mackenbach, J. P., & Hoek, H. W. (2007). Discrimination and the incidence of psychotic disorders among ethnic minorities in The Netherlands. *International Journal of Epidemiology, 36*, 4, 761-768.
- Venters, H. & Keller, A. S. (2012). Diversion of patients with mental illness from court-ordered care to immigration detention. *Psychiatric Services, 63*, 4, 377–379.
- Vita, A., Deste, G., Barlati, S., Grano, A., Poli, R., Sacchetti, E. (2016). Does cognitive remediation modify the use of psychiatric services and the patterns of care of patients with schizophrenia? *Schizophrenia Research, 175*, 1 - 3, 85-89.
- Walker, A. M., Klein, M. S., Hemmens, C., Stohr, M. K., & Burton, V. S. (2016). Further examination of the rights lost by the mentally ill and mentally incompetent. *Community Mental Health Journal, 52*, 3, 272–280.
- Walkup, J. T., McAlpine, D. D., Olfson, M., Labay, L. E., Boyer, C., & Hansell, S. (2000). Patients with schizophrenia at risk for excessive dosing. *Journal of Clinical Psychiatry, 61*, 344–348.
- Walsh, E., Buchanan, A., & Fahy, T. (2002). Violence and schizophrenia: Examining the evidence. *British Journal of Psychiatry, 180*, 490–495.
- Wang, P. S., Berglund, P. & Kessler, R. C. (2001). Recent care of common mental disorders in the United States. *Journal of General Internal Medicine, 15*, 284–292.

- Wang, P. S., Demler, O. & Kessler, R. C. (2002). Adequacy of treatment for serious mental illness in the United States. *American Journal of Public Health*, 92, 92–98.
- Warner, R. (2010). Does the scientific evidence support the recovery model? *The Psychiatrist Online*, 34, 3-5.
- Wehring, H. J. & Carpenter, W. T. (2011). Violence and schizophrenia. *Schizophrenia Bulletin*, 37, 5 877–878.
- Whitley, R. & Lawson, W. B. (2010). The psychiatric rehabilitation of African Americans with severe mental illness. *Psychiatric Services*, 61, 508–511.
- Wiley-Exley, E., Domino, M. E., Ricketts, T. C., Cuddeback, G., Burns, B. J., & Morrissey, J. (2013). The impact of assertive community treatment on utilization of primary care and other outpatient health services: The North Carolina experience. *Journal of the American Psychiatric Nurses Association*, 19, 4, 195-204.
- Wilkinson, R. & Pickett, K. (2009). *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London, UK: Penguin.
- Willard, V. W., Long, A., & Phipps, S. (2016). Life stress versus traumatic stress: The impact of life events on psychological functioning in children with and without serious illness. *Journal of Psychological Trauma: Theory, Research, Practice, and Policy*, 8, 1, 63-71.
- Williams, D. R. & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*, 32, 1, 20.
- World Health Organization. (Undated). Information sheet: Premature death among people with severe mental illness. Geneva, Switzerland: Author.
- World Health Organization. (2001). *The World Health Report 2001: Mental health: new understanding, new hope*. Geneva, SW: World Health Organization.
- Wykes, T., Huddy, V., Cellard, C., McGurk, S. R., & Czobor, P. (2011). A meta-analysis of cognitive remediation for schizophrenia: Methodology and effect sizes. *American Journal of Psychiatry*, 168, 5, 472–485.
- Xu, J., Wang, J., Wimo, A., & Qiu, C. (2016). The economic burden of mental disorders in China, 2005–2013: Implications for health policy. *BMC Psychiatry*, 16, 137, 1-9.
- Yamaguchi, S., Sato, S., Horio, N., & Yoshida, K. (2017). Cost-effectiveness of cognitive remediation and supported employment for people with mental illness: A randomized controlled trial. *Psychological Medicine*, 47, 1, 53-65.
- Yanos, P. T., Roe, D., & Lysaker, P. H. (2010). The impact of illness identity on recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation*, 13, 2, 73–93.
- Yeh, M., Takeuchi, D. T., & Sue, S. (1994). Asian-American children treated in the mental health system: A comparison of parallel and mainstream outpatient service centers. *Journal of Clinical Child Psychology*, 23, 1, 5-12.

- Young, A. S., Klap, R., Sherbourne, C. D. & Wells, K. B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*, 58, 55–61.
- Ziedonis, D. M., Williams, J. M. & Smelson, D. (2003). Serious mental illness and tobacco addiction: A model program to address this common but neglected issue. *American Journal of Medical Science*, 326, 4, 223–230.

Criterion III. Diversity

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

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

Because the population is diverse:

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

Cultural competency for psychologists, commonly thought to be comprised of knowledge, skills, awareness, and dynamic sizing (Sue, Zane, Hall, & Berger, 2009), is essential for accurate assessment of health and pathology, as well as for the ability to tailor treatment to the diversity found in individuals. Cultural competence is especially important when working with the SMI population 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. 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., Laro, 2014; Luhrmann, 2007; Versola-Russo, 2006). Further, the DSM-5 highlights culture-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. Reflecting the importance of diversity issues in the SMI/SED field, the Psychiatric Rehabilitation Association (PSA) has developed extensive guidance and 10 Principles of Multicultural Psychiatric Rehabilitation Services for working with the population in an inclusive manner (see <https://www.psychrehabassociation.org/principles-multicultural-psychiatric-rehabilitation-services>). This initiative has influenced the SMI/SED Specialty Council's reasoning about these issues.

While a thorough discussion of diversity issues in SMI/SED is outside the scope of this application, below we present exemplar information on factors such as age, gender, gender identity and sexual orientation, ethnicity, race, migration history and level of acculturation, adverse childhood experiences (including trauma history), and poverty on patterns of diagnosis and access to treatment among persons diagnosed with SMI/SED. The information presented below highlights the importance of diversity factors in influencing optimal SMI/SED research and practice. Equally critical, we detail the wide range of possible functional outcomes in SMI/SED. The Specialty recognizes and values diversity in all its possibilities, and strives to assure these sentiments are inculcated in those obtaining training and/or working with individuals having an SMI/SED diagnosis. Developing cultural competence is considered a core aspect of Specialty instruction and practice in SMI/SED, as reflected in major papers on training in the Specialty of SMI Psychology and public sector psychology by Carr and Miller (2017), Chu et al., (2012), and Stacy, Klee & Jansen, 2018.

Specialty-Specific Scientific and Theoretical Knowledge

Interpretations of symptoms labelled “psychotic” are often culture bound. The experience of hearing voices, for example, is typically seen as reflecting unwanted illness in many Western cultures, while it may be interpreted as a desirable sign of connection with the religious or spiritual world in non-Eurocentric groups (McCarthy-Jones, Waegeli, & Watkins, 2013). Cultural influences, societal beliefs, family norms and religion must all be considered in understanding SMI/SED symptoms (Versola-Russo, 2006). SMI Specialty psychologists work to integrate cultural competency in the interplay between research and practice (Cook, Razzano, & Jonikas, 2010). While a full exposition of all that is known about cultural and individual factors impacting on individuals diagnosed with a SMI/SED is beyond the scope of this application, exemplars of the key role these variables play are provided next. A more extensive discussion of diversity issues is also included in the *Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment* (American Psychological Association & Jansen, 2014).

Age

Serious mental illnesses can occur at any age, though they disproportionately develop in individuals under age 30 (Heilbronner, Samara, Leucht, Falkai, & Schulze, 2016; Leboyer, Henry, Paillere-Martinot, & Bellivier, 2005). Individuals with SED are youth/adolescents who have early warning signs of psychosis, or early onset psychosis, or severe mood symptoms (e.g., manic episodes). For youth with early warning signs, this period is often referred to as the clinical high risk period, and it may also be called by other names such as the prodromal syndrome. While it is clear that many children and youth experience mental health problems, those with SED have the most serious emotional disorders, and are those whose functioning is the most compromised if appropriate treatment and supports are not provided.

There are highly specialized programs designed to improve outcomes in first episode non-affective psychosis, which include interventions specifically designed for adolescents and young adults (typically ages 15-35) who have developed a recent (often within the past year or so) psychosis. These interventions, now subsumed under the title “coordinated specialty care”, typically include tailored medication, and manualized and specialized psychosocial interventions such as individual psychological therapy, family education and support, and supported employment and education (Heinssen, Goldstein, & Azrin, 2016; Mueser et al., 2015). Participation in these age-specific specialized interventions has been found to improve outcomes compared to participation in customary care (Kane, et al., 2016). Psychologists working with those experiencing a first episode psychosis require additional training to provide and/or oversee the provision of these highly prescriptive treatments with fidelity to the model (Mueser et al., 2018).

Schizophrenia in late life is emerging as a major public health concern worldwide and impacts on persons affected, their families and caregivers, public health systems, and the public as costs escalate (Becker & Mehra, 2005; Cohen et al, 2000; Folsom et al., 2006; Jeste & Maglione, 2013). There are different symptoms and unique challenges associated with SMI in older adults (Harvey, 2005); the central issue is that of age-related changes in the clinical features of schizophrenia, which include delusions, hallucinations, emotional changes, cognitive impairments, and adaptive life skills (Harvey, 2005), along with social issues stigma, such as loneliness, homelessness, and comorbidities (Bartels, 2004; Bartels, Dums, & Shea, 2004; Wetherell & Jeste, 2004). There are specialized psychological interventions for individuals experiencing psychosis later in life, including ones designed to improve health (Pratt, Bartels, Mueser & Forester, 2008) and community adjustment in middle aged and older adults (Granholm et al., 2005). Importantly, because of the high probability of developing comorbid physical illnesses, both because of medication side-effects and lifestyle factors, the physical effects of aging in middle-age and older SMI consumers are often accelerated (Goldstein et al, 2015; McGinty, Baller, Azrin, Juliano-Bult, & Daumit 2015). They require aggressive physical health interventions, even as mental health symptom outcomes may improve in

later stages of life, at least in schizophrenia (Jeste, Wolkowitz, & Palmer, 2011). Life span issues, while not central to the Specialty area, are of significant importance in the Specialty and merit careful attention.

Sex/Gender

Patterns of schizophrenia onset have been found to vary by sex, with earlier onset for males (peak incidence between ages 15 and 24), and more gradual increase over age 18 for females (peaking between 20-29, and then again between ages 45-54) (Tiffin & Welsch, 2013). Perhaps because of their earlier onset and their propensity for a greater preponderance of negative symptoms, males diagnosed with schizophrenia tend to have worse outcomes than females (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012). With regard to bipolar illness in adults, gender differences in prevalence of bipolar I are less apparent, though males may be more likely to present with an initial manic (rather than depressed) episode (Kawa et al., 2005); bipolar II is more prevalent in females (Nivoli et al., 2011). Patterns of SED onset differ by sex and/or gender, with higher rates for boys (6 percent) than for girls (4 percent) (Federal Interagency Forum on Child and Family Statistics, 2015). The London Child Health and Development Study (CHADS; Laurens & Cullen, 2016) found that a trio of antecedents of schizophrenia were more prevalent for boys (13.4 percent) than for girls (5.8 percent) in the 9-11-year-old children screened.

Individuals Who are Gay, Lesbian, Bisexual, & Gender Non-Conforming

Research from the National Institute of Mental Health (NIMH) suggests that an estimated 18% of Americans experience a mental illness annually, accounting for over 44 million people (NIMH, 2018). Within the general population, SMI/SED affects many diverse groups, including individuals who characterize their sexual orientation as gay, lesbian, or bisexual, as well as individuals who identify as gender non-conforming or transgender (hereafter GLBT). Like other members of the general population, GLBT individuals not only experience SMI/SED, but in fact, the literature demonstrates that GLBT people are at higher risk for SMI/SED (Cochran et al., 2003; Kidd et al., 2016; SAMHSA, 2015). For example, GLBT individuals experience mental disorders at twice the rate of heterosexual individuals (Semlyn et al., 2016), with two- and one-half times the rate of depression, anxiety and substance use (Kates et al., 2016). Rates of suicide attempts among trans and gender non-conforming individuals are substantially higher than cisgender individuals in the general population, e.g., 41% and 5%, respectively (Haas et al., 2014). In the 2015-2016 National Survey of Drug Use and Health conducted by SAMHSA, data indicated that 40% of GLB adults had experienced mental illness in the past year, compared to 18% in the general population. Among them, 14% experienced SMI, compared to approximately 4% of the general population (SAMHSA, 2015).

The fact that little has been written about the experiences of GLBT people with SMI/SED reflects a larger context lacking information regarding the sexual health and gender identity of people with SMI/SED in general (Barber, 2009; Cook, 2000; Kidd et al., 2016). This lack of published research, however, is not exclusive to individuals with SMI/SED. For decades, sexual health and reproductive wellness have been vastly under-recognized and under-researched areas within the overall disability literature, including a lack of evidence-informed information regarding sexuality and psychiatric disabilities (Cook, 2000; Mona et al., 2017). These limitations are notable, given that the majority of SMIs, including bipolar disorder and schizophrenia, emerge during late adolescence and early adulthood, typically periods of development when individuals define and express their gender identities, explore sexuality, and develop intimate partner relationships. Thus, many individuals with SMI/SED, not only those who identify as GLBT, encounter obstacles in developing as sexual individuals and forming relationships as a result of symptom invasion or repeated hospitalization (Barber, 2009).

Individuals in this population also report the dual social stigma of both their sexual orientation and/or gender identity in addition to the overarching stigma toward SMI/SED itself (Corrigan, 2004; Rosenberg et al., 2005). As such, individuals who are GLBT report more exposure to social stigma, violence, and trauma, all known to directly impact the onset and severity of SMI/SED. For example,

according to a federal report from the National Center for Transgender Equality and National Gay and Lesbian Task Force, 51% of transgender individuals reported being bullied at school, 61% were the victims of physical assault, and 64% reported past history of sexual assault (Grant et al., 2011).

The effects of stigma are not only detrimental to emotional wellness overall, but they also can present obstacles to treatment, particularly as it relates to SMI/SED among diverse populations. Rates of mental illness not only demonstrate disparities between sexual and gender minorities compared to heterosexual or cisgender groups, there is a fundamental lack of understanding of the experiences of SMI/SED among GLBT individuals. First, there are relatively few studies examining the presentation and treatment needs of GLBT people with SMI/SED (Kidd et al., 2016). For example, some individuals note that they have hidden their sexual orientation from mental health providers, including psychologists, resulting from fears of rejection, ridicule, and in more severe cases, physical violence (Lucksted, 2004). Many GLBT individuals with SMI report seeking care within the GLBT community of providers, yet these groups are often ill-equipped to provide relevant, evidence-informed services for people with SMI/SED. Another nationally representative study reported that 19% of individuals who identified as trans or gender non-conforming were refused medical care based on their gender identity; rates were higher among individuals of color within the sample (Grant et al., 2011).

In sum, many factors affect the needs of, and access to mental health care for GLBT individuals, including those with the most severe mental health experiences. By most evidential accounts, people who identify as GLBT with SMI/SED experience obstacles to care relevant to the intersection of their sexual orientation or gender identity and their mental illness. Research, therapeutic interventions, and workforce development and support related to these factors are critical to the recovery and wellness of these clients.

Race/Ethnicity and Immigration Status

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

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

Migration is increasingly understood as an important risk factor for the development of psychosis. The exact magnitude of this risk varies, depending on the given migrant group and setting in which the study is conducted. In the UK, for example, psychosis risk ranges from slight increases (of 1.5 or less) for

white migrants, to 2-4 times greater risk for people of Pakistani and Bangladeshi origin, and up to 10 times higher rates among black Caribbean and African groups (Kirkbride et al., 2012). An increased risk of schizophrenia among first and second-generation immigrants, especially those from developing countries, has been noted (Kuniyoshi & McClellan, 2014). The cause of this increased risk is much debated. As Kirkbride (2017) notes, it is not found in all cultures (for example, Hispanics in the US do not have a heightened risk for psychosis), and may reflect in part the suffering and stress many emigrants encounter before they leave their original homes as well as the stigma and discrimination they face in their new homes.

Poverty and Adverse Childhood Experiences

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

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

Poverty and High Rates of Income Inequity

Social determinants of health (SDH) – the conditions in which individuals live and work – is a concept that has garnered increasing attention in relation to its role in perpetuating health inequity within and across countries (Marmot & Wilkinson, 2006). Poverty is endemic in the SMI/SED population, leading to high rates of homelessness and reduced access to other resources (Folsom et al., 2005). In the US, children living below the poverty level were twice as likely (8 percent) to have serious emotional difficulties than those whose family incomes were 200 percent or more of poverty level (4 percent) (Federal Interagency Forum on Child and Family Statistics, 2015).

There are many reasons for the prevalence of poverty in this population. First, because these illnesses develop in adolescence and early adulthood, many educational and career development plans which might render a higher income in adulthood are derailed (Baron & Salzer, 2002). Even those who

work tend to make little economic progress in their careers (Baron & Salzer, 2000). Second, many individuals with these disorders are unemployed (Luciano & Meara, 2014). As a result, even individuals who originally came from middle-class families and then develop an SMI often “drift” into lower socio-economic status over time (Perry, 1996). Finally, as many sociologists and economists have eloquently articulated, once one slips into poverty, it becomes very difficult to transition out of it (Temin, 2018). Simply meeting the expectations to utilize the available social service safety net — Supplemental Security Income (SSI) and Nutrition Assistance Programs, supported housing, Medicaid, transportation assistance, fuel assistance programs, etc. — can become almost a full-time job, and leave little time for pursuing strategies to increase income, even if the individual has a desire to do so. Many of these social programs also have disincentives to increasing income—for example, recipients of SSI lose one dollar of their SSI allowance for every two dollars they make after the first \$85 per month.

Poverty complicates many aspects of SMI/SED recovery (Cohen, 1993; Marrone & Golowka, 1999; Topor et al., 2014). At a most basic level, it often determines access to care, as individuals with SMI/SED typically are using the public health system so they often have little choice in the kind of care they receive. Poverty also often determines access to resources. For example, if an individual cannot afford a car, he/she often becomes dependent on mass transit, rides from others, or a bike, and can only access a small subset of clinics, services, school and employment opportunities, and stores served by the available transit. In addition, economic disadvantage and resource deprivation can cause stress, which can be related to symptom exacerbations (Zubin & Spring, 1977).

Differential Access to Treatment Related to Culture or Ethnicity

Language barriers, poverty, and cultural norms all impact on access to mental health treatment, and so they impact on access to appropriate SMI/SED treatment. At a most basic level, there is a dearth of psychologists who can conduct therapy in languages other than English. Further, immigrant and some racial groups are disproportionately economically disadvantaged and are unable to afford mental health care, or are opting not to do so. In addition, there are data to suggest that even when culturally diverse SMI/SED populations access treatment, it may be substandard or not meet their needs.

For example, Salcedo, McMaster, and Johnson (2016) examined differences in mood stabilizer use and mental health service utilization between 163 adult English-speaking Hispanic and non-Hispanic white respondents with bipolar disorder. Demographics, symptom presentation, and acculturation were examined as covariates. None of the 26 Hispanic respondents were taking mood-stabilizing medication, compared to 21% of non-Hispanic whites, and Hispanics were less likely to receive medications for emotional problems, see a professional for manic episodes, or attend psychotherapy. Even after accounting for differences in symptom profiles and sociodemographics, ethnicity continued to be a significant predictor of mood stabilizer use and psychotherapy attendance. Similarly, Horvitz-Lennon, McGuire, Alegria, and Frank (2009) examined Florida Medicaid data from a racially diverse sample of individuals who had at least two claims with a diagnosis of schizophrenia. Medicaid spending was much less for African Americans and Hispanics than it was for Caucasians, and much of this disparity was as a result of lower psychotropic medication costs for African-Americans. In the area of community-based services for people with SMIs, Phillips, Barrio & Brekke (2001) found that nonwhite ethnic populations showed poorer outcomes in work and social functioning than whites in a PSR. Reasons for the disparity in outcomes were unclear.

With regard to SED in children, Alegria, Vallas, and Pumariega, (2010) published a comprehensive review of ethnic and racial mental health disparities in children. They begin by saying “Despite the enormous toll that mental health problems take on the well-being of youth and families (\$247 billion annually), disparities in access to and intensity of quality mental health services appear to persist for racial/ethnic minority children, who are more likely to receive less and inferior health services as compared to non-Latino white peers.” (p 759). School-based mental health is one way to allow a diverse group of youth to access the necessary mental health services. Kourkoutas and Xavier (2010) discuss the importance of using multiple contextual and theoretical models and strength-based assessments

when developing school-based prevention and intervention programs for children who are at-risk for or have developed emotional disorders. This ecological and social model allows for better understanding of diverse backgrounds when assessing and treating children with SED within the schools. Bear, Finer, Guo, and Lau (2014) assessed a school-based mental health intervention program and its ability to reach a wide range of at risk students to reduce racial disparities in mental health services. These specific interventions and needs assessments are important in understanding the role that mental health services play within a culturally diverse population such as that found in the US.

Variation in Ability / Range of Functioning in SMI/SED

The *courses* of both schizophrenia spectrum and bipolar disorders are variable—these tend to be episodic disorders, with briefer periods of symptom exacerbation being interspersed with longer periods of lower level (though often not absent) symptom levels (Heilbronner, Samara, Leucht, Falkai, & Schulze, 2016; Judd et al., 2003). Thus, over a course of treatment, a psychologist must often repeatedly tailor interventions to varying levels of symptoms and functioning, which often change in a non-linear fashion. Psychologists working with the SMI/SED population must be able to identify and address the severe symptoms and pervasive functional deficits that reduce the quality and quantity of life of some individuals diagnosed with SMI/SED, while also being capable of providing appropriate support for those individuals who are able to function autonomously in jobs and/or relationships.

Further, SMI/SED long-term *outcomes* are highly variable—some individuals experience a high level of unremitting symptoms, are not/cannot meet societal norms for independent functioning, and require supervision most of their lives, while others make strong recoveries after an initial period of illness and function well / independently for the majority of the time (Geddes & Miklowitz, 2013; Lang, Kösters, Lang, Becker, & Jäger, 2013). Many consumers exhibit significant functional impairments (e.g., social skills deficits, problems with successfully participating in activities of daily living, un- or underemployment, diminished social networks) resulting from symptoms, neurocognitive problems, and developmental lags limiting skills acquisition in adolescence and young adulthood (Tandon, Nasrallah, & Keshavan, 2009). On the other hand, with the advent of better-tolerated psychopharmacology and innovative psychosocial treatments, there are a growing number of individuals with a diagnosis of schizophrenia or bipolar illness who lead full lives and achieve employment success (Cohen et al., 2016; Marwaha, Durrani, & Singh, 2013).

How Knowledge is Acquired

Several psychologists with expertise in SMI/SED have written eloquently about the importance of attention to cultural diversity in training the next generation of practitioners (see, for example, Stacy, Klee, & Jansen, 2018, and Carr & Miller, 2017). In fact, Chui, et al. (2012) define “cultural competence in clinical work” and organizational work in “strategies to reduce health disparities” as core competencies in public sector psychology. Diversity training for work with this population is essential and must include theoretical as well as practical and applied topics. Issues related to the full range of human diversity are incorporated into all aspects of training including primary and secondary placements, seminars, lectures, and supervision sessions.

Diversity training in this Specialty must occur in all components of didactic and experiential training and must be practical and applied. In addition to supervision sessions and primary and secondary clinical placements, a cornerstone in the knowledge development around diversity issues in the SMI Psychology Major Area of Study Specialty is the diversity seminar, which is a core component of every SMI Psychology Specialty training program. The seminar is devoted to discussion of contemporary research literature on diversity and cultural competency issues in SMI/SED. Training is provided in terms of addressing ethical issues, as well as attitudes, knowledge, and skills in relation to all forms of diversity. Residents are expected to demonstrate sensitivity to the full range of human diversity and make a substantial effort to recognize, understand, appreciate and discuss topics such as age, sex, gender, ability/disability/illness, culture, ethnicity, race,

language/culture of origin, sexual orientation, socioeconomic status, and religious/spiritual beliefs and attitudes, among others, as well as the intersection of these and how they are considered and integrated in provision of services. The exploration of power differentials, dynamics, and privilege is at the core of understanding issues of diversity and impact on social structures and institutionalized forms of discrimination, including important ethical issues and legal decisions that may influence the person's perception of her/his potential for improved quality of life and are an important component of the seminar.

Diversity seminar topics and speakers are selected to increase self-awareness and improve delivery of care for individuals with SMI/SED, in alignment with the values of the Specialty. While topics and speakers typically cover a broad range, those that are particularly pertinent to persons with SMI/SED are highlighted. These include: the poor attention often given by health care providers to physical health complaints of persons with SMI/SED, which are often more prevalent in specific ethnic groups, discriminatory practices including failure to follow treatment guidelines when people of color and diverse cultural backgrounds are seen, bias in diagnosis, failure to tailor treatments to the unique cultural needs of consumers, and need for attention to language barriers, traditional beliefs about mental illness, and religious/cultural issues (see Criteria II and VI for a full discussion with references for these issues).

Specialty training sites vary somewhat in the specific topics covered in the diversity seminar, reflecting both local and national concerns; each residency site would include topics that are specific to their local and or national interests. As an exemplar, topics covered (some extended over multiple sessions) in a yearly seminar in the UCSD/San Diego VA Psychosocial Rehabilitation Fellowship, which trains fellows to work with the SMI/SED population, include:

- Military Culture I
- Military Culture II
- Considering Perspectives on Mental Health and Its Treatment in Other Parts of the World
- Current Events and Diversity
- Privilege
- Unconscious Bias Part I
- Unconscious Bias Part II
- Diversity and the LGBTQ Population
- LGBT Changing Community
- Power, Privilege and Identity
- Adaptations to PTSD Treatment
- Psychosis and Religion
- Geriatrics/Older adults/Cognitive Issues
- Reservist Culture
- Masculinity, MST and Therapy
- Moral Injury
- Cultural Differences in Supervision

Knowledge acquisition is also supported through directed readings during the fellowship training, including journal club readings on SMI/SED issues as well as exposure to important work on the broader topic of cultural competence in the conduct of psychology. Within APA, the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*

(2002) provide essential direction on appropriate attention to diversity issues for all clinicians, researchers, and faculty, including those working with individuals diagnosed with SMI/SED. The guidance from the APA Office of Ethnic Minority Affairs and the APA Socioeconomic Status Office also has significant relevance for SMI/SED populations. For example, the Office of Ethnic Minority Affairs *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* reminds psychologists of the importance of 1) recognizing cultural diversity; 2) understanding the role that culture and ethnicity/race play in the sociopsychological and economic development of ethnic and culturally diverse populations; 3) understanding that socioeconomic and political factors significantly impact the psychosocial, political and economic development of ethnic and culturally diverse groups; and 4) helping clients to understand/maintain/resolve their own sociocultural identification, and understand the interaction of culture, gender, and sexual orientation on behavior and needs. The APA Socioeconomic Status Office highlights the association among poverty and disability status, as well as their correlates, including under-education and lack of access to resources (including appropriate medical and mental health treatment). These all have relevance when assessing, developing treatment plans, and intervening with individuals diagnosed with SMI/SED disorders.

Finally, though the diversity seminar is a core instructional component of those pursuing a Major Area of Study in the SMI Psychology Specialty, programs also infuse information about diversity issues throughout the whole range of course work. Assuring cultural competence is not segregated as an “extra thing to learn”. For example, in a course of psychosocial interventions in SMI/SED, trainees read key texts such as:

- Corrigan, Mueser, Bond, Drake & Solomon (2008). Cultural competence in psychiatric rehabilitation. In Corrigan, Mueser, Bond, Drake & Solomon (Eds.) *Principles and Practice of Psychiatric Rehabilitation: An Empirical Approach*. The Guilford Press: New York.
- Desjardins, Gritke & Hill (2011). Trans-cultural issues in person-centered care for people with serious mental illness. In Rudnick & Roe (Eds.) *Serious Mental Illness: Person-Centered Approaches*. Radcliffe Publishing: New York.
- Pernell-Arnold & Finley (2000). Integrating multicultural competence in psychosocial rehabilitation. In Hughes & Weinstein (Eds.) *Best Practices in Psychosocial Rehabilitation*. International Association of Psychosocial Rehabilitation Services: Columbia, MD

These and other texts are studied along with the relevant literature on the interventions they are leaning so they can integrate their growing knowledge of cultural and diversity issues simultaneous to acquiring information about a psychosocial intervention.

Processes in Place for Assessment and Continued Development of the Knowledge Base

Assessing knowledge around diversity issues in behavioral health settings is complicated, as measuring knowledge, attitudes, and beliefs about complex, far ranging, and evolving topics are central to the endeavor (Stanhope et al. 2005). Further, there are data to suggest that self-evaluations of cultural competence often lack validity (Kaslow et al., 2004). In light of these challenges, Specialty training programs with a Major Area of Study in SMI Psychology use a multidimensional assessment strategy, including repeated self-evaluation along with reviews by multiple supervisors through the training period, as well as encouragement to become a lifelong learner in this area once the formal training period is concluded.

The primary measurement tool Specialty programs are expected to use can be seen in seen in Appendix III. The Specialty uses the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*, which has several items reflecting cultural competence. This measure can be used with self-ratings and

supervisor ratings, and captures both knowledge and practice. The *California Brief Multicultural Competence Scale* (Gamst et al., 2004), while not exclusive to SMI/SED issues, assesses a broad range of cultural issues and possesses strong psychometric properties (Gamst & Liang, 2013) and many Specialty programs use this as a supplemental measure. Trainees and supervisors typically complete the measures at program entry, during evaluations, and at completion in order to capture self-perceived and observed knowledge, sensitivity, and skill in working with diverse populations effectively.

With regard to cultural competence knowledge, the Specialty embraces a life-long learning model; as society evolves, expectations of appropriate care change, and more is learned about diversity factors that impact on mental health. In addition to research published in professional journals, the Specialty also draws culturally-relevant resources from SAMHSA, the Center for Mental Health Services, the National Institute of Mental Health, the National Mental Health Association, the UPenn Collaborative on Community Integration (a Rehabilitation Research & Training Center Promoting Community Integration of Individuals with Psychiatric Disabilities), the National Center for Cultural Competence (<https://nccc.georgetown.edu/>) and the University of South Florida's Research and Training Center for Children's Mental Health (studies and disseminates information to enhance provider's cultural competence to work with diverse adults and youth diagnosed with SED/SMI). These groups offer multiple conferences with opportunities for clinicians and researchers to gain more information about working with diverse populations diagnosed with SMI/SED. These conferences include opportunities to listen to engaging speakers during symposia, ask questions during panel discussions, and read and listen during paper and poster presentations.

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

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

Training in a Major area of Study in an SMI Psychology Specialty program must integrate both knowledge and practice to be useful. Applications of cultural knowledge acquired in the classroom take place during practice training experiences. Thus, diversity training when working with the SMI/SED population is primarily practical and applied, with cultural competence defined as a foundational competency. Practice training for post-doctoral residents in this Specialty occurs in several main areas: primary and secondary placements, seminars, didactics, research, supervision, consultation, teaching, and administration. While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training experiences should exist across all programs. With regard to diversity experience, in addition to participation in the diversity seminar described above, fellows should receive clinical training in at least one (and preferably more) clinical setting which 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.

Culture, race, and ethnicity, and other aspects of diversity can all impact on treatment seeking, engagement, and impact in SMI/SED (Kopelowicz et al, 2012; Lopez, Kopelowicz & Canive, 2002). Those who specialize in working with persons with SMI/SED must come to the understanding that Western models of diagnosis pathologize attitudes, beliefs, and behaviors that are acceptable (and often even normative) in other cultures, and that this phenomenon in part accounts for the higher level of diagnosed psychopathology found in the non-predominant cultural groups (Dutta, et al., 2007). As such, within Specialized practice with the SMI/SED population, efforts to address this problem now include the *Cultural Formulation Interview* (American Psychiatric Association, 2013) as part of DSM-5 training (Lewis-Fernández, Aggarwal, Hinton, Hinton and Kirmayer, 2016). Specialty training in the *DSM-5® Handbook* on the *Cultural Formulation Interview* or a similar tool is an essential component of the clinical training experience, and trainees often benefit from interacting with cultural experts, who can help them tailor assessment and treatment techniques to make them more accessible to all ethnic and cultural groups.

Training programs with a Major Area of Study in SMI Psychology are encouraged to offer trainees creative opportunities to acquire additional practice competence in cultural issues. For example, in the San Diego Psychosocial Rehabilitation Fellowship, SMI Psychology trainees are invited to serve on the SMI clinic's (PRRC) Diversity Committee, which is tasked with ensuring the clinic adheres to its Cultural Diversity and Competence Plan, and fellows take part in a yearly Multicultural Potluck for everyone who works in the SMI clinic. Fellows may also take advantage of the Diversity Mentorship Program run by the larger University/VA training program, which aims to connect interested fellows with mentors who can help them explore the intersection of a variety of identity markers, including one's race, ethnicity, sexual orientation, region of origin, socioeconomic background, etc. and their professional identity. All fellows assist in recruiting candidates for the following year's fellowship class (e.g., by conducting interviews), and discussion of candidates' diversity status is a part of this decision-making process since the program always striving to recruit diverse fellows. Finally, consideration of cultural issues is woven into clinical supervision for everyone.

At the West Haven Psychosocial Rehabilitation Fellowship program, faculty routinely create space for discussions of diversity by directly discussing culture and diversity in supervision using Federal Equal Employment Opportunity (EEO) statements but also adding additional wording valuing the importance of diversity. Information on upcoming diversity related events, such as the "Yale Block Party" and "New Haven Pride" is disseminated and attendance encouraged, and unconscious bias during ranking of applicants is discussed, with an effort to increase objective ratings through the use of objective anchors. For example, experience with recovery-oriented clinical setting would net an applicant and additional 10 points, and staff are trained to engage in conversation about recruiting and retaining diverse trainees and staff members.

At the Minneapolis VA SMI Psychology Fellowship training program, trainees are required to complete Monthly Reflection assignments on diversity issues. Writings can be on topics such as a clinical case (therapy or assessment), a didactic presentation on a multicultural topic in mental health or medical care (this can be a VA Grand Rounds, Psychology Brown Bag, or from a conference), or based on participation in a cross-cultural community activity, or scholarly reading. Trainees must submit 10 reflections during the training year. The training program also encourages participation in the Psychology Multicultural and Diversity Committee (PMDC), diversity-themed didactics and presentations, and cultural/diversity opportunities in the Twin Cities area.

The Specialty takes a leadership role in encouraging psychologists to keep abreast of new developments in cultural diversity as it applies to individuals with an SMI/SED diagnosis. As Smith, Constantine, Dunn, Dinehart, and Montoya (2006) correctly observe, diversity training is even more effective when it is grounded in theory, and knowledge in this area continues to be developed. Continuing professional development opportunities regarding diversity issues include accessing published research as well as attending trainings at professional meetings such as the APA convention. Journal articles are increasingly attending to these issues; the APA journal, *Psychiatric Rehabilitation Journal*, which publishes "original contributions related to the rehabilitation, psychosocial treatment, and recovery of people with serious mental illnesses" typically includes 10-15 papers per year focusing on cross-cultural issues in SMI/SED treatment and rehabilitation, and our website encourages members and those interested in working with the SMI/SED population to stay current with such readings and CE programming. Similarly, APA Division 18 has a multicultural diversity committee which keeps division members abreast of new findings through the Division newsletter and on listserves as well as by hosting open meetings at the annual APA convention.

Demonstrating Cultural Competence

Assessing cultural competence in mental health providers is challenging (Stanhope et al., 2005). Our overall expected learning outcomes from participation in the diversity training embedded in this Specialty include the following:

At the end of their post-doctoral fellowship training, trainees should be able to:

- Identify and describe how their own personal/cultural history, attitudes, and biases may affect how they understand and interact with people different from backgrounds;
- Identify and describe salient aspects of their patient's unique worldview and how to successfully integrate this into assessment and treatment;
- Recognize the need for consultation, and properly identify/utilize culturally relevant knowledge bases and resources;
- Implement successful multiculturally competent assessment, intervention, and professional communication skills within clinical practice, supervision, and consultation;
- Display consistent understanding and respectful attitudes, current knowledge and skills in relation to all aspects of human diversity.

Post-doctoral training programs with a Major Area of Study in SMI Psychology are expected to use cultural competency as a key criterion of successful training. Success in meeting these five training objectives is determined through evaluation of course work and practice. By definition, these evaluations assess both knowledge and practice. Specialty trainees at the post-doctoral level should be able to incorporate a diversity framework into case conceptualizations, for example and to demonstrate awareness of the cultural/language/intellectual limitations associated with any of the measures or interventions they are utilizing. All of these tasks require a breadth of cultural knowledge. Fellows' competence in attending to diversity matters and providing culturally competent care is evaluated by themselves and their supervisors on formal evaluations at the start, middle, and end of fellowship year (self-ratings for all 3 time points and supervisor ratings for the middle and end) in line with the recommendations of Jones et al. (2013) using several relevant items from the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)* developed by the SMI Psychology Specialty Council (see Appendix III). Supervisors integrate data from many sources to arrive at accurate ratings. Data are included from observation of comments during class discussions, evaluation of clinical work through review of session material in supervision, and review of written products (e.g., assessments, treatment plans, etc.). Many Specialty training sites augment the use of the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)* with a measure targeting cultural issues to obtain sufficient data to determine if the five training objectives have been met. The *California Brief Multicultural Competence Scale* (Gamst et al., 2004), while not exclusive to SMI/SED issues, assesses a broad range of cultural issues and possesses strong psychometric properties, and allows for self-ratings and capturing growth through the fellowship year.

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

It is becoming increasingly critical for clinicians working with the SMI/SED population to account for cultural factors in their engagement strategies, assessments, case conceptualizations, and interventions. Data suggesting that culturally adapted interventions are more effective across a broad population (e.g., Griner & Smith, 2006) highlight the importance of psychologists working with the SMI/SED population to consider the importance of diversity issues in the development and testing of interventions. The importance of understanding the interface of diversity factors such as race and SMI/SED cannot be overstated. For example, one of the most robust cross-national findings in identifying predictive outcome factors in schizophrenia is that consumers from families expressing high expressed emotion attitudes and behaviors (i.e., prompting, nagging, intense involvement with the ill family member) are more likely to relapse after an exacerbation, compared to those from low expressed emotion families

(Hooley, 2007), and some of our most well-replicated SMI/SED interventions are designed to reduce expressed emotion in families of a member with an SMI who has had a recent symptom exacerbation (Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001). However, there have now been two papers indicating that, in U.S. African American families, relatives' high expressed emotion is associated with better (not worse) schizophrenia outcomes (Gurak & Weisman de Mamani, 2017; Rosenfarb, Bellack & Aziz, 2006); here family interventions to reduce expressed emotion may be contraindicated. Clinicians working with families of individuals experiencing psychosis can be most helpful if they understand these nuanced cultural findings.

The Specialty is committed to encouraging all psychologists to continue to add to their knowledge and skill base in diversity as it applies to individuals with an SMI/SED diagnosis. Journal articles are increasingly attending to these issues; for example, APA's Division 18 (Psychologists in Public Practice) bestowed its 2016 best paper award on a publication entitled *The Connecticut Latino Behavioral Health System: A culturally informed community-academic collaboration* (Paris et al., 2016). Similarly, the Division has a multicultural diversity committee which keeps division members abreast of new findings through the Division newsletter and on listserves as well as by hosting open meetings at the annual APA convention. Typically, the Division also sponsors 1 or 2 symposia each year at the APA convention on SMI/SED diversity issues—for example, in 2017, the Division hosted a symposium on women's issues and SMI. The APA journal, *Psychiatric Rehabilitation Journal*, which publishes "original contributions related to the rehabilitation, psychosocial treatment, and recovery of people with serious mental illnesses" typically includes 10-15 papers per year focusing on cross-cultural issues in SMI/SED treatment and rehabilitation. One of the key members of our Specialty Council, the Special Interest Group (SIG) on Schizophrenia and Other Serious Mental Disorders also sponsors 1 – 2 CE symposia each year, (sponsored either by the SIG or by the overall association) on cultural issues and SMI at the annual meeting. For example, at the November, 2018 annual meeting, there was a symposium on Culture, Psychosis, and Help-Seeking Patterns for Mental Illness, which was well-attended; the authors have been asked to develop the talks into a series of papers on cultural issues in SMI for the *American Journal of Orthopsychiatry*. The Specialty Council website encourages those interested in working with this population to remain current with such readings.

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

To reflect the development of knowledge and dissemination of multicultural diversity and subgroups relevant to SMI/SED populations, some examples of more specific studies of trends and changing demographics follow. With regard to adults, Cantor-Graae, and Selten, (2005) conducted a review and meta-analysis on the relation of migrant status and development of psychosis in the UK, and found that rates of psychosis were elevated even in second-generation immigrant families, and that individuals emigrating from developing countries were at more elevated risk than those from developed ones. Dealberto (2010) reviewed the literature on migrant status and increased risk of schizophrenia throughout the world; the paper emphasized understanding the higher schizophrenia rates reported in persons of color. The investigator concluded that, in countries of both recent and longstanding

immigration, schizophrenia was more frequent in immigrants than in native-born populations, and especially so in dark skinned immigrants. This comparative review suggested the presence of “a hidden epidemic of schizophrenia and psychosis in immigrants to North America and an unrecognized epidemic of schizophrenia in Black subjects living in North America” (p 325). Berg et al. (2018) found that, among those diagnosed with first episode psychosis, after controlling for education level, first-generation immigrants were less likely to recognize psychotic symptoms and viewed hospitalization and treatment by a psychiatrist as less beneficial than the non-immigrant group. The investigators concluded that interventions must be tailored to meet the needs of these diverse cultural groups to be effective.

Children and adolescents present a specialized population requiring the SMI Psychologist to be current on this literature. Training programs specializing in work with SED populations must ensure that their curricula prepare individuals to practice competently in the Specialty for work with this population who appear to have increased need. Fazel, Doll, and Langstrom (2008) found that adolescents who were in correctional or detention facilities were 10 time more likely to suffer from an SMI concern (e.g., psychosis, depression, conduct disorder) than those in the general population.. Moreno and colleagues (2007) evaluated the national trends of bipolar diagnoses in children and found that the number of youth diagnosed with bipolar disorder increased from 25 children in 1994-1995 to 1003 in 2002-2003 per 100,000 people in the population. This increase in diagnosis illustrates a need for clinical ongoing specialized research to determine the etiology of these diagnoses as well as more training in assessment and treatment. Olfson, Druss, and Marcus (2015) recently reported, in a similar pattern of findings, that outpatient mental health treatment and psychotropic-medication use in children and adolescents increased in the United States between 1996–1998 and 2010–2012 and youth with more severe impairment had the greatest relative increase in use, although fewer than half accessed services in 2010–2012.

Taken together, these studies indicate that the investigation of diversity issues in the assessment and treatment of persons with SMI/SED is a vibrant field arriving at new and important insights. The SMI Psychology Specialty can play a key role both in improving care for individuals diagnosed with an SMI or SED as well as helping psychologists stay abreast of new findings in the area, and advocating for greater attention to cultural issues along the care landscape (Carr & Miller, 2017).

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

The Specialty Council has recognized the essential importance of developing guidelines to direct optimal training of new psychologists. Accordingly, the SMI Psychology Training Guidelines (Appendix I and available on the Specialty Council website (www.psychtrainingsmi.com)) outline the training requirements for Specialty programs in SMI Psychology. SMI/SED cultural competence is defined as a foundational competency and the Training Guidelines require post-doctoral trainees, at a minimum, to 1) participate in a yearly diversity seminar, 2) be placed at clinical sites where they will have exposure to diverse clients and supervisors, 3) learn to use the DSM-5 *Cultural Formulation Interview*, 4) and be assessed regularly on their competency in this area. As discussed under point 3 immediately above, training programs with a Major Area of Study in SMI Psychology are also encouraged to develop site-specific activities to enhance cultural practice competency.

The SMI Psychology Specialty encourages the use of APA’s *Recovery to Practice Curriculum* (American Psychological Association & Jansen, 2014) as a practice guideline for the SMI/SED population. In this practice guideline, attention to diversity issues is a core feature of the curriculum, with a module devoted exclusively to health disparities due to demographic factors, community inclusion, and issues with forensic populations. Additional attention to diversity issues is interwoven throughout the chapters on Specialty-focused assessment and intervention with the SMI population. The *Curriculum* is available from APA at www.apa.org/pi/rtp, or via the Specialty Council website (www.psychtrainingsmi.com).

The Specialty also recognizes the importance of other seminal works on diversity which, though not SMI/SED specific, continue to add to the knowledge base in the Specialty and for trainees. These would include the *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* and the *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* as well as the recommendations offered in the APA publication *Psychological Treatment of Ethnic Minority Populations* and on the website *Best Practices for Mental Health Facilities Working With LGBT Clients*. The SMI Psychology Specialty supports the APA's Board of Educational Affairs' Virtual Working Group to address concerns about restrictions on diversity training in graduate education and their statement affirming commitment to transparency in a training program's commitment to serving a diverse public (BEA Virtual Working Group, 2015). We believe the SMI/SED population is one of those diversity populations and that diversity within the SMI/SED population must be part of education, practice and life-long learning.

Several governing bodies provide both training and practice guidelines in working with children diagnosed with SED while recognizing cultural and individual differences. The *Standards of Accreditation for Health Service Psychology* is one means of ensuring that throughout training clinicians are well versed in cultural and diversity training when working with SMI/SED populations. For example, internships, postdoctoral, and practicum opportunities require supportive environments training individuals to work with a variety of diverse individuals. More specific information can be found on the APA website: <http://www.apa.org/ed/accreditation/accreditation-roadmap.aspx>.

Additionally, APA has a set of guidelines designed for practitioners that reflect the importance of working with youth through culturally diverse practices. There are a wide variety of guidelines that can be used when approaching diversity related to children who are diagnosed with SED. The guidelines can be found on APA's website: <http://www.apa.org/practice/guidelines/index.aspx>.

References

- Adkins, E. C., Zalta, A. K., Boley, R. A., Glover, A., Karnik, N. S., & Schueller, S. M. (2017). Exploring the potential of technology-based mental health services for homeless youth: A qualitative study. *Psychological Services, 14*, 238-45.
- Alegria, M., Vallas, M., & Pumariega, A. (2010). Racial and ethnic disparities in pediatric mental health. *Child and Adolescent Psychiatric Clinics of North America, 19*, 759–774.
- American Psychological Association & Jansen, M. A. (2014). *Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment*. Washington DC: American Psychological Association.
- Arnold, L. M., Keck, P. E., Collins, J., Wilson, R., Fleck, D. E., Corey, K. B., ... & Strakowski, S. M. (2004). Ethnicity and first-rank symptoms in patients with psychosis. *Schizophrenia Research, 67*, 207-212.
- Ascher-Svanum, H., Nyhuis, A. W., Faries, D. E., Ball, D. E., & Kinon, B. J. (2010). Involvement in the US criminal justice system and cost implications for persons treated for schizophrenia. *BMC Psychiatry, 10*, 1-10. <https://doi.org/10.1186/1471-244X-10-11>
- Barber, M. E. (2009). Lesbian, gay, and bisexual people with severe mental illness. *Journal of Gay & Lesbian Mental Health, 13*, 133-142.

- Baron, R. C., & Salzer, M. S. (2002). Accounting for unemployment among people with mental illness. *Behavioral Sciences & the Law*, 20, 6, 585-599.
- Baron, R. C., & Salzer, M. S. (2000). The career patterns of persons with serious mental illness: Generating a new vision of lifetime careers for those in recovery. *Psychiatric Rehabilitation Skills*, 4, 1, 136-156.
- Barnes, A. (2008). Race and hospital diagnoses of schizophrenia and mood disorders. *Social Work*, 53, 77-83.
- Bartels, S. J. (2004). Caring for the whole person: Integrated health care for older adults with severe mental illness and medical comorbidity. *Journal of the American Geriatrics Society*, 52, S249-S257.
- Bartels, S. J., Dums, A. R., & Shea, D. G. (2004). Mental health policy and aging. *Mental health services: A public health perspective*, 232-254.
- Bear, L., Finer, R., Guo, S., & Lau, A. S. (2014). Building the gateway to success: An appraisal of progress in reaching underserved families and reducing racial disparities in school-based mental health. *Psychological Services*, 11, 388-397.
- Becker, K. D., Boustani, M., Gellatly, R., & Chorpita, B. F. (2017). Forty years of engagement research in children's mental health services: Multidimensional measurement and practice elements. *Journal of Clinical Child & Adolescent Psychology*, 1-23.
<https://doi.org/10.1080/15374416.2017.1326121>
- Becker, M. & Mehra, S. (2005). Serious Mental Illness in Florida nursing homes: A study of resident, facility, cost, and quality of care characteristics. Technical report presented to the Florida Agency for Health Care Administration.
- Berg, A. O., Barrett, E. A., Nerhus, M., Camilla, B., Simonsen, C. E., Færden, A., ... & Melle, I. (2018). Clinical and socio-cultural insight in immigrants in their first episode of psychosis. *Early Intervention in Psychiatry*, 12, 2, 185-192. doi: 10.1111/eip.12297
- Board of Educational Affairs (BEA) Virtual Working Group on Restrictions Affecting Diversity Training in Graduate Education (2015). Preparing professional psychologists to serve a diverse public: A core requirement in doctoral education and training. A pedagogical statement. *Training and Education in Professional Psychology*, 9, 269-270.
- Cantor-Graae, E., & Selten, J. P. (2005). Schizophrenia and migration: A meta-analysis and review. *American Journal of Psychiatry*, 162, 12-24.
- Carr, E. R., & Miller, R. (2017). Expanding our reach: Increasing the role of psychologists in public and community mental health. *Psychological Services*, 14, 352-361.
- Center for Behavioral Health Statistics and Quality. (2016). 2015 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Substance Abuse and Mental Health Services Administration.

- Chu, J. P., Emmons, L., Wong, J., Goldblum, P., Reiser, R., Barrera, A. Z., & Byrd-Olmstead, J. (2012). Public psychology: A competency model for professional psychologists in community mental health. *Professional Psychology: Research and Practice*, 43, 39-49.
- Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, 71, 53-61.
- Cohen, C. I. (1993). Poverty and the course of schizophrenia: Implications for research and policy. *Psychiatric Services*, 44, 951-958.
- Cohen, C. I., Cohen, G. D., Blank, K., Gaitz, C., Katz, I. R., Leuchter, A., ... & Shamoian, C. (2000). Schizophrenia and older adults: An overview: Directions for research and policy. *The American Journal of Geriatric Psychiatry*, 8, 1, 19-28.
- Coleman, K. J., Stewart, C., Waitzfelder, B. E., Zeber, J. E., Morales, L. S., Ahmed, A. T., ... & Hunkeler, E. M. (2016). Racial-ethnic differences in psychiatric diagnoses and treatment across 11 health care systems in the mental health research network. *Psychiatric Services*, 67, 749-757.
- Cook, J. A. (2000). Sexuality and people with psychiatric disabilities. *Sexuality and Disability*, 18, 195-206.
- Cook, J. A., Razzano, L. A., & Jonikas, J. A. (2010). Cultural diversity and how it may differ for programs and providers serving people with psychiatric disabilities. In Balcazar, F., Suarez-Balcazar, Y., Taylor-Ritzler, T., & Keys, C. (Eds). *Race, culture and disability: Rehabilitation science and practice*. Burlington MA: Jones & Bartlett Learning.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, 7, 614-625.
- Costello, E. J. (2016). Early detection and prevention of mental health problems: Developmental epidemiology and systems of support. *Journal of Clinical Child & Adolescent Psychology*, 45, 710-717.
- Dealberto, M. J. (2010). Ethnic origin and increased risk for schizophrenia in immigrants to countries of recent and longstanding immigration. *Acta Psychiatrica Scandinavica*, 121, 325-339.
- Dein, S. (2017). Recent work on culture and schizophrenia: Epidemiological and anthropological approaches. *Global Journal of Archaeology and Anthropology*, 1, 3: 555562. DOI: 10.19080/GJAA.2017.01.555562
- Dutta, R., Greene, T., Addington, J., McKenzie, K., Phillips, M., & Murray, R. M. (2007). Biological, life course, and cross-cultural studies all point toward the value of dimensional and developmental ratings in the classification of psychosis. *Schizophrenia Bulletin*, 33, 868-876.
- Fazel, S., Doll, H., & Långström, N. (2008). Mental disorders among adolescents in juvenile detention and correctional facilities: A systematic review and meta regression analysis of 25 surveys. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47, 1010-1019.

- Fearon, P., Kirkbride, J. B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., ... & Mallett, R. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: Results from the MRC AESOP Study. *Psychological Medicine*, 36, 1541-1550.
- Federal Interagency Forum on Child and Family Statistics (2015). *America's children: Key National indicators of well-being, 2015*. Washington, DC: U.S. Government Printing Office.
- Folsom, D. P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan, S., ... & Jeste, D. V. (2005). Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *American Journal of Psychiatry*, 162, 370-376.
- Folsom, D. P., Lebowitz, B. D., Lindamer, L. A., Palmer, B. W., Patterson, T. L., & Jeste, D. V. (2006). Schizophrenia in late life: Emerging issues. *Dialogues in clinical neuroscience*, 8, 1, 45-52.
- Gamst, G., Dana, R. H., Der-Karabetian, A., & Aragon, M. (2004). Cultural competency revised: The California brief multicultural competence scale. *Measurement and Evaluation in Counseling and Development*, 37, 163-183.
- Gamst, G. C., & Liang, C. T. (2013). A review and critique of multicultural competence measures: Toward a social justice-oriented health service delivery model. Paniagua, F. A., & Yamada, A. M. (Eds.) *Handbook of multicultural mental health: Assessment and treatment of diverse populations*. New York, NY: Academic Press, (pp. 547-569).
- Geddes, J. R., & Miklowitz, D. J. (2013). Treatment of bipolar disorder. *The Lancet*, 381, 1672-1682.
- Goldstein, B. I., Carnethon, M. R., Matthews, K. A., McIntyre, R. S., Miller, G. E., Raghuvier, G., ... & McCrindle, B. W. (2015). Major depressive disorder and bipolar disorder predispose youth to accelerated atherosclerosis and early cardiovascular disease. *Circulation*, 132, 965-986.
- Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*. National Center for Transgender Equality.
- Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, 43, 531-548.
- Gurak, K., & Weisman de Mamani, A. (2017). Caregiver expressed emotion and psychiatric symptoms in African-Americans with schizophrenia: An attempt to understand the paradoxical relationship. *Family process*, 56, 2, 476-486.
- Haas, A. P., Rodgers, P. L., & Herman, J. L. (2014). Suicide attempts among transgender and gender non-conforming adults. *Work*, 50, 59.
- Harvey, P. D. (2005). *Schizophrenia in late life: Aging effects on symptoms and course of illness*. Washington DC: American Psychological Association.
- Heilbronner, U., Samara, M., Leucht, S., Falkai, P., & Schulze, T. G. (2016). The longitudinal course of schizophrenia across the lifespan: Clinical, cognitive, and neurobiological aspects. *Harvard Review of Psychiatry*, 24, 118-128.

- Heinssen, R. K., Goldstein, A. B., & Azrin, S. T. (2016). Evidence-based treatment for first-episode psychosis: Components of coordinated specialty care. National Institutes of Health website.
- Hooley, J. M. (2007). Expressed emotion and relapse of psychopathology. *Annual Review of Clinical Psychology*, 3, 329-352.
- Katz, M. M., Marsella, A., Dube, K. C. et al. (1988). On the expression of psychosis in different cultures: Schizophrenia in an Indian and in a Nigerian community. *Culture, Medicine and Psychiatry* 12, 3: 331-355.
- Lennon, M., McGuire, T. G., Alegria, M., & Frank, R. G. (2009). Racial and ethnic disparities in the treatment of a Medicaid population with schizophrenia. *Health Services Research*, 44, 2106-2122.
- Jeste, D. V., & Maglione, J. E. (2013). Treating older adults with schizophrenia: Challenges and opportunities. *Schizophrenia Bulletin*, 39, 5, 966-968.
- Jeste, D. V., Wolkowitz, O. M., & Palmer, B. W. (2011). Divergent trajectories of physical, cognitive, and psychosocial aging in schizophrenia. *Schizophrenia Bulletin*, 37, 451-455.
- Jones, J. M., Sander, J. B., & Booker, K. W. (2013). Multicultural competency building: Practical solutions for training and evaluating student progress. *Training and Education in Professional Psychology*, 7, 12.-22.
- Judd, L. L., Akiskal, H. S., Schettler, P. J., Coryell, W., Endicott, J., Maser, J. D., ... & Keller, M. B. (2003). A prospective investigation of the natural history of the long-term weekly symptomatic status of bipolar II disorder. *Archives of General Psychiatry*, 60, 3, 261-269.
- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... & Marcy, P. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173, 362-372.
- Kaslow, N. J., Borden, K. A., Collins, F. L., Forrest, L., Illfelder-Kaye, J., Nelson, P. D., ... & Willmuth, M. E. (2004). Competencies conference: Future directions in education and credentialing in professional psychology. *Journal of Clinical Psychology*, 60, 699-712.
- Kawa, I., Carter, J. D., Joyce, P. R., Doughty, C. J., Frampton, C. M., Elisabeth Wells, J., ... & Olds, R. J. (2005). Gender differences in bipolar disorder: Age of onset, course, comorbidity, and symptom presentation. *Bipolar Disorders*, 7, 119-125.
- Kelleher, I., & Cannon, M. (2011). Psychotic-like experiences in the general population: Characterizing a high-risk group for psychosis. *Psychological Medicine*, 41, 1-6.
- Kidd, S. A., Howison, M., Pilling, M., Ross, L. E., & McKenzie, K. (2016). Severe mental illness in LGBT populations: A scoping review. *Psychiatric Services*, 67, 7, 779-783.
- Kirkbride, J. B. (2017). Migration and psychosis: Our smoking lung? *World Psychiatry*, 16, 119-120.
- Kirkbride, J. B., Errazuriz, A., Croudace, T. J., Morgan, C., Jackson, D., Boydell, J., ... & Jones, P. B. (2012). Incidence of schizophrenia and other psychoses in England, 1950–2009: A

- systematic review and meta-analyses. *PLoS One*, e31660.
<https://doi:10.1371/journal.pone.0031660>
- Kopelowicz, A., Zarate, R., Smith, V. G., Mintz, J., & Liberman, R. P. (2003). Disease management in Latinos with schizophrenia: A family-assisted, skills training approach. *Schizophrenia Bulletin*, 29, 211-217.
- Kopelowicz, A., Zarate, R., Wallace, C. J., Liberman, R. P., Lopez, S. R., & Mintz, J. (2012). The ability of multifamily groups to improve treatment adherence in Mexican Americans with schizophrenia. *Archives of General Psychiatry*, 69, 265-273.
- Kourkoutas, E. E., & Xavier, M. R. (2010). Counseling children at risk in a resilient contextual perspective: A paradigmatic shift of school psychologists' role in inclusive education. *Procedia-Social and Behavioral Sciences*, 5, 1210-1219.
- Kunioyoshi, J. & McClellan, J. M. (2014). Early-onset schizophrenia. In E. J. Mash & R. A. Barkley (Eds.), *Child Psychopathology*, Third Edition (pp. 573-592), New York: Guilford.
- Lang, J. M., & Connell, C. M. (2017). Development and validation of a brief trauma screening measure for children: The child trauma screen. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9, 390-398.
- Lang, F. U., Kösters, M., Lang, S., Becker, T., & Jäger, M. (2013). Psychopathological long-term outcome of schizophrenia—A review. *Acta Psychiatrica Scandinavica*, 127, 173-182.
- Laroi, F., Luhrmann, T. M., Bell, V., Christian, W. A., Deshpande, S., Fernyhough, C. ... Woods, A. (2014). Culture and hallucinations: Overview and future directions. *Schizophrenia Bulletin*, 40 (supp 4), S213-S220.
- Leboyer, M., Henry, C., Paillere-Martinot, M. L., & Bellivier, F. (2005). Age at onset in bipolar affective disorders: A review. *Bipolar Disorders*, 7, 111-118.
- Lehman, A. F., Steinwachs, D. M., Dixon, L. B., Postrado, L., Scott, J. E., Fahey, M., ... & Shore, A. (1998). Patterns of usual care for schizophrenia: initial results from the schizophrenia patient outcomes research team (PORT) client survey. *Schizophrenia Bulletin*, 24, 11.-20.
- Lehman, A. F. (1988). A quality of life interview for the chronically mentally ill. *Evaluation and Program Planning*, 11, 51-62.
- Lewis-Fernández, R., Aggarwal, N. K., Hinton, L., Hinton, D. E., & Kirmayer, L. J. (eds) (2016). *DSM-5 Handbook on the Cultural Formulation Interview*. Washington, DC: American Psychiatric Press.
- Lopez, S. R., Kopelowicz, A., & Canive, J. M. (2002). Strategies in developing culturally congruent family interventions for schizophrenia: The case of Hispanics. *Family Interventions in Mental Illness: International Perspectives*, 61-90.
- Luciano, A., & Meara, E. (2014). Employment status of people with mental illness: National survey data from 2009 and 2010. *Psychiatric Services*, 65, 1201-1209.

- Lucksted, A. (2004). Lesbian, gay, bisexual, and transgender people receiving services in the public mental health system: Raising issues. *Journal of Gay & Lesbian Psychotherapy*, 8, 25-42.
- Luhrmann, T. M. (2007). Social defeat and the culture of chronicity: Or, why schizophrenia does so well over there and so badly here. *Culture, Medicine and Psychiatry*, 31, 135-172,
- Marmot, M. & Wilkinson, R. G. (Eds). (2006). *Social determinants of health*. 2nd Ed. Oxford, UK: Oxford University Press.
- Marrone, J., & Golowka, E. (1999). If work makes people with mental illness sick, what do unemployment, poverty, and social isolation cause?. *Psychiatric Rehabilitation Journal*, 23, 187-193.
- Matheson, S. L., Shepherd, A. M., Pinchbeck, R. M., Laurens, K. R., & Carr, V. J. (2013). Childhood adversity in schizophrenia: A systematic meta-analysis. *Psychological Medicine*, 43, 225-238.
- McGinty, E. E., Baller, J., Azrin, S. T., Juliano-Bult, D., & Daumit, G. L. (2015). Quality of medical care for persons with serious mental illness: A comprehensive review. *Schizophrenia Research*, 165, 227-235.
- Medley, G., Lipari, R. N., Bose, J., Cribb, D. S., Kroutil, L. A., & McHenry, G. (2016). Sexual orientation and estimates of adult substance use and mental health: Results from the 2015 national survey on drug use and health. Substance Abuse and Mental Health services Administration. Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015.htm>.
- Merikangas, K. R., Jin, R., He, J. P., Kessler, R. C., Lee, S., Sampson, N. A., ... & Ladea, M. (2011). Prevalence and correlates of bipolar spectrum disorder in the world mental health survey initiative. *Archives of General Psychiatry*, 68, 241-251.
- McCarthy-Jones, S., Waegeli, A., & Watkins, J. (2013). Spirituality and hearing voices: Considering the relation. *Psychosis*, 5, 247-258.
- Mona, L. R., Cameron, R. P., & Clemency Cordes, C. (2017). Disability culturally competent sexual healthcare. *American Psychologist*, 72, 1000-1010.
- Moreno, C., Laje, G., Blanco, C., Jiang, H., Schmidt, A. B., & Olfson, M. (2007). National trends in the outpatient diagnosis and treatment of bipolar disorder in youth. *Archives of General Psychiatry*, 64, 1032-1039.
- Mueser, K. T., Gottlieb, J. D., Xie, H., Lu, W., Yanos, P. T., Rosenberg, S. D., ... & McHugo, G. J. (2015). Evaluation of cognitive restructuring for post-traumatic stress disorder in people with severe mental illness. *The British Journal of Psychiatry*, 206, 501-508.
- Mueser, K. T., Meyer-Kalos, P. S., Glynn, S. M., Lynde, D. W., Robinson, D. G., Gingerich, S., ... & Wiseman, J. L. (2018). Implementation and fidelity assessment of the NAVIGATE treatment program for first episode psychosis in a multi-site study. *Schizophrenia Research*. Advance online publication. doi.org/10.1016/j.schres.2018.08.015

- Nazzari, K. H., Forghany, M., Geevarughese, M. C., Mahmoodi, V., & Wong, J. (2014). An innovative community-oriented approach to prevention and early intervention with refugees in the United States. *Psychological Services, 11*, 477-485.
- Nivoli, A. M., Pacchiarotti, I., Rosa, A. R., Popovic, D., Murru, A., Valenti, M., ... & Colom, F. (2011). Gender differences in a cohort study of 604 bipolar patients: the role of predominant polarity. *Journal of Affective Disorders, 133*, 443-449.
- Ochoa, S., Usall, J., Cobo, J., Labad, X., & Kulkarni, J. (2012). Gender differences in schizophrenia and first-episode psychosis: A comprehensive literature review. *Schizophrenia Research and Treatment, 1-9*. <https://doi:10.1155/2012/916198>
- Olfson, M., Druss, B. G., & Marcus, S. C. (2015). Trends in mental health care among children and adolescents. *New England Journal of Medicine, 372*, 21, 2029-2038.
- Paris Jr, M., Silva, M. A., Diaz, E., Bedregal, L. E., Cole, R. A., & Añez-Nava, L. M. (2016). The Connecticut Latino behavioral health system: A culturally informed community-academic collaboration. *Psychological Services, 13*, 140-147.
- Park, C., McDermott, B., Loy, J., & Dean, P. (2011). Adolescent admissions to adult psychiatric units: patterns and implications for service provision. *Australasian Psychiatry, 19*, 345-349.
- The Pennsylvania Office of Mental Health and Substance Abuse Services Strategic Plan for Cultural Competence (2nd ed., Tech.). (n.d.). Retrieved from http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/s_002546.pdf
- Perry, M J. (1996). The relationship between social class and mental disorder. *Journal of Primary Prevention, 14*, 17-30.
- Pettifor, J., Sinclair, C., & Falender, C. A. (2014). Ethical supervision: Harmonizing rules and ideals in a globalizing world. *Training and Education in Professional Psychology, 8*, 201-210.
- Pickett, K. E., James, O. W., & Wilkinson, R. G. (2006). Income inequality and the prevalence of mental illness: A preliminary international analysis. *Journal of Epidemiology & Community Health, 60*, 646-647.
- Pitschel-Walz, G., Leucht, S., Bauml, J., Kissling, W. & Engel, R. R. (2001). The effect of family interventions on relapse and rehospitalization in schizophrenia - A meta-analysis. *Schizophrenia Bulletin, 27*, 1, 73-92.
- Phillips, E. S., Barrio, C., & Brekke, J. S. (2001). The impact of ethnicity on prospective functional outcomes from community-based psychosocial rehabilitation for persons with schizophrenia. *Journal of Community Psychology, 29*, 6, 657-673.
- Podlogar, M. C., & Novins, D. K. (2015). Quality of care in American Indian child and adolescent behavioral health: A pilot study of patient and family perspectives. *Psychological Services, 12*, 112-122.
- Rajkumar, R. P. (2014). Gender identity disorder and schizophrenia: Neurodevelopmental disorders with common causal mechanisms?. *Schizophrenia Research and Treatment, 14*, 1-8.

- Ranji, U., Beamesderfer, A., Kates, J., & Salganicoff, A. (2014). Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the US. Washington, DC: Henry J. Kaiser Family Foundation.
- Rodriguez-Menendez, G., Dempsey, J. P., Albizu, T., Power, S., & Campbell Wilkerson, M. (2017). Faculty and student perceptions of clinical training experiences in professional psychology. *Training and Education in Professional Psychology, 11*, 1-9.
<http://dx.doi.org/10.1037/tep0000137>
- Rojas-Flores, L., Clements, M. L., Hwang Koo, J., & London, J. (2017). Trauma and psychological distress in Latino citizen children following parental detention and deportation. *Psychological Trauma: Theory, Research, Practice, and Policy, 9*, 352-361.
- Rosenberg, S., Rosenberg, J., Huygen, C., & Klein, E. (2005). No need to hide. *Best Practices in Mental Health, 1*, 72-85.
- Rosenfarb, I. S., Bellack, A. S., & Aziz, N. (2006). Family interactions and the course of schizophrenia in African American and White patients. *Journal of Abnormal Psychology, 115*, 112-120.
- Salcedo, S., McMaster, K. J., & Johnson, S. L. (2017). Disparities in treatment and service utilization among Hispanics and non-Hispanic whites with bipolar disorder. *Journal of Racial and Ethnic Health Disparities, 4*, 354-363.
- Sartorius, N., Shapiro, R. & Jablensky, A. (1974). The international pilot study of schizophrenia. *Schizophrenia Bulletin, 1*, 11, 21-34.
- Semlyen, J., King, M., Varney, J., & Hagger-Johnson, G. (2016). Sexual orientation and symptoms of common mental disorder or low wellbeing: Combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry, 16*, 1-9.
- Smith, T. B., Constantine, M. G., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology, 53*, 132-145.
- Stacy, M., Klee, A., & Jansen, M. (2018). Postdoctoral psychology training in preparation for specialization in serious mental illness. *Training and Education in Professional Psychology, 12*, 96-104.
- Stanhope, V., Solomon, P., Pernell-Arnold, A., Sands, R. G., & Bourjolly, J. N. (2005). Evaluating cultural competence among behavioral health professionals. *Psychiatric Rehabilitation Journal, 28*, 225-233.
- Sue, S., Zane, N., Gordon, C., Hall, N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548.
- Temin, P. (2018). *The vanishing middle class: Prejudice and power in a dual economy*. Cambridge, MA: MIT Press.

- Topor, A., Andersson, G., Denhov, A., Holmqvist, S., Mattsson, M., Stefansson, C. G., & Bülow, P. (2014). Psychosis and poverty: Coping with poverty and severe mental illness in everyday life. *Psychosis*, 6, 117-127.
- Toth, S. L., Stronach, E. P., Rogosch, F. A., Caplan, R., & Cicchetti, D. (2011). Illogical thinking and thought disorder in maltreated children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 50, 659-668.
- Tsong, Y., & Goodyear, R. K. (2014). Assessing supervision's clinical and multicultural impacts: The supervision outcome scale's psychometric properties. *Training and Education in Professional Psychology*, 8, 189-195.
- Varese, F., Smeets, F., Drukker, M., Lieveerse, R., Lataster, T., Viechtbauer, W., ... & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective-and cross-sectional cohort studies. *Schizophrenia Bulletin*, 38, 661-671.
- Versola-Russo, J. (2006). Cultural and demographic factors of schizophrenia. *International Journal of Psychosocial Rehabilitation*, 10, 89-103.
- Weisman de Mamani, A., Weintraub, M. J., Gurak, K., & Maura, J. (2014). A randomized clinical trial to test the efficacy of a family-focused, culturally informed therapy for schizophrenia. *Journal of Family Psychology*, 28, 800-810.
- Wetherell, J. L., & Jeste, D. V. (2004). Older adults with schizophrenia. *Elder Care*, 3, 8-11.
- Wilton, R. (2004). Putting policy into practice? Poverty and people with serious mental illness. *Social Science & Medicine*, 58, 25-39.
- Zubin, J., & Spring, B. (1977). Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychology*, 86, 103-126.

Criterion IV. Distinctiveness

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

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

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

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

Introduction

Psychologists who specialize in SMI Psychology possess a unique set of skills and experiences that enable them to affect psychological recovery and health of individuals diagnosed with SMI/SED. One straightforward distinction between psychologists specializing in the area of SMI/SED and other health services psychologists lies in the presenting problems and referral questions they address on a daily basis. For example, counseling and clinical psychologists typically focus on a range of presenting problems within the Diagnostic and Statistical Manual but rarely provide treatment to individuals with psychotic illness or more severe forms of psychopathology. The SMI/SED psychologist focuses on these latter patients. The Federal definition of SMI is included below:

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

These individuals often require hospitalization and longer-term rehabilitation settings, (both in-patient and out-patient) as well as highly specialized treatments to recover (Turner, van der Gaag, Karyotaki, & Cuijpers, 2014). While an office-based generalist psychologist might work with patients with these diagnoses, the SMI/SED psychologist specializes in the long-term, recovery focused assessment and treatment of these individuals – treatment requiring a unique and distinctive set of competencies to address the complexity and severity of the patient’s presenting problems. Additionally, most often the general practitioner psychologist, even those board certified in clinical or counseling psychology, do not follow their patients into the hospital or rehabilitation setting; instead, they rely on the specialized care provided to their patients in those settings.

The SMI Psychology Specialty involves unique clinical competencies, such as recovery related treatments (e.g., <http://www.apa.org/pi/mfp/psychology/recovery-to-practice/all-curriculums.pdf>) that are unique to its science and practice. In considering existing psychological specialties, it is useful to note that some deal with unique populations, (for example the specialty of child and adolescent psychology deals with youth, clinical health psychology deals with high-risk or medically ill individuals) and some with distinctive conceptualizations and techniques they apply to

their patient populations (for example the specialties of psycho analysis and cognitive behavioral psychology). The SMI Psychology Specialty has both a unique patient population (i.e., those diagnosed with the most severe and persistent mental health and psychological disorders) as well as a set of specific competencies, assessment and treatment techniques scientifically validated to provide quality care to that defined population. **Thus, the SMI Psychology Specialty is distinctive in both populations served and in clinical practices utilized.**

The similarities that do exist across the recognized specialties arise from the fact that all doctoral level training in health service psychology is broad and general, providing trainees with some opportunity to work with a variety of populations and across a variety of health care settings. For example, at the doctoral or internship level, a trainee might have an Experience or Exposure to a setting where patients diagnosed with SMI/SED are treated (Rozenky, 2015). They similarly might have an Experience, Exposure or even an Emphasis in clinical child psychology and/or clinical health psychology; those might be a component of a true, broad and general learning experience as required for accreditation by APA as a health service psychology program. However, to warrant a program being recognized as educating those within a specialty, there must be a Major Area of Study in that specialty similar to those defined by the members of the Council of Specialties in Professional Psychology. Such a Major Area of Study is detailed in this petition. At the post-doctoral level, there is limited overlap with other specialties because post-doctoral trainees in most specialty areas receive little or no in-depth exposure to individuals with SMI/SED because by definition, a post-doctoral specialty program must have at least 80% of its time dedicated to its own specialty area. Only those programs, at the post-doctoral level, with a Major Area of Study in SMI/SED would meet the APA CRSPPP criteria and provide learners with intensive training in assessments and interventions that have been developed and found efficacious for individuals diagnosed with SMI/SED.

The SMI Psychology Specialty is designed to prepare competent psychologists for Specialty practice utilizing a conceptual model that is distinct from traditional specialties such as Clinical, Counseling, and other post-doctoral specialties. While there are areas of overlap, especially when working with individuals whose illness is less severe or during periods of symptom remission and following recovery, in general, there are many critical clinical distinctions between people who have SMI or SED and others who seek services from psychologists. Most obvious are the **nature and degree** of symptomatology, problematic behaviors arising from symptomatology and/or because of delayed or omitted development, loss or unlearned adaptive functioning, social isolation and exclusion, and adverse life events such as extreme abuse and trauma, etc. (Goodwin & Jamison, 2007).

In partnership with SAMHSA, APA has developed a full, distinctive training Curriculum on the essential principles and practices for trainees pursuing a Major Area of Study in SMI/SED. The 15-module course includes both factual information as well as guidance to trainers on how to augment with material with practice activities and the inclusion of individuals with lived experience as trainers. The comprehensive Curriculum, entitled *Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment* (American Psychological Association & Jansen, 2014) is available at <https://www.apa.org/pi/mfp/psychology/recovery-to-practice/training.aspx/> and includes the following modules:

1. Introduction to Recovery Based Psychological Practice

This module introduces the recovery model applied to behavioral health. Characteristics and fundamental components of recovery are defined.

2. Role of Psychologists and Health Care Reform

This module provides a historical overview of the concept of recovery as applied to mental health and describes its evolution. An understanding of the role of psychologists and how health care reform is shaping the future of recovery is explored.

3. Assessment

This module discusses clinical assessment methodologies consistent with a recovery framework that are strengths-based and focused on the functional capabilities of the individual.

4. Partnership and Engagement

This module examines the importance of engaging people in the service delivery process and presents some of the impediments that keep people from becoming partners in this process. A discussion of how to successfully engage and involve individuals is presented.

5. Person-Centered Planning

This module provides an overview of person-centered planning in recovery-oriented care. At its core, person-centered planning is a collaborative and interdisciplinary approach to treatment in which individuals are empowered to find their own path to recovery.

6. Health Disparities

This module provides an overview of the causes of the premature death experienced by people with serious mental illnesses and includes a discussion of the intersection of race, ethnicity, gender and culture related to these causes.

7. Interventions I: Guiding Principles and Integrated Framework

This module is the first in a series of three intervention modules designed to be used together. Guiding principles that underlie the provision of all psychosocial rehabilitation services (PSR) are discussed, and an integrative framework is presented.

8. Interventions II: Evidence Based Practices

This module is the second in a series of three intervention modules designed to be used together. The evidence-based practices developed, researched, and found to help people achieve their desired outcomes are presented.

9. Interventions III: Promising or Emerging Practices and Supporting Services

This module is the third in the series of intervention modules, and describes services that have shown promise of achieving specified outcomes. Supporting services that are widely acknowledged as essential services for helping people recover from the effects of serious mental illness are also highlighted.

10. Issues in Forensic Settings

This module is the first of two forensics modules designed to be used together. This first module highlights the many issues and impediments people with serious mental health disorders face in the justice system.

11. Interventions in Forensic Settings

This is the second in the series of two forensics modules designed to be used together. This module presents information about the interventions currently recommended to help people in the system avoid re-incarceration and achieve a stable and satisfying life in the community.

12. Community Inclusion

This module presents an overview of the issues that serve to exclude people with mental health disorders from participation in their communities. These include stigma, discrimination, poverty, and vulnerability. The circular and detrimental impact of social isolation and exclusion on an individual's mental health are explored.

13. Peer Delivered Services

This module focuses on the role of peers in helping individuals recover and achieve a satisfying and productive life in the community. Peer support as an integral component of the mental health service delivery system is presented.

14. Systems Transformation

Transforming a mental health system or an organization to one that is focused on helping people recover requires a fundamental paradigm shift from a system that is provider driven to one that is driven by the individuals who use the system and their families. This module presents key ingredients, challenges, successes and the role of psychologists in systems change.

15. Scientific Foundations

This module provides the empirical basis for recovery, and presents the pros and cons of using quantitative versus qualitative methods to study interventions for people with serious mental illnesses. An introduction to mixed methods research, which offers a solution to the problems of using either quantitative or qualitative methods, is presented.

The *Curriculum* can be used as part of a post-doctoral specialty training program in SMI/SED psychology, and a review of the topics highlight some of the distinctive elements of practice in this field (e.g., the importance of advocacy for community inclusion for this population; the place of peer-delivered services). The in-depth information provided below is offered to highlight the very real differences of the SMI/SED population, and the problems they face as well as the procedures and techniques developed specifically for these individuals and proven effective for them, as described in the *Curriculum*. Where there are similarities and/or differences with other specialties, we have noted these as well.

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

Populations: Similarities and Differences with Other Specialties

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

The presentation of symptoms of SMI/SED is distinct from that of other individuals with psychological disorders not only by these symptoms’ severity, but also by their unique nature (i.e., positive symptoms such as hallucinations and delusions, negative symptoms such as anhedonia and alogia), the resulting pervasive nature of the functional limitations that ensue from them, and the debilitating societal stigma and self-stigma that they often incite. SMI and SED are found in people in all ethnic, racial and socioeconomic groups, all genders, all religions, regions or countries of origin or in which people live.

SMI Psychology is a Specialty with a combined patient population and specific assessment and intervention focus. The SMI Specialty is not age specific, like clinical child psychology or professional geropsychology. With regard to age, it is more like neuropsychology or clinical health psychology in that it encompasses a wide age range with specific problems or diagnostic presentations, and similar to the specialties of sleep, cognitive behavioral psychology or psychoanalysis as within this wide age range, there are defined clinical interventions to address the presenting problems. When considering the age of those seeking treatment for SMI/SED, It should be noted while the problems can appear at any age,

there are highly specialized programs designed to improve outcomes in first episode non-affective psychosis, which include interventions specifically designed for adolescents and young adults (typically ages 15-35) who have developed a recent (often within the past year or so) psychosis. These interventions, now subsumed under the title “coordinated specialty care”, typically include tailored medication, and manualized and specialized psychosocial interventions such as individual psychological therapy, family education and support, and supported employment and education (Heinssen, Goldstein, & Azrin, 2016; Mueser et al. 2015). Participation in these age-specific specialized interventions has been found to improve outcomes compared to participation in customary care (Kane et al., 2016). Psychologists working with consumers experiencing a first episode psychosis typically require additional training to provide and/or oversee the provision of these highly prescriptive treatments with fidelity to the model (Mueser et al., 2018). Conversely, there are also specialized psychological interventions for individuals experiencing psychosis later in life, including ones designed to improve health in older adults (Pratt, Bartels, Mueser, & Forester, 2008) and community adjustment in middle aged and older adults (Granholm et al., 2005). Thus, life span issues, while not central to the specialty area, are of significant importance in treatment tailoring.

As the title of this Specialty denotes, the population of interest is a mixed diagnostic group, with an emphasis on disorders where 1) psychosis is often predominant, 2) symptoms may wax and wane but may be long-standing, and 3) community functioning is often impaired—disorders on the schizophrenia spectrum, bipolar illness, and depression with psychotic features. The PSR principles and procedures presented in this specialty are applicable to all of these consumer groups. They can all benefit from recovery and person-centered care, strength-based assessment, attention to common medical comorbidities, and advocacy to support integration into the community, for example. Further, many of the unique interventions designed for the consumer group and discussed below are cross-diagnostic—social skills training, behavioral family therapy, illness management and recovery, CBT treatment for PTSD in SMI/SED—and are suitable for individuals with impairment in the relevant intervention area, regardless of specific diagnosis. Nevertheless, trainees pursuing a Major Area of Study in SMI Psychology are also provided with relevant diagnostic specific knowledge and practices as well. For example, while impaired compared to the general population, neurocognition is typically less impaired in bipolar illness than in schizophrenia (Cuesta et al, 2011). This pattern of findings suggests that trainees need to have more support for adapting processes and procedures to meet cognitive challenges when working with consumers diagnosed with schizophrenia rather than bipolar illness. Similarly, there are some interventions, such as interpersonal and social rhythm therapy (Frank, Swartz, & Kupfer, 2000) that are tailored to the specific needs of persons diagnosed with bipolar disorder, and others, such as cognitive-behavioral treatment for psychosis (CBT-P; Kingdon & Turkington, 1994) targeted to individuals experiencing primarily positive symptoms of psychosis. In the discussion below, diagnostic differences are drawn as warranted by the data.

A key challenge in working with the SMI/SED population is assessing and intervening with individuals with a wide range of community functioning. Many have significant functional impairments (e.g. social skills deficits, problems with successfully participating in activities of daily living, un or underemployment, diminished social networks), resulting from symptoms, neurocognitive problems, and developmental lags in adolescence and young adulthood (Tandon, Nasrallah, & Keshavan, 2009). On the other hand, with the advent of better-tolerated psychopharmacology and innovative psychosocial treatments, there are a growing number of individuals with a diagnosis of schizophrenia or bipolar illness who lead full lives and achieve employment success (Cohen et al, 2016; Marwaha, Durrani, & Singh, 2013). Psychologists working with the SMI/SED population must be able to identify and address the severe symptoms and pervasive functional deficits that reduce the quality and quantity of life of some individuals diagnosed with SMI/SED, while also being capable of providing appropriate support for those individuals who are able to function more autonomously. The complexity of this endeavor, which is the purview of the field entitled “psychosocial or psychiatric rehabilitation”, is typically not covered in a course of training in clinical or counseling psychology (Mueser, Silverstein, & Farkas, 2013).

Health Service Psychologists have expertise to bring to the treatment and study of individuals

diagnosed with SMI/SED. For many years, when less was known about specific information, attitudes, and skills that could promote recovery in people with SMI/SED through PSR, the basic level of knowledge obtained in clinical and counseling psychology training was often considered to be sufficient to contribute to the treatment of individuals diagnosed with these disorders. However, the proliferation of information and interventions to support recovery from SMI/SED now necessitates specialty training (Reddy, Spaulding, Jansen, Menditto, & Pickett 2010; Stacy, Klee, & Jansen, 2018).

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

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

People diagnosed with SMI/SED face a multitude of problems and challenges over and above their symptoms that those without these disorders typically face much less frequently or intensely (Davidson & Stayner, 1997; Lynch et al, 2014; Topor et al, 2014). That is a factor that differentiates the work of the SMI Psychology Specialty from other psychology practitioners. Many of these problems may be faced by individuals with other mental health conditions either in less severe form, with different and presenting characteristics, or with less comorbidity. However, for people with SMI/SED the problems described below are more severe, often render engagement and provision of treatment more difficult, and require specialized interventions. In recognition of this, evidence-based and promising practices have been developed and tested specifically for this population, highlighting the unique nature of the problems faced by people with SMI/SED and the specialized assessments and interventions needed to treat them (Pinkham, et al., 2012).

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

Psychological Problems

The psychological problems faced by those with SMI/SED can vary but most frequently include severe symptomatology (the characteristic symptoms of hallucinations, delusions, extreme mood swings, disorganized thinking, and disordered or flattened affect) as well as neuropsychological problems, trauma sequelae, severe anxiety, depression, co-morbid substance use, and problems that arise as a result of incarceration or hospitalization in forensic psychiatric facilities. The hallmark symptoms of SMI/SED constitute the sine qua non of SMI/SED and, because these are so well known by every mental health professional, we do not elaborate upon them here. Other psychological problems associated with SMI/SED but less frequently familiar to professional psychologists include:

- Neurologic/cognitive deficits and problems (Green, Horan, & Lee, 2015; Heinrichs, 2005)
- Psychological problems experienced as a result of trauma (Goodman, Rosenberg, Mueser, & Drake, 1997; Grubaugh et al., 2011)
- Severe depression resulting from trauma or from losses following onset of SMI/SED (Rodrigues & Anderson, 2017)
- Co-morbid substance use (Bahorik, Newhill, Queen, & Eack, 2014)
- Lack of self-efficacy or feelings of agency in the world (Carpenter, Heinrichs, Waagman, 1988; Lysaker & Leonhardt, 2012)
- Internalized stigma (Corrigan, Watson, & Barr, 2006)

Generalist health service psychologists have expertise in dealing with many of the problems noted above (e.g., addressing trauma). However, the neurocognitive deficits and positive and negative symptoms found in schizophrenia, as well as the mood instability and cognitive impairments in bipolar

disorder, significantly complicate intervening on these problems. Consider the case of treatment of trauma in psychosis. Cognitive-processing therapy (Resick & Schnicke, 1992), which relies primarily on cognitive-restructuring of core traumatic beliefs, is well established as a psychological treatment for PTSD in the community (Steenkamp, Litz, Hoge, & Marmar, 2015). Mueser, et al., (2015) adapted the treatment for a broad SMI/SED sample by including greater emphasis on breathing retraining and focusing the cognitive restructuring more on “here and now” issues; they found positive results in a randomized controlled trial (RCT). However, other investigators have not been able to replicate these results in an exclusively schizophrenia sample (Steel et al., 2017). In considering these contradictory findings, Steel and colleagues (2017) conjecture that it may be 1) individuals diagnosed with schizophrenia need an even more nuanced adaptation of cognitive-restructuring, including more emphasis on prompting emotional experiences, or 2) that symptom fluctuation in PTSD and psychosis is very high in this population, requiring much more careful attention to ongoing assessment to actually discern a treatment effect or 3) that individuals diagnosed with schizophrenia, whose traumatic event is *related to their mental health symptoms or treatment (e.g., being put in restraints; fearing from one's life because of delusional paranoia)*, may meet diagnostic criterion for PTSD but need a more tailored treatment. These are all intriguing possibilities, and suggest questions ripe for research. Furthermore, they highlight the fact that just expanding use of the general manualized cognitive-behavioral treatment for PTSD in a population diagnosed with SMI/SED or schizophrenia is probably not sufficient; interventions tailored to the deficits and impairments in the population are often needed.

Biological Problems

While their etiology is not fully understood, most SMIs are now conceptualized as having a biological component, typically involving changes in either brain structure or function (Sekar, et al., 2016; Schizophrenia Working Group of the Psychiatric Genomics Consortium, 2016) as well as environmental/psychological components. Competently understanding this biopsychosocial matrix and implications for assessment and treatment clearly requires specialized knowledge and skills. Genetics are implicated in these biological changes (Schizophrenia Working Group of the Psychiatric Genomics Consortium, 2014); however, environment also plays a role, as exposure to childhood adversity (Varesse et al, 2012) and traumatic exposure (Gibson, Alloy, & Ellman, 2016) also increase risk for psychosis. Understanding the impact of neuroscience variables requires a specialized set of skills well beyond the broad and general training of health service psychology and unique from most other recognized specialties. Additionally, the impact of medical co-morbidities is particularly challenging for older adults who can be impacted more substantially than younger persons (Bartels, 2004).

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

SMI/SED physiologic problems include:

- Premature death by Natural Causes - Respiratory Diseases, Cancers, Diabetes and Cardiovascular Diseases: Primarily Attributable to Smoking and Obesity which may be

exacerbated by medication side-effects (Janssen, McGinty, Azrin, JulianoBult, & Daumit, 2015)

- Death/injury through Suicide (Witt, Hawton, & Fazel, 2014)
- Death/injury through Exposure to Violence (Khalifeh et al, 2015; Monahan, Vesselinov, Robbins & Appelbaum, 2017; Roy et al, 2014).

In light of these significant health challenges, psychologists with expertise in SMI/SED must be able to adapt standard health psychology interventions to meet the unique needs to this consumer group. Consider, for example, the case of cigarette smoking. The prevalence of cigarette smoking is double to triple the rate among individuals diagnosed with schizophrenia compared to the non-diagnosed population (Mitchell & Dahlgren, 1986). SMI/SED consumers are more likely to smoke cigarettes, in part, because nicotine reduces the sedation from antipsychotic medication, as well as being addictive in its own right (Goff, Henderson, & Amico, 1992). Existing smoking cessation programs, such as the popular American Lung Association *Freedom from Smoking* program, often include complicated instructions and presume access to resources such as a quit buddy or funds for self-rewards for quitting which are not available to the population diagnosed with schizophrenia or severe bipolar illness. Further, as summarized by Tsoi and colleagues (2013), unlike non-schizophrenia smokers, nicotine replacement strategies seem to offer little benefit to cessation in schizophrenia, while contingent reinforcement for reductions in smoking may be more useful. Some prescribed pharmacological agents may also be helpful, but they have also been associated with increased suicidality in a subset of individuals diagnosed with schizophrenia (Tsoi, Porwal, Webster, 2013). Thus, Specialty knowledge and expertise are required to adapt smoking cessation interventions to the needs of consumers diagnosed with schizophrenia. For example, Dr. Jean Addington, a Canadian psychologist with expertise in SMI/SED, and her colleagues described their adaptations to a standard smoking cessation programs thusly

The group program included positive reinforcement, learning and practicing alternative behaviors, and anxiety reduction strategies. There was a tolerance for positive (schizophrenia) symptoms, and social and financial limitations were considered. Teaching modifications were made to address neurocognitive deficits such as restricted information-processing capacity, memory and attentional difficulties, and poor executive functioning (Addington, El-Guebaly, Campbell, Hodgins, & Addington, 1998, p. 975).

It is the ability to both learn standard, evidence-based interventions for SMI/SED disorders and the capacity to adapt existing interventions to meet the unique needs of the consumer population that are core features of a Major Area of Study in SMI Psychology.

Social Problems

The social problems experienced by people with SMI/SED are endemic and require a specialized approach to the diagnostic and treatment planning needed to help a patient move towards rehabilitation and recovery. Some of these problems result from the core features of the disorders; for example, social withdrawal (and thus social isolation) is a prominent symptom in schizophrenia and depression. However, other social problems ensue from the poor level of community functioning that often accompanies schizophrenia and bipolar illness. Those who cannot finish their education successfully or hold down a job often are typically doomed to a life in poverty, with limited access to safe housing, food, health care, and basic life necessities. The physical health problems we mentioned above that cause premature disability and death are exacerbated by social issues such as stigma, physician prejudice, and inability to access health care, to name just a few (Corrigan, & Kosyluk, 2014; McGinty, et al., 2015; Smith, et al., 2017; Walker, McGee, & Druss, 2015). Substance use, poor executive functioning, and lack of access to basic resources often cause people with SMI/SED to become entangled with the criminal justice and forensic systems, resulting in the double stigmas of mental illness and criminality. In addition, much concern has been expressed regarding placement of older adults with schizophrenia in nursing homes leading to a decline in cognitive status and overall functioning, and an increase in mortality (Harvey, 2005). There is a need for expertise in both the understanding of SMI and geriatric mental health to

prevent inappropriate institutionalization and to promote the least restrictive environment of care for this most vulnerable population (Harvey, 2005). Some of the social problems faced by people with SMI/SED include:

- Heightened risk of incidence in countries with high levels of economic inequity (Burns, Tomita, & Kapadia, 2014; Warner, 1985).
- Societal stigma and discrimination (Farrelly et al, 2014; Parcesepe & Cabassa, 2013).
- Heightened risk for involvement in the criminal justice and forensic system (Lynch et al, 2014; Sarteschi, 2013).
- Heightened risk for homelessness (Montgomery, Metraux, & Culhane, 2013).
- Un/underemployment (Krupa, Chen, & Carter, 2015).
- Difficulties finding and maintaining intimate partner relationships (Wright, Wright, Perry, & Foote-Ardah, 2007).

As can be seen, many of those with SMI/SED live with economic deprivation, societal discrimination, more frequent exposure to the criminal justice system, homelessness, and social isolation. Each of these can complicate the conduct of generalist psychological assessment and therapeutic interventions by limiting consumer ability to access and sustain participation in mental health treatment in traditional clinic settings.

Clinical Procedures and Assessment and Intervention Techniques

The assessment and intervention knowledge and skills that comprise the competencies learned in the broad and general education and training of health service psychologists are the foundation for clinically effective work with SMI/SED populations. However, specific procedures and techniques grounded in these foundational skills are essential to meet the unique and broad ranging needs of this patient population. This then makes specialty training to meet the needs of the SMI/SED population imperative (Mueser, Silverstein, & Farkas, 2013; Stacy, Klee, & Jansen, 2018). In addition to basic competencies of a health service psychologist, those treating individuals with SMI/SED must be able to diagnose the unique biopsychosocial factors impinging on the individual with the SMI/SED diagnosis and provide the specific evidence-based practices which have been found to be effective with this population (e.g., social skills training, cognitive-behavioral therapy for psychosis, illness management and recovery, family therapy, etc. (Geddes, & Miklowitz, 2013; Mueser, Deavers, Penn, & Cassisi, 2013; Mueser, Silverstein, & Farkas, 2013). While any of the following areas can be part of a broad and general clinical portfolio of a health service psychologist, the Specialist in SMI Psychology must also possess specific knowledge and competencies in all these areas. Specific, specialized knowledge and skills are required to successfully provide quality services to this unique population).

In addition to demonstrating basic clinical/counseling skills, those treating individuals with SMI/SED must be able to:

1. Use a collaborative set to develop a therapeutic relationship with an individual who may be paranoid, have a high level of amotivation or apathy, and/or lack insight into why they are receiving treatment (Carr & Miller, 2017).
2. Conduct a careful and thorough assessment, which must range far beyond capturing the presenting problem, symptoms, strengths, and life circumstances to include assessing domains such as: community functioning (Can the individual use transportation? Care for personal hygiene? Economically support him/herself?), medication adherence, impact of the mental illness on physical health, family

support and attitudes, need/access to public resources, developmental lags in community functioning due to illness, and the impact of self-stigma and discrimination. (Chu et al., 2012a; Reddy, Spaulding, Jansen, Menditto, & Pickett, 2010).

3. Make an accurate diagnosis in spite of the fact that symptoms profiles are often similar across various SMI/SED disorders (e.g., psychosis can be present in schizophrenia, schizoaffective disorder, bipolar illness, and depression with psychotic features; negative symptoms and depression can often appear quite similar) or can be confounded with substance abuse; this requires advanced training and expertise to distinguish between them (Chu et al., 2012a; Reddy, Spaulding, Jansen, Menditto, & Pickett, 2010).
4. Monitor response to treatment over time using carefully-selected assessment tools that capture the range of symptoms and deficits in functioning often seen in this population but also account for challenges consumers may have with accurate self-report (American Psychological Association & Jansen, 2014).
5. Using PSR principles, collaborate and consult effectively with the larger treatment team, including medication prescribers, case managers, social workers, physical health providers, residential program supervisors, peer providers, and other support individuals, who are typically involved when a person is diagnosed with an SMI/SED (Carr & Miller, 2017; Chu et al., 2012a).
6. Advocate for those who are having difficulty navigating complex social services systems (e.g., social security, housing authorities, food programs, criminal justice system) whose resources may be integral to sustaining the consumer and/or assuring his/her well-being. (Carr & Miller, 2017) as well as for social justice for this often stigmatized population (Carr, Bhagwat, Miller, & Ponce, 2014).
7. Adopt a recovery-oriented attitude using shared-decision making, the promotion of consumer empowerment, and the instillation of hope to support illness recovery (Borg & Kristiansen, 2004; Buck et al., 2013)
8. Effectively supervise mental health service providers with less formal education, including individuals with lived experience (peer providers) (Cohen, Abraham, Burk, & Stein, 2012; Davidson, Bellamy, Guy, & Miller, 2012).
9. Manage transitions and treatment planning to higher or lower levels of care as individuals improve or relapse over time (Viggiano, Pincus, & Crystal, 2012).
10. Provide the specialized evidence-based intervention practices which have been established to be effective with this population (Chu et al., 2012a; Mueser, Silverstein, & Farkas, 2013).

Training in specialized interventions designed, developed and empirically validated or adapted **specifically for those with an SMI/SED diagnosis** is needed. The 2009 Schizophrenia Patient Outcomes Research Team (PORT) study remains the most rigorous and undisputed summary of efficacious interventions to date (Kreyenbuhl, Buchanan, Dickerson & Dixon, 2010). The PORT study identified eight evidence practices (EBPs) and four promising practices that are effective in the specialized treatment for schizophrenia and other SMI/SED diagnoses. These are further discussed in Criterion VI and in the *Recovery to Practice Curriculum* cited throughout this petition, and include:

- Assertive community treatment
- Supported employment
- Family psychoeducation
- Cognitive behavioral therapy (CBT) and CBT for psychosis (CBTp)

- Token economy
- Skills training
- Psychosocial interventions for alcohol and substance use disorders
- Psychosocial interventions for weight management
- Medication/illness management
- Cognitive remediation
- Psychological treatments for recent onset schizophrenia
- Peer support and peer-delivered services

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

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

The complexity of these activities is typically not covered in the broad and general training of health service psychologists nor in the more limited exposure or experiences in that broad and general training. Psychologists must also be prepared to engage in clinical activities with adults, older adults, children and adolescents with SMI/SED and their families within a variety of settings in this Specialty. These settings include private practice, home-based therapeutic settings, mental health clinics and centers, drop-in centers, schools, homes for aged and disabled, hospitals, community and public health agencies, adult and juvenile justice and service agencies, and advocacy organizations.

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

a. Assessment

Please Note: Some of the information on assessment below is from Glynn and Mueser (2018), and from the *APA Recovery to Practice Curriculum* (American Psychological Association and Jansen, 2014). We provide greater detail about some assessments, especially those aimed at culturally relevant aspects of determining strengths, in Criterion VI. We also provide some additional assessment information in Criteria V. And in Criteria V and VI and in the Training Guidelines, we offer a listing of the most widely known and used assessment instruments in a wide array of categories.

An essential aspect of the broad and general training of most health services psychologists is learning how to conduct a psychological assessment leading to diagnosis and treatment planning. A psychologist specializing in the treatment of SMI/SED must conduct comprehensive psychological assessments, but his/her work must be tailored to the unique characteristics of the population. This means the psychologist with a Specialty in SMI Psychology must 1) know the current scientific literature familiar to generalist clinical and counseling psychologists, as well as 2) know the rationale and optimal strategies for supplementing traditional assessment strategies to capture a broader array of consumer domains more pertinent to this population (e.g., community functioning, family attitudes). It is the specialized training required for point 2, which involves broadening the knowledge bases of assessment tools to fit the population (which we highlight here).

We note that the assessment knowledge areas discussed in criteria IV, V, and VI are comparable, though here we provide more thematic information in response to the question about distinctiveness, while in criteria V and VI and in the Training Guidelines we provide more specific examples of measures that might be taught in a Major Area of Study in SMI Psychology.

Knowledge about the rationale and optimal strategies for expanding traditional assessment strategies to capture a broad array of domains most relevant to SMI/SED population

An SMI Psychologist must have knowledge of specialized measures, which capture both psychotic and non-psychotic symptoms, and have training in when and how to use them. While any health service psychologist in the diagnostic process might use many of these instruments the unique competencies of those dedicated to the SMI/SED population allow a specialized integration of materials given the unique training to work with this population. An analogy would be, the primary care practitioner is trained to review the results of an electrocardiogram (EKG); however, it is the *specialized* training of the cardiologist that the primary care physician relies upon to review that same cardiogram when looking for a specialized understanding (diagnosis) of any abnormality found and the implication for specialized treatment. Importantly, it is the patient who will seek out the specialized services of the cardiologist when they, themselves, understand they are part of the identified “cardiac” population needing specialized services (Kaslow, Graves, & Smith, 2012).

Knowledge of specialized tools to permit accurate diagnoses

As the diagnosis of a schizophrenia-spectrum or serious affective disorder has important treatment implications, a careful assessment is necessary to ensure accurate identification of the disorder. Aside from undetected substance abuse or medical conditions that can lead to common symptoms of schizophrenia or mania, there is also great overlap with the symptoms of schizophrenia, schizoaffective disorder, bipolar disorder and major depression. In individuals experiencing psychosis, the primary distinction between schizophrenia and mood disorders is drawn based on the course and co-occurrence of different symptoms (e.g., the presence of psychotic symptoms in people when depression or mania is absent suggests a disorder on the schizophrenia spectrum, while the presence of psychotic symptoms in people where depression or mania is present suggests a disorder on the affective spectrum). Drawing such a nuanced distinction requires obtaining accurate historical information from individuals who often have challenges with recall and cognition.

Accurate diagnosis of psychotic disorder involves training in specialized instruments, not typically taught in a generalist psychology training program. The most widely used standardized instrument for diagnostic interviewing that has specialized utility within the SMI/SED population is the *Structured Clinical Interview for DSM-5* (SCID-5) (First, Williams, Karg, & Spitzer, 2015a, 2015b). The SCID has a psychosis version with demonstrated excellent reliability and validity for the diagnosis of schizophrenia and bipolar illness, although considerable specialty training and clinical interviewing experience are required to administer it (Ventura, Liberman, Green, Shaner, & Mintz, 1998), and it is a time-consuming interview to conduct and score, often requiring one to two or more hours to complete in symptomatic individuals. The SCID is very comprehensive, permits a variety of psychiatric diagnoses to be made from the same

interview, and is most often used as a research instrument. However, its potential for identifying the core disorder and comorbidities such as substance use or PTSD makes it an especially useful tool in the SMI/SED population.

Knowledge of specialized instruments tailored to monitor psychotic and affective symptoms on an ongoing basis is within the purview of this specialty, but often not part of generalist training. Ongoing symptom monitoring can be achieved using specialized tools such as the *Expanded Brief Psychiatric Rating* (BPRS; Lukoff, Nuechterlein, & Ventura, 1986) or the *Positive and Negative Symptom Scale* (PANSS; Kay, Opler, & Fiszbein, 1987), which assesses both psychotic and non-psychotic SMI psychopathology. The assessment of negative symptoms in SMI is particularly challenging, and there are new tools to help clinicians do a better job in this domain - the *Clinical Assessment Interview for Negative Symptoms* (CAINS) (Kring, Gur, Blanchard, Horan, & Reise, 2013) and the *Brief Negative Symptoms Scale* (BNSS) (Kirkpatrick, et al., 2011)—to supplement that gold standard *Scale for the Assessment of Negative Symptoms* (SANS) (Andreasen, 1989). This is a rapidly growing area of interest, with new data and refinements in measures being proposed frequently (see, for example, Kumari & Malik, 2017). There also continues to be concern about the reliability of bipolar II diagnoses with any available tool (Miller, Johnson, & Eisner, 2009), and careful clinician attention to reports of mood changes and behavior changes is needed to improve accuracy (Kendall, Morriss, Mayo-Wilson, & Marcus 2014).

Co-morbidities are common in this population. For example, in a national representative genomic sample of over 20,000 individuals, presence of a psychotic disorder increased the odds ratio of having a co-occurring substance use disorder to greater than 3:1 (Hartz, et al, 2014) compared to the control condition. With regard to exposure to trauma, in the US national comorbidity study of almost 6000 non-institutionalized adults, psychosis was related to a greater than 1.8:1 odds ratio of exposure to trauma compared to the group that did not report psychosis (Shevlin, Dorahy, & Adamson, G. (2007). Accurately ascertaining the presence of these co-morbidities can be complicated in this population, due to challenges in accurate reporting because of insight, symptoms, or cognitive deficits (Bell, Fiszdon, Richardson, Lysaker, & Bryson, 2007; Lincoln, Ziegler, Lüllmann, Müller, & Rief, 2010). Specialist training must include information on using appropriate tools to ascertain accurately the presence of multiple diagnoses in this population. These tools have been developed and normed for this patient population group, and are not the ones that are typically used by general health service psychologists. For example, while trauma rates are thought to be very prevalent in those experiencing psychosis (Gibson, et al., 2016), assessment of post-traumatic stress disorder (PTSD) in schizophrenia is optimally done using a modified version of the well-regarded *Clinician Administered PTSD Scale* (CAPS; Blake, et al., 1995) wherein the probes are simplified to increase the validity of responses in individuals with the cognitive challenges that often accompany schizophrenia (CAPS-S; Gearon, Bellack, & Tenhula, 2004). Similarly, depressive and negative symptoms in schizophrenia often seem phenotypically similar, yet they are conceptually and etiologically distinct. Rather than utilizing a standard self-report measure for depression such as the revised *Beck Depression Inventory*, SMI clinicians must be made aware of and trained to use specialized instruments (in this case, the *Calgary Scale for Depression in Schizophrenia*) (Addington, Addington, & Maticka-Tyndale, 1993; Addington, Addington, & Maticka-Tyndale, 1994) to assure accuracy of diagnosis of comorbid disorders in individuals experiencing psychosis.

Psychologists who specialize with children and adolescents have focused on research and utilizing test materials with an understanding of the unique burden of assessment on the SMI/SED population. The diagnosis of schizophrenia is made with the same criteria applied to children and adolescents as to adults (Kuniyoshi & McClellan, 2014). Structured interviews such as the *Schedule for Affective Disorders and Schizophrenia for School Aged Children* (K-SADS) are used as diagnostic instruments, although the K-SADS is long for clinical use. The *Children's Interview for Psychiatric Syndromes* (ChIPS) was developed to decrease parent/child and interviewer burden, and was shown to be valid for clinical and research use (Young, Bell & Fristad, 2016). Other tools include the *Diagnostic Interview for Children and Adolescents* (DICA) (Reich, 2000), *Child and Adolescent Psychiatric Assessment* (CAPA) (Angold & Costello, 2000), *Schizophrenia Prediction Instrument Child and Youth* version (SPI-CY) by Schultz-Lutter and Koch (as cited in Tiffin & Welsh (2013) and the *Comprehensive*

Assessment of At-Risk Mental States (CAARMS; Yung et al., 2005). In short, specialized training and expertise is required for an adequate assessment of SMI/SED symptoms.

Knowledge of strategies and tools to identify consumer strengths (in contrast to focusing on deficits)

Traditional psychological assessments focus on identifying deficits and problem areas so they can be categorized and then remediated. While identification of deficits and limitations is clearly important when working with individuals diagnosed with an SMI/SED, there is growing emphasis on developing the specialized skills needed to identify strengths and assets in this population (Frost et al, 2017; Tse et al, 2016). Many psychologists and other mental health practitioners now acknowledge that a more comprehensive, positive, and specialized assessment approach that looks beyond the individual and his or her symptoms and diagnosis is essential for helping the person fight internalized stigma (Corrigan et al., 2015) and think about the their future, decide what his or her goals are, what kind of life the person wants to have, and determine the best ways to achieve those goals (Davidson, et al., 2008; Farkas, Sullivan Soydan & Gagne, 2000; Pratt & Mueser, 2002).

Adults experiencing psychosis often have limited community functioning; they are frequently unemployed, living with family or in a supervised or subsidized setting, and may have limited social networks and be unpartnered (Goldberg & Harrow, 2011; Green, 1996; Iasevoli et al., 2016; Judd et al., 2005). It can be very easy to focus only on consumer symptoms and limitations and not on their strengths. However, a core feature of the SMI/SED recovery model is identifying and maximizing strengths, and building on them, at least as much as addressing clients' weaknesses (Tse et al., 2016). Thus, for example, when a psychologist in this Specialty is helping a client consider employment, rather than focusing on the client's years of unemployment and lack of technical skills in the assessment, he/she will focus on ascertaining what the client is currently good at and how he/she prefers to spend his/her time—perhaps drawing, video game playing, following a sports team—and then see how these avocations might be able to lead to a job or profession. These strength-based assessments are a core component of evidence-based supported employment interventions such as Individual Placement and Support (IPS; Becker & Drake, 2003). For a clinical, counselling, or vocational psychologist trained in more traditional assessment and case formulation techniques, this is often a new approach to vocational assessment.

Knowledge to characterize the range of impairments in community functioning

A recovery orientation requires psychologists to support consumers in achieving their goals and promoting their self-determination (Cohen, Abraham, Burk, & Stein, 2012). Most often, this involves not just helping reduce symptoms, but also helping patients have a richer quality of life, which can then be measured (Karow, Wittmann, Schöttle, Schäfer, & Lambert, 2014). However, SMI/SED patients' range of successful community functioning can vary dramatically, requiring specialized skills and tools designed to capture both very low and very high levels of adaptive functioning. While some individuals diagnosed with an SMI/SED have very adaptive community functioning (Cohen et al, 2016), many are adjudicated disabled and are unemployed, have limited social networks and few romantic relationships, have little scheduled productive time, and live in supervised housing (Insel, 2010; Kooyman, Dean, Harvey, & Walsh, 2007). The SMI/SED Specialized Psychologist needs knowledge of assessment skills and techniques that capture gradations at the lowest levels of functioning (e.g., number of days homeless or in jail) (Glynn & Mueser, 2018; Bellack et al., 2006). Research and clinical reports in the SMI literature note that several frequently used community functioning assessments by generalists, such as the *Social Adjustment Scale* (Weissman & Bothwell, 1976) or the *Global Assessment of Functioning* (GAF; Endicott, Spitzer, Fleiss, & Cohen, 1976) lack items that sufficiently characterize the lives of adults diagnosed with an SMI (Goldman, Skodol, & Lave, 1992; Glynn & Mueser, 2018). Useful assessment tools must be able to capture variability in experiences and situations even at the extremes. Rather than having one or two items to capture functioning, most published measures tailored to the SMI/SED population are dimensional (e.g., Barker, Barron, McFarland, & Bigelow, 1994) with one to several items

assessing different domains of functioning (e.g., social support, independent living) in a more fine-grained manner. The scales vary in their length, level of training required for the assessment administrator, relative emphasis on global life domains vs. specific instrumental skills, and whether the scales emphasize objective or subjective aspects of functioning. There is no one scale which will meet every clinical or research need, so specialized training and expertise is required to acquire the knowledge base to select an optimal measure for the SMI/SED population depending on the circumstances.

Knowledge of recovery attitudes, self-stigma, and distress from symptoms

Generalist health service psychologists are, of course, interested in their patients' subjective appraisals of their circumstances. However, among psychologists working with SMI/SED individuals there is heightened interest in measuring the person's own attitude toward his/her illness and his/her symptoms (Glynn & Mueser, 2018). In many ways, this focus reflects the growing influence of the recovery movement (Cohen, Abraham, Burk, & Stein, 2012; Carr & Miller, 2017) in mental health, and the premise that providing person centered care requires fully understanding the consumer's viewpoint. With regard to assessment, this recovery focus encompasses two essential domains of measurement: 1) the presence of recovery attitudes, including self-stigma, and 2) self-reported distress experienced from symptoms that others might assume (rightly or wrongly) are very disturbing. While general clinical and counselling psychologists may attend to these topics, psychologists with a Specialty in SMI Psychology must be highly knowledgeable about assessment in both of these domains if they are to develop and implement effective interventions.

Assessing recovery attitudes is a relatively new and highly specialized area of investigation, now with several distinct measurement tools to identify factors related to recovery in schizophrenia (Cavelti, Kvrjic, Beck, Kossowsky, & Vauth, 2012). Generally, these tools can be classified into one of two categories, i.e., ones assessing positive aspects of the recovery process, and ones assessing negative self-assessments related to a diagnosis of a significant mental illness. With regard to assessing a recovery orientation, one of the widely used measures is the *Mental Health Recovery Measure* (MHRM) (Young & Bullock, 2005). The MHRM is a behaviorally-anchored self-report measure designed for use with persons who have serious and persistent mental illnesses such as recurrent major depression, bipolar disorder, or schizophrenia. Another widely used measure of recovery is the *Recovery Assessment Scale* (RAS) (Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995; Ralph, Kidder, & Phillips, 2000).

An individual diagnosed with an SMI/SED is at risk for developing negative self-assessments related to a diagnosis (Corrigan et al, 2015). Reflecting the science of assessment and diagnosis of the SMI/SED population, there has been much recent interest in creating measures to assess these negative self-appraisals, which have been labeled self-stigma or internalized stigma. Self-stigma is a particular concern, as it has been linked to poorer psychosocial treatment adherence in the SMI/SED population (Fung, Tsang, & Corrigan, 2008), and higher rates of depression (Ritsher, Otilingam, & Grajales, 2003) in individuals diagnosed with schizophrenia. Several specialized scales are available to assess self-stigma, including the *Self-Stigma of Mental Illness Scale* (SSMI) (Corrigan, Watson, & Barr, 2006), the *Internalized Stigma of Mental Illness Scale* (ISMI) (Ritsher et al., 2003), and the *Stigma Scale* (SS) (King et al., 2007).

One of the specialized roles of the psychologist working with the SMI/SED population is conducting assessments to determine the impact of a psychiatric illness on one's sense of self (either positive or negative). This person-centered approach to assessment has also highlighted the importance of understanding the client's level of distress ensuing from psychotic symptoms. Paradoxically, those with lived experience of the symptoms of schizophrenia or bipolar illness do not necessarily find them distressing (Baumeister, Sedgwick, Howes, & Peters, 2017). Some individuals who experience internal voices consider them to be benign or even helpful, and may reject the idea that these experiences reflect the presence of a disorder or necessitate treatment. Similarly, those experiencing a hypomanic episode often enjoy the energy and enthusiasm it brings to their life. Thus, it is essential for psychologists to have

the knowledge and specialized skills to distinguish between the presence of a symptom and the distress the experience it causes the client. Post-doctoral Specialty training programs in SMI Psychology offer instruction in tools such as the *Psychotic Symptom Rating Scale (PSYRATS)* (Haddock, McCarron, Tarrier, & Faragher, 1999) a semi-structured 17-item interview which assesses multiple subjective dimensions of hallucinations and delusions. In contrast to other psychotic symptom measures, details are elicited by the respondent on several unique subjective aspects of delusions and hallucinations (e.g., perceived intensity, controllability, preoccupation, distress).

Knowledge of strategies to assess and support decision making capability/capacity

A core tenet of ethical treatment by psychologists is the requirement to obtain informed consent for treatment, which involves guiding both a full discussion of the diagnosis and proposed treatment plan with the client, and obtaining his/her consent to participate in this plan. In light of the cognitive challenges and anosognosia commonly found in consumers diagnosed with psychotic disorders, it is not surprising that the capacity for some consumers to make informed decisions about treatment is an area of ongoing concern within the specialty. While many of those diagnosed with these disorders acknowledge their mental health challenges and are eager for assistance, others are reluctant to do so, or their comprehension of the information presented to them is unclear. To address these concerns, there have been more formalized tools developed to systematically assess for capacity to engage in treatment. One of these, the *Aid to Capacity Evaluation (ACE)* (Joint Centre for Bioethics, undated), is a cross diagnostic tool, while another, the *MacArthur Competency Assessment Tool for Treatment (MacCAT-T)* (Grisso, Appelbaum, & Hill-Fotouhi, 1997), is a flexible yet structured method targeted to individuals diagnosed with an illness on the schizophrenia spectrum. These can be used when embarking on a course of assessment to assure the consumer is an active and adequately informed treatment participant.

Knowledge about assessment of family attitudes and burden among caregivers

Most adults presenting for psychological treatment do not include members of their families of origin in the psychotherapy. However, acquiring scientific information about the impact of family attitudes on prognosis is a critical component of specialized SMI Psychology training. Brown, Birley, & Wing, (1972) and Brown, Monck, Carstairs, & Wing (1962) demonstrated that family attitudes, reflective of high levels of distress measured at the time of a loved one's psychotic relapse, predict greater rates of subsequent patient relapse, especially if the relative and patient had more than 35 hours of contact per week. This high level of family distress has been labeled "high expressed emotion" (EE), and the relationship between high EE and subsequent relapse is among the most potent predictors of outcome in depression, schizophrenia and bipolar illness (Butzlaff & Hooley, 1998). EE is reflected in critical comments or tone or reported extreme self-sacrificing behavior during a semi-structured interview (the *Camberwell Family Interview*) at the time of the initial relapse (Leff & Vaughn, 1985), and is likely evidenced in actual interactions with the client (Mueser et al., 1993; Strachan, Leff, Goldstein, Doane, & Burt, 1986).

The measurement of EE requires an extensive research assessment and scoring procedure, which is a highly specialized skill (Leff & Vaughn, 1985). Hooley and Parker (2006) suggested that one feasible alternative method for assessing EE is to ask clients how critical their relative is of them. An alternative measure to ratings of perceived criticism is the *Patient Rejection Scale (PRS)* (Kreisman et al., 1988; Kreisman, Simmens, & Joy, 1979). This 24-item scale consists of both positively and negatively worded items reflecting feelings of love and acceptance, criticism, disappointment, and rejection; it can be considered an analogue of the critical comments and hostility factors composing the concept of EE.

The psychologist who specializes in the assessment and treatment of those with an SMI/SED diagnosis also understands that the impact of caregiving on the families of individuals with serious psychiatric illnesses. Many of these relatives experience a high level of burden, which reverberates in the family and can create negative affect which increases stress on the consumer (Gater et al, 2014). There is no consensus measure of family burden, and many of the measures used with families of individuals

diagnosed with schizophrenia and bipolar illness were developed for use in other disorders (e.g., the *Zarit Burden Scale*) (Zarit, Reever, & Bach-Peterson, 1980) or are interview-based and quite intensive to administer, such as the *Family Experiences Interview Schedule* (FEIS) (Tessler & Gamache, 1996). One measure which appears to have good potential to capture burden in the families of those with SMI/SED is the *Burden Assessment Scale* (BAS) (Reinhard, Gubman, Horwitz, & Minsky, 1994), which may have particular value as it does not require interviewer training and is designed to focus on the experience of burden, and is not confounded with issues of coping or skill in illness management.

Cultural competence in SMI/SED assessment

As outlined under criterion III, cultural issues play a significant role in the diagnosis and treatment of individuals diagnosed with SMI/SED, and thus those receiving training in this area are provided with instruction in cultural sensitivity (Carr & Miller, 2017; Stacy, Klee, & Jansen, 2018). Even if the clinician and SMI/SED treatment seeker are both English-speakers, there is a robust literature indicating that African Americans are more likely than Caucasians to be diagnosed with schizophrenia (see, for example, Barnes, 2008 and Coleman et al., 2016). There continues to be debate about whether these racial disparities are true differences in prevalence and incidence of the disorders, or result from (potentially biased) diagnostic methods (Arnold et al., 2004). In a worldwide mental health survey, the prevalence of bipolar disorders was consistent across diverse cultures and ethnic groups, (Merikangas et al., 2011); however, pockets of heightened rates of bipolar illness have been reported throughout the world (Fearon et al., 2006). Migration is increasingly understood as an important risk factor for the development of psychosis. The exact magnitude of this risk varies, depending on the given migrant group and setting in which the study is conducted. An increased risk of schizophrenia among first and second-generation immigrants, especially those from developing countries, has been noted (Kandiyohi & McClellan, 2014). The cause of this increased risk is much debated. As Kirkbride (2017) notes, it is not found in all cultures (for example, Hispanics in the US do not have a heightened risk for psychosis), and may reflect in part the suffering and stress many emigrants encounter before they leave their original homes as well as the stigma and discrimination they face in their new homes.

Cultural, racial, and ethnicity can all impact on treatment seeking, engagement, and impact in serious mental illness (Kopelowicz et al., 2012; Lopez, Kopelowicz & Canive, 2002). Specialty training in the DSM-5® *Handbook on the Cultural Formulation Interview* or a similar tool is essential, and trainees often benefit from interacting with cultural experts, who can help them tailor assessment techniques to make them more accessible to all ethnic and cultural groups. Cultural competence is a core aspect of Specialty training in SMI Psychology (Chu et al., 2012b; Stacy, Klee & Jansen, 2018).

Knowledge to identify, characterize, and help alleviate psychosis-related cognitive deficits

The cognitive deficits in schizophrenia and bipolar disorder have been well characterized, both in basic processes such as memory and attention (Vöhringer et al., 2013) and in social cognition (Green, Horan, & Lee, 2015; Samamé, Martino, & Strejilevich, 2012). General health service psychologists typically have at least exposure, and perhaps even an emphasis, in using more traditional cognitive assessment tools, such as the *WAIS* or *Wisconsin Card Sort*, to capture cognitive functioning in the broader population; neuropsychologists clearly have even more advanced expertise. However, there are specific questions about validity, often related to motivation and willingness to follow the instructions of the assessments, that arise when evaluating cognition in individuals with psychosis (Strauss, Morra, Sullivan, & Gold, 2015). More recently, specialized cognitive assessment measures which have been developed and normed with this population (Cuesta, et al, 2011) including the *Brief Cognitive Assessment Tool for Schizophrenia* (B-CATS) (Hurford, Marder, Keefe, Reise, & Bilder, 2009) and the *Screen for Cognitive Impairment in Psychiatry* (SCIP; Purdon, 2005). A Specialty training program with a Major Area of Study in SMI Psychology typically includes instruction on cognitive deficits in SMI/SED, alternative strategies for the assessment of cognition in these diverse populations, and practice in adapting clinical practices to account for these cognitive impairments. These adaptations might include, for example, conducting shorter intervention sessions, assuring intervention sessions are highly

interactive, using multimodal interventions, using more prompts and coaching in session, and simplifying out-of-session assignments.

Knowledge to assess risk (self-harm and aggression)

Individuals diagnosed with schizophrenia and bipolar illness are at greater risk for both self-harm and victimization than the general population. With regard to self-harm, suicide rates are greater in the SMI/SED population than the general population (Chesney, Goodwin, & Fazel, 2014) and there are some data to suggest risk of aggression is heightened when individuals experience a high level of positive symptoms (Hodgins, Hiscoke, & Frese, 2003). Thus, the SMI Psychologist must always keep safety paramount and monitor vigilantly for signs of consumers being unwell and/or risk for self-harm or violence against others. Training in tools such as the *Historical Clinical Risk Management-20 Version 3* (Douglas, Hart, Webster, & Belfrage, 2013), augmented by attention to clinical status, medication and treatment adherence, and attention to signs of hopelessness and despair, are an important component of Specialty training in SMI Psychology.

Knowing how and when to supplement self-report data with more objective measures

While psychologists with broad and general training as health service psychologists and those working in other recognized specialties utilize clinical interviews and observations as core components of their assessments, they typically supplement these with self-report instruments such as the *Minnesota Multiphasic Personality Inventory-2* (MMPI-2), the *Millon Clinical Multiaxial Inventory-iii* (MCMI-iii), the *Beck Depression Inventory* (BDI), or the *Post-Traumatic Check List* (PCL), to inform their case conceptualizations and treatment plans. In contrast, those specializing in the SMI/SED population appreciate that there must be less reliance on self-report instruments because they know that psychotic symptoms, cognitive difficulties, and anosognosia (Amador et al., 1994) sometimes lead to inaccurate self-reports and can result in potentially unreliable, invalid measurement (Takeuchi, Fervaha, Remington, 2016). While some measures, such as the *MMPI-II* and the *MCMI-II* have validity measures that help clinicians discern whether testing with the SMI/SED population is valid, psychologists specially trained to conduct SMI/SED assessments must be knowledgeable about strategies for collecting alternative interview, observational, and collaborative data when the validity is poor. As part of their training, they must be taught to discern when self-report data are adequate, and when strategies for collecting and interpreting interview, observational, and collaborative data must be utilized, and perhaps even emphasized, when conducting an assessment.

Knowing how to use behavioral observations as a reflection of psychotic symptoms

A critical aspect of general health service psychologist training in assessment is making accurate observations. In Specialty training in SMI Psychology, this training in careful observation is even more highlighted and refined (Chu, et al., 2012b). While broader health service psychology education certainly trains students to carry out behavioral observations across different patient populations and diagnoses, there is a specialized set of skills and tools required to measure the behaviors of those with SMI/SED diagnoses because their symptoms may cause them to misreport or deny they have a particular concern or problem (anosognosia).

In the case of observable behaviors, many commonly used SMI/SED symptom assessment instruments such as the *BPRS* and the *SANS* include specific behavioral observation items to quantify states such as excitement or negative symptoms. SMI Psychologists also receive specialized training in recognizing and distinguishing between catatonic behavior and negative symptoms, and between negative symptoms and depressive symptoms. Psychologists who work with children and adolescents with SED become knowledgeable about how to obtain and use parent and child interviews, data from school and medical records, observations, formal, age-normed psychological tests, behavior rating scales, and personality and neuropsychological assessments to evaluate concerns as well as developmental history across multiple contexts. Some specific examples include the *Children's Interview*

for *Psychiatric Syndromes* (Child Version ChIPS and Parent Version P-ChIPS; Rooney, Fristad, Weller & Weller, 1999), *Diagnostic Interview for Children and Adolescents* (DICA; Reich, 2000), and *Child and Adolescent Psychiatric Assessment* (CAPA; Angold & Costello, 2000).

Knowing how to assess recovery orientation at the agency level

SMI Psychologists are also uniquely qualified to promote change at the systems level. In addition to knowing how to assess an individual's recovery orientation and attitudes, SMI Psychologists should receive training in how to assess recovery orientation at the program or agency level. There are several assessment measures, such as the *Recovery Self-Assessment* (RSA; O'Connell, Tondora, Croog, Evans, & Davidson, 2005) that have been designed to assess the strengths and needs of agencies (e.g., to improve consumer involvement) in order to become more recovery-oriented or consistent with the principles of PSR. These measures typically involve assessments of various perspectives, including patients, family members, staff, and administrators. For a review of these measures, see for example https://www.mentalhealth.va.gov/communityproviders/docs/review_recovery_measures.pdf, and Williams and colleagues (2012) who identified thirteen measures designed to measure the recovery orientation of services. They found that measures were inconsistent in terms of their definitions of recovery, making it difficult to select from them. They also noted that further work is needed to demonstrate the psychometric properties of these measures. The SMI Psychologist should be aware of these issues in order to utilize these measures effectively and explain their limitations.

b. Intervention

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

Post-doctoral training with a Major Area of Study in SMI Psychology offers an intensive period to gain expertise in highly focused new skills (Rodolfa et al, 2005). Equally important, an SMI Psychology post-doctoral fellowship must also foster the development of new attitudes and beliefs, which are a critical part of the training (Cohen et al, 2012; Roe et al, 2006). An SMI Psychologist must possess the appropriate intervention skills *as well as* hopeful attitudes and beliefs, as supported by emerging research data (Carr & Miller, 2017). To be effective in this field, psychologists must believe that individuals diagnosed with SMI/SED can live rich, full lives (whether they experience symptoms or not) and have the professional competencies to help these individuals build these lives. Developing these intervention skills and positive attitudes and beliefs are the essential aspects of the education and training in a Major Area of Study in SMI Psychology (Cohen et al., 2012; Roe et al., 2006; Stacy, Klee & Jansen, 2018). Mueser, Silverstein, & Farkas (2013) note that training in clinical psychology (other than SMI Psychology Specialty training) does not typically nurture the attitudes or the expertise to work with the SMI/SED population, and thus Specialty training in this domain is especially needed. Several SMI Psychology Specialized post-doctoral training programs with a focus on inculcating recovery-attitudes are now in existence (see for example, Cohen et al., 2012; Stacey, Klee, & Jansen, 2018), as well as collaborative training programs across mental health disciplines (see, for example, Mabe, Ahmed, Duncan, Fenley, & Buckley, 2014; Razzano et al., 2010). Typically, these programs, whether in psychology or multidisciplinary, involve readings (including first-person accounts written by consumers), a research or quality improvement project, interactions with individuals with lived experience, lectures and discussions, with a focus on exposing trainees to recovery tenets (specified below) and acquainting trainees with the often better-than-expected prognosis in SMI/SED (Zipursky, Reilly & Murray, 2012), as well as exposure to publications on the objective positive results from initiatives to transition SMI/SED services grounded in the medical model to programs that are more recovery-oriented (Malinovsky et al, 2013; Zuehlke, Kotecki, Kern, Sholty, & Hauser, 2016).

Developing recovery-oriented attitudes during specialty training

It was once thought that schizophrenia led to irreversible deterioration while bipolar illness (then known as “manic depression”) had a more intermittent, less corrosive course (Kraepelin, 1919/1971). It is now clear that, lacking effective treatment, individuals diagnosed with bipolar illness can also have a poor prognosis (Forte, et al., 2015), and that comprehensive interventions, grounded in a wide-ranging and thorough assessment, can improve outcomes in schizophrenia (Green, et al., 2013). Studies over the past several decades have shown that many adults with serious mental illnesses can and do improve when they are provided with the specialized services that assist them in gaining or regaining the skills needed to live a satisfying and productive life (Morin, & Franck, 2017). In fact, despite long held beliefs that SMIs are chronic deteriorating illnesses, several meta analyses and summaries of published research continue to document that many individuals diagnosed with SMIs can, and do recover from the effects of their illness (Warner, 2010), and indeed that many have the potential to achieve long-term remission and functional recovery (Zipursky, Reilly & Murray, 2012).

Specialized psychological treatment can be a key intervention to produce better outcomes in SMI/SED (Morin & Frank, 2017). Provision of services within the context of an empathic, genuine, trusting relationship where the person with SMI is involved in a partnership involving developing an agreement on and design of the components of services he or she will receive, is generally considered to be important for the success of recovery-oriented interventions (Anthony, Rogers & Farkas, 2003; Mueser, 2012).

Given specialized intervention approaches, effective SMI Psychological services are guided by the following principles (American Psychological Association & Jansen, 2014):

- Recognition that recovery and return to a satisfying and productive life are possible and that recovery can occur at any age;
- Provision of interventions that are grounded in research and achieve results;
- Acceptance that, to the greatest extent possible, those with SMI/SED and their families are full partners with the service delivery system and determine the services they will receive.

The education and training of those psychologists who specialize in working with the SMI/SED populations are prepared, through a Major Area of Study, to become competent specialists. Their training is grounded in several additional principles have been identified as important for provision of effective recovery-oriented services. These were originally specified by participants in the National Consensus Conference on Mental Health Recovery and Transformation (U.S. Department of Health and Human Services, 2006) and recently updated to reflect the importance of culture, trauma, and inclusion in family and social networks. These are:

- Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.
- Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals.
- Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds – including trauma experiences – that affect and determine their pathway(s) to recovery.
- Recovery pathways are highly personalized: They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches.
- Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks.
- Recovery is holistic: Recovery encompasses an individual’s whole life, including mind, body,

spirit, and community.

- Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.
- Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.
- Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations - including values, traditions, and beliefs - are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.
- Recovery is supported by addressing trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues.
- Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.
- Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

Other mental health professions, such as psychiatry, are increasingly recognizing the essential nature of positively-focused, recovery-oriented beliefs and attitudes in SMI/SED work (Jeste, Palmer, & Saks, 2017). The evidence supporting the importance of these principles for recovery is quite consistent and comes from first person accounts of people who have received services. Whenever they are asked about the elements of service provision that made a difference to them, the principles outlined above are often referenced (Deegan, 1988; Frese, Knight & Saks, 2009; Jacobson, 2001; Mead & Copeland, 2000; Ridgway, 2001; Wisdom, Bruce, Saedi, Weis, & Green, 2008).

Developing expertise in essential intervention skills

Knowledge of manualized evidence-based and promising practices tailored to the unique needs of the population

In light of the severity and breadth of symptoms found in persons diagnosed with an SMI or SED such as schizophrenia or bipolar illness the scope of the therapeutic challenge is often large and a broad comprehensive intervention framework is required (Chien, Leung, Yeung, & Wong, 2013). Specialty residents must learn specific interventions tailored to the population, such as cognitive behavioral therapy for psychosis (CBTp) or behavioral family therapy, but must also learn how to sequence and integrate the interventions, so as not to overwhelm patients who are uniquely sensitive to stress (Carr & Miller, 2017; Cohen et al, 2012). The range of interventions shown to be effective in SMI/SED has evolved considerably over the past twenty-five to thirty years as outlined in the PORT report (Kreyenbuhl et al., 2009) and detailed above in point 4.1.c. Evidence-based interventions such as social skills training, illness management and recovery, cognitive remediation, behavioral family therapy, interpersonal and social rhythm therapy, and CBTp can all be effective, depending on the consumer's circumstances and presenting problems. While generalist health services psychologists may have exposure, and even an emphasis, on evidence-based treatments for SMI/SED in their earlier training, it is typically only when engaged in a fellowship training with a Major Area of Study in SMI Psychology that trainees can devote enough time to provide these highly technical and complicated interventions under supervision to become proficient (Roe et al., 2006). Becoming proficient in these interventions is critical as staff

competency and fidelity to the evidence-based model is related to SMI/SED consumer outcomes in illness management and recovery (McGuire, et al., 2017) and supported employment (Becker, Smith, Tanzman, Drake, & Tremblay, 2001).

Foundationally, Specialty post-doctoral training programs with a Major Area of Study in SMI Psychology offer comprehensive instruction in the relevant evidence-based interventions designed specifically for this patient population (most are listed under item 1c above) (Chu, Eamons, et al., 2012b). Generally, this training involves supervised readings of relevant articles and manuals, as well as instruction and discussion about for whom the interventions are designed, and then supervised practice of the interventions to assure manual fidelity; it typically requires several months of supervised practice with several cases to become competent in these interventions.

It should be noted that many evidence-based treatments for the SMI/SED population are grounded in treatments that might be taught in a generalist health service doctoral or internship training program, but they must be substantially modified and adapted when used with the SMI/SED population. For example, CBTp shares similarities with CBT for depression, such as an emphasis on cognitive restructuring and behavioral activation. However, the two interventions have substantial differences, with CBTp including more attention to developing a therapeutic alliance across the first several sessions, as well as inclusion of material devoted to normalizing psychotic experiences as well as generating a shared conceptualization of the development of the psychosis (Kingdon & Turkington, 1994). Attaining expertise in these types of specialized interventions is a critical task when pursuing a Major Area of Study in a post-doctoral SMI Psychology Specialty training program.

Unique characteristics of the population also require adaptations to more commonly used interventions by the health services psychologist. Many persons with SMI/SED have high levels of suspiciousness, lack of insight, or negative symptoms, so treatment engagement can be challenging. Trainees in a Major Area of Study in the SMI Psychology Specialty need to be aware of these possibilities and the literature on treatment engagement in SMI/SED (e.g., Dixon, Holoshitz, & Nossel, 2016; Leclerc, Mansur, & Brietzke, 2013) and be taught practices such as motivational interviewing and alliance building, infused with a recovery orientation, appreciation of boundaries, and respect for self-determination, to address these impediments.

Learning to match those with SMI/SED to interventions is also no small achievement. For example, CBTp is very well regarded (Turner, van der Gaag, Karyotaki, & Cuijpers, 2014) but since the primary therapeutic work is challenging distorted beliefs, as originally manualized it is not always a good match for individuals who experience predominantly negative symptoms rather than delusions (Staring, ter Huurne, & van der Gaag, 2013). Trainees must be taught to adapt the intervention to the unique characteristics of the individual; consequently, learning to develop useful case formulation integrating psychological, cultural, clinical and historical data is a critical task in a Specialty training program in SMI Psychology (Carr & Miller, 2017). With specific reference to children, the Society of Clinical Child & Adolescent Psychology created a website to summarize evidence-based treatments for a broad range of child and adolescent mental health diagnoses. While many of these therapies are used for children and youth with SED, and therapies for children/youth with bipolar disorder are presented (effectivechildtherapy.org), the site does not include interventions for children/youth with psychotic-like symptoms or schizophrenia, further strengthening the need for specialty training.

Knowledge of useful intervention paradigms to integrate services

Many psychologists, and indeed, many practitioners in every health and mental health field, increasingly value evidence-based treatments for SMI/SED (Rousseau & Gunia, 2016), although some have concerns about the approaches (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). Importantly, research evidence has been accumulating that an integrated approach that combines multiple interventions within a recovery oriented context may be the most effective approach (Lyman, et al., 2014; Spaulding & Deogun, 2011) and scholars are increasingly calling for such an integrated, recovery

oriented system with SMI/SED (Davidson & Chan, 2014), and even suggesting an integrative approach may be optimal for individual psychotherapy for schizophrenia as well (Hamm, Hasson-Ohayon, Kukla & Lysaker, 2013). Above and behind learning a manualized intervention, learning optimal ways to integrate services is a critical task of fellowship training in this Specialty, and exceeds what is typically covered in generalist health services training (Mueser, Silverstein, & Farkas, 2013; Stacy, Klee, & Jansen, 2018).

Because of the depth and breadth of their symptoms, disabilities, and impairments, an overall framework for serving individuals with SMI/SED is critical to organizing services (Anthony, Cohen, Farkas & Gagne, 2002; Anthony, Howell & Danley, 1984; Farkas & Anthony, 1989). The model presented below is an approach to working with people with SMI and is titled the Choose, Get, Keep method; it is subsumed under the title of PSR, which is distinct from generalist health service psychology. The authors offered this conceptualization:

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

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

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

The integration framework involves tasks for the consumer (choosing a valued role, getting a valued role, and keeping a valued role) as well as processes for the provider (engaging the consumer, linking with existing worker/worker/student/ residential/social role opportunities, assessing critical skill and/or support strengths and deficits, assessing and developing readiness for opportunities and then creating them, developing skills to succeed in the preferred role, and developing supports to succeed in the preferred role). Person-centered planning and setting treatment goals are also key tasks (Farkas & Anthony, 2010)

Knowledge of shared decision making procedures and person involvement in planning and evaluating services

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

Active participation in treatment choice by consumers with SMI/SED diagnoses has been shown to have several benefits, including increased satisfaction with services and increased adherence (Adams & Drake, 2006; Fisher, Sharpe, Anderson, Manicavasagar, & Juraskova, 2018; Sajatovic et al., 2014). Additional benefits have been identified including the person's increased level of knowledge about their condition, increased self-efficacy, greater planning for coping with difficult situations, and increased knowledge of alternatives (Patel, Bakken & Ruland, 2008). Consumer involvement in designing and delivering mental health services (e.g., program planning, implementation, and evaluation) is increasingly seen as a critical component of a quality management system for any mental health service (Blackwell, Eilers & Robinson, 2000). Because there may be times when people with SMI/SED cannot make sound

decisions due to symptom flare-ups, preparation of an advance directive that provides guidance about the person's preferences in different situations has been recommended (Deegan & Drake, 2006). Training programs with a Major Area of Study in SMI Psychology include training in empowering those with SMI/SED to be more actively involved in their care and using shared-decision making. There are many readings available on strategies to empower SMI/SED consumers and enhance treatment adherence (e.g., Cañas et al., 2013) as well as training tools to promote shared-decision making (U. S. Department of Health and Human Services, 2010). Training in these process is integral to a training program with a Major Area of Study in SMI Psychology (Roe et al., 2006).

Understanding the importance of gender-specific and culturally sensitive services for the SMI/SED population

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

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

The importance of culturally sensitive services

As discussed more fully under criterion III, it is critical that training programs with a Major Area of Study in SMI Psychology provide targeted training addressing cultural, racial, and ethnic issues as they influence treatment engagement and participation (Chu, Eamons et al, 2012b). Typically, this training includes regular seminars, readings, interactions with members of different ethnic and cultural groups, and supervised work with consumers of different cultures and racial/ethnic groups over a period of 1-2 years. As we noted in our discussion of cultural issues in Criterion III, race and ethnicity, and cultural/immigrant status can play an influential role in the genesis of a psychiatric disorder as well as in influencing appropriate treatment. Being culturally competent and understanding these issues are part of the education and training in SMI Psychology Specialty programs at all levels of training and in treatment planning and its implementation. While much of our data in SMI/SED prevalence comes from

epidemiological studies of western cultures, mental health problems among non-white, minority cultural groups can be great, and the actual prevalence may be higher than reported due to a reluctance to access services or to report problems. For example, an increased risk of schizophrenia among first and second-generation immigrants, especially those from developing countries, has been noted (Kuniyoshi & McClellan, 2014). Cultural discontinuity and oppression have also been linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the most dramatic impact on youth (Kirmayer, Macdonald & Brass, 2000).

In light of the psychosis risk factors associated with minority and immigrant status, it is not surprising that investigators are now attempting to understand service utilization by these groups, and the problems identified thus far are concerning. Lack of culturally and linguistically appropriate services has been reported as a reason for the failure to access services by non-majority groups (Elliott, 2003). Additionally, many culturally distinct groups are not used to speaking frankly about problems and may speak in metaphors or use less descriptive words to describe their life situation or problem (Vasiliadis, et al., 2005), which often complicates treatment by professionals who may not understand the subtleties of these communications. Minority problems and issues are often not recognized by traditional service providers; this speaks to the importance of outreach to ensure access so that appropriate services are available for all who need them, and to the importance of specialized training for service providers, including psychologists. Nevertheless, it is important to note that culturally informed treatment can be very effective, and models such as those proposed by Paris et al. (2016) for a broad diagnostic group of U.S. Latino treatment-seekers. With regard to SMI/SED, Weisman de Mamani, Weintraub, Gurak, & Maura, (2014) and Kopelowicz, Zarate, Wallace, Liberman, Lopez, & Mintz, (2015) demonstrated efficacy in family interventions informed by cultural consideration for individuals diagnosed with schizophrenia.

c. Consultation

Being an effective consultant is an essential role for the SMI Psychologist (Levant et al., 2001; Roe et al., 2006), and didactic and experiential training in providing consultation is a core feature of SMI Psychology Specialty training programs (Carr & Miller, 2017). While the format of consultation conducted by most health service psychologists and that conducted by SMI Psychologists is similar; it is the specialized content, the distinctive population with whom they confer, and often the settings in which they do so, that distinguishes SMI Psychology Specialists (Carr & Miller, 2017; Chu et al., 2012a). As noted by Cohen et al. (2012) and Chu et al. (2012a), much of the consultant work in SMI/SED has evolved from the community mental health movement, so a good working knowledge of the history and tenets of that movement is essential. To be effective consultants on SMI/SED issues, psychologists must also have the theoretical and scientific knowledge to provide relevant disorder-specific information on symptoms, diagnosis, prognosis, etc. tailored to the needs and sophistication level of those to whom they consult; thus, they must possess the assessment and intervention knowledge described in point 4.2.a and 4.2.b immediately above, as well as expertise in the professional practices mentioned under point 3 below. In addition, to function as core members of interprofessional teams, SMI Psychologists must have knowledge of the roles of other professionals with whom they interact (e.g., medication prescribers, case managers, legal and medical personnel, vocational counsellors, etc.), both to facilitate relationship building and be respectful of appropriate professional boundaries.

Because individuals diagnosed with an SMI/SED typically rely on many psychological, social, and medical services, there are many “touchstones” in which psychologists can offer guidance and education to other professionals about optimal psychosocial care strategies, recovery-informed care, and shared decision-making. Providing information on the philosophy and practices of PSR can be a cornerstone to these consultative interactions. For example, SMI Psychologists often must confer with members of the legal and criminal justice system, as well as those who help individuals access resources such as social security disability payments, housing vouchers, appropriate health services, etc. With the growing emphasis on integrating behavioral and physical health services, (Crowley & Kirschner, 2015; Woltmann, Grogan-Kaylor, Perron, Georges, Kilbourne, & Bauer, 2012) and the high rates of health problems (DeHert et al., 2011) and early mortality in adults diagnosed with schizophrenia and bipolar illness

(Hoang, Goldacre, & Stewart, 2013; Hoang, Goldacre, & Stewart, 2013), it is perhaps not surprising that SMI Psychologists have an increasing opportunity to collaborate with internists and general medical practitioners who are managing the medical care of individuals diagnosed with SMI/SED. This can include the psychologist inquiring about side-effects and medication adherence during patient meetings and sharing information with prescribers and other medical providers as appropriate. If the clients with whom they work are living in restrictive settings (e.g., locked hospital ward or residential facility), SMI Psychology Specialists may be asked to consult on the development of behavioral intervention plans to be implemented by paraprofessional staff, de-escalate aggressive situations and promote pro-social behavior (Carr & Miller, 2017; Cohen et al., 2012). Because of the impact of medical co-morbidities on older adults, integrated care for this group of individuals is important (Bartels, et al., 2004). Finally, these residents must learn to facilitate community (re)integration in their clients, by knowing community resources and being able to use direct encouragement and the social network of the client to anticipate and overcome barriers to community involvement.

SMI Psychologists are often also called on to consult with the relatives of the persons whom they are treating, and must become conversant with emerging best practices, such as Consumer-Focused Brief Family Consultation (Jewell et al., 2012). They may be advising families about how to access care for their loved one, or how to support engagement in treatment. Psychologists working with children and adolescents diagnosed with SED consult with a wide variety of professionals including pediatricians, child psychiatrists, child protection workers, teachers, nurses, social workers, school and community counselors, lawyers, and others concerned about the child or adolescent.

Trainees must be knowledgeable about basic forms of mental health consultation and models as outlined by experts such as Caplan and Caplan (1999). In an SMI Psychology post-doctoral training program, this may be acquired from formal study, from modeling experienced consultants, and from supervised experience (Chu et al., 2012b). Training in consultation in an SMI Psychology Specialty fellowship program must include both clinical consultation and organizational consultation (Chu, Emmons et al., 2012b). Clinical consultation involves working with other professionals to improve outcomes of a specific client, while organizational consultation involves working to improve systems of care (Carr et al., 2017). The SMI Psychologist must be comfortable and capable of working in the unique environments in which SMI/SED consultation is conducted, (e.g., hospitals, medical clinics, mental health centers, residential settings, courts and juvenile justice agencies, public welfare agencies, etc.) (Carr et al., 2014). Organizational consultation may include training in providing mental health instruction (e.g., Crisis Intervention Training) to first responders (e.g., police and public safety, emergency medical technicians) for risk situations involving individuals with SMI/SED (Watson & Fulambarker, 2012) as well as training for other systems of care on principles of PSR and recovery-oriented care in a respective, positive manner.

d. Supervision

Training in clinical and administrative supervision is a core component of preparation in this Major Area of Study at the post-doctoral level (Cohen et al., 2012; Chu et al., 2012a; Carr et al., 2017). Because of their challenges with community functioning, many individuals diagnosed with SMI/SED rely on the care of individuals with a wide-range to professional backgrounds, and many of these individuals are paraprofessionals or peer providers. Importantly, the complexity of the treatment of SMI/SED significantly influences the training of post-doctoral residents and fellows in how to conduct supervision with more junior trainees of all mental health disciplines, making specific training of this competency within this population distinctive and important (Roe et al., 2006; Cohen et al., 2012). In fact, in a broad survey of the competencies psychologists need to work in public mental health settings, Chu, et al., (2012a) found that providing supervision was ranked as the most important functional skill. Thus, in addition to supervising more junior trainees in the discipline of psychology, training in a Major Area of Study in SMI Psychology must include training in supervising paraprofessionals and peer providers (Cohen et al., 2012). In many hospital, residential, and community mental health settings, the psychologist is supervising professionals from other disciplines, unlicensed line staff, and individuals with

lived experience providing services to clients (Chinman et al., 2017); learning to supervise these disparate groups requires instruction on the needs, job descriptions, roles, and professional rewards specific to each group (Roe et al., 2006). Emphasizing a strengths-based approach and building on competencies are also essential attitudes and skills, with which junior supervisees often need assistance to implement in a meaningful way (McCammon, 2012). Supervision trainees must also build on their prior learning of the evidence-based interventions for SMI/SED, and build competence in using valid fidelity instruments (McGuire, et al., 2012) so they can provide accurate feedback to more junior supervisees.

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

Post-doctoral SMI Psychology trainees must acquire knowledge needed to supervise more junior trainees learning or performing under complex, often unfamiliar conditions. For example, those who are supervised often need assistance in implementing interventions in non-traditional settings, outside of office or agency settings. Further, severity of some client/patient behaviors may require that the supervisor address such issues as how to interact therapeutically with those engaging in bizarre speech or experiencing delusions or hallucinations so that the care provider is neither invalidating nor colluding with the illness. The supervisor may also need to assist supervisees with strategies for managing clients/patients engaging in disturbing behavior in public, engaging in aggressive behavior, becoming paranoid or suspicious of the clinician, or engaging in risky behavior. The supervisee also benefits from guidance from the training supervisor on strategies to engage patients/clients with SMI/SED and prevent attrition from care, as lack of insight about need for treatment is common (Henriksen & Parnas, 2013), and its prevalence contributes to the need for a Specialty training program in SMI Psychology. Supervisees also benefit from learning how to train more junior colleagues to anticipate and weather the non-linear pace of progress experienced by many individuals with SMI/SED and to monitor themselves for unconscious bias and stigmatizing thoughts.

Attention to cultural issues is a core aspect of learning to be a supervisor in SMI/SED. While cultural competence is essential in therapeutic interventions with all types of clients/patients, this may be of particular importance in distinguishing unusual behaviors from culturally divergent ones, and may have profound impact on understanding and assisting diverse clients with SMI/SED as they develop therapeutic alliances, and as they face stereotypes, oppression, and bias in the community. An additional challenge faced by training supervisors is guiding more junior trainees as they engage in patient

advocacy and social justice interventions for their SM/SED clients (Carr, Bhagwat, Miller, & Ponce, 2014). Both on an individual and a community level, advocacy for clients in these populations is needed, and has been conceptualized as a core competency in the Specialty (Carr et al., 2014; Chu, et al., 2012a). Supervisors may need to assist trainees to gain knowledge and skills in combining the practitioner role with community engagement, and learning strategies to promote organizational change (Carr et al., 2014; Toporek & Vaughn, 2010).

e. Research & Inquiry

Training in conducting and consuming research is a core competency in the SMI Psychology postdoctoral Specialty (Roe et al., 2006; Carr & Miller, 2017; Chu, et al., 2012a; Stacy, Klee, & Jansen, 2018). Besides basic research training, there are three very distinctive issues in SMI/SED research that are central aspects of the SMI/SED research knowledge base and have most salience when conducting research with the SMI/SED population (Gupta, & Kharawala, 2012). The first of these involves assuring one has obtained informed consent (or assent if working with children) for research participation in this vulnerable population. Persons diagnosed with SMI/SED often have cognitive difficulties which might preclude them thoroughly comprehending the procedures and intent of a research project for which they are eligible. It is essential that SMI/SED researchers take extra precautions to assure studies are adequately explained to potential participants and that these participants are queried about what they understand about the study prior to joining it in order to assure they are giving free and informed consent as they enter (Appelbaum, 2006). Fortunately, Fischer, et al., (2013) published a recent paper demonstrating that if careful recruitment and consent procedures are followed, individuals diagnosed with schizophrenia can understand and retain the information about a study through one-year follow-up. Trainees in the Specialty must be provided with information and use strategies to confirm comprehension of study details and competence to provide informed consent with this population (Klein et al., 2018; Wirshing, Wirshing, Marder, Liberman, & Mintz, 1998).

The second issue involves working with local IRB boards around research issues pertaining to the SMI/SED population (Gupta & Kharawala, 2012). Because individuals with a psychosis represent a vulnerable population, and are often provided treatment in restrictive settings, IRB members often have concerns about what strategies and policies should be in place to protect subjects. There is often a tension between participant self-determination and protection against risk, especially when considering the rights of those with potentially impaired capacity to consent. Many IRB board members have little or no experience with psychosis, and may tend to be over-protective of the population, thus depriving potential research participants of their right to be in a study. SMI/SED researchers may need to educate these members on critical issues when conducting research with this population, such as the importance of participant autonomy and self-determination while still not subjecting individuals to undue risk.

The third distinctive issue involves including individuals with lived experience, and their carers, that is, individuals with a diagnosis of SMI/SED and their loved ones, as part of the team designing and conducting the research trial (Kara, 2013). This effort reflects the greater community-based participatory research initiative, which is especially active in the SMI/SED lived experience community. Over approximately the last 10 years, there has been growing advocacy, especially within the SMI/SED consumer movement, to include service users as full members of research teams. Standard operating procedures for doing so are being crafted (Evans et al., 2013), and a Lived Experience Research Network was established (<https://livedexperianceresearchnetwork.wordpress.com>). However, for many researchers in the area, this has not been an easy transition, and more support is needed to assist SMI/SED researchers in including service users in their work (Staley, Kabir, & Szmukler, 2013). In a training program with a Major Area of Study in SMI Psychology, trainees need to learn about the movement, read the relevant literature (i.e., Jones & Shattell, 2016), and have exposure to teams committed to involve all stakeholders in co-production of relevant research.

f. Public Interest

Distinct from many other specialties, advocacy is conceptualized as a core professional task in this Specialty, which merits some exposure in pre-doctoral training (Reddy et al., 2010) and formal training at the post-doctoral level (Carr & Miller, 2014; Stacy, Klee, & Jansen, 2018). Psychologists who work with those with SMI/SED diagnoses are especially sensitive to issues of social injustice, discrimination, and health care disparities because they work with consumers who often have limited financial resources, may be dependent on the greater society for their upkeep, livelihood, and medical care, and who are frequently stigmatized by society (Pescosolido, 2013; Parcesepe & Cabassa, 2013). While these psychologists often must advocate for the specific needs of those whom they treat, many SMI Psychologists have also assumed a role in wider advocacy work, and opportunities to acquire skills in advocacy are an important part of the Specialization training in SMI Psychology (Chu, et al., 2012b). Typically, this training involves reading seminal works in the area, classroom lecture and discussion, and assuming responsibility for a small project around social justice/SMI/SED issues such as homelessness (Stacy, Klee, & Jansen, 2018) over the course of the fellowship period.

SMI Psychologists also have a long and rich history of advocacy to protect the public welfare (see, for example, Rosenthal & Rubenstein, 1993) including assuming a leadership role in fighting the repeal of the Affordable Care Act and for passage of the 21st Century Cures Act. For example, at the APA annual meeting in 2014, members of APA Division 18 (Psychologists in Public Service) debated former Rep. Tim Murphy about provisions in early versions of the 21st Century Cures Act that might have led to coercive treatment of SMI/SED clients; fortunately, these concerns were addressed in the final version of the bill. APA also has a component of the governance structure, the APA Task Force on SMI/SED, a member of this Specialty Council, which works closely with its parent group (the Board of Professional Affairs) around advocacy activities, especially regarding federal legislation. The overall advocacy work on SMI/SED conducted by APA and led by many SMI Psychologists is described in <https://www.apa.org/monitor/2014/12/ceo.aspx>. Of course, in this work, SMI Psychologists follow the ethical principles set forth by APA as well as the state regulations required by their licensure.

SMI Psychologists have also formed productive partnerships with other community stakeholders, including the National Alliance on Mental Illness (NAMI), the Mental Health Association, and consumer's groups, to develop public health and educational campaigns. Psychologists concerned about the use of excessive police force in interactions with seriously mentally ill individuals were instrumental to the development of the Critical Incident Training program in Memphis (Watson & Fulambarker, 2012), which has spread nationally and internationally. Psychologists have taken a prominent role in fighting the stigma associated with an SMI/SED diagnosis (Gaskin, 2015; Jones & Corrigan, 2014). Psychologists with special interest in SMI/SED issues have assumed a role in developing public policy through the work of federal employees such as Robert Heinssen, Ph.D. Director, Division of Services and Intervention Research, National Institute of Mental Health, who led the Recovery After an Initial Episode of Schizophrenia (RAISE) initiative (Mueser & Cook, 2014) which led to a dramatic national increase in block grant funding for first episode psychosis, mandated by Congress (Goldman & Karakus, 2014; Heinssen, 2018). Psychologists in the Department of Veterans Affairs have fostered the development and dissemination of recovery oriented care and evidence-based practices within in the VA (Karlín, & Cross, 2014) which has included specialty training in treatments for SMI such as social skills training (Bellack, Mueser, Gingerich, & Agresta, 2013) and behavioral family therapy (Mueser & Glynn, 1995). The VA has also taken a leadership role in developing a post-doctoral training program in PSR to meet the needs of persons diagnosed with SMI/SED, which has profoundly changed VA care nationally (Cohen et al 2012; Stacy, Klee, & Jansen, 2018).

There are several prominent thought leaders/psychologists with lived experience of SMI such as Drs. Fred Frese (recently deceased), Pat Deegan, Irene Harris, and Nev Jones who all demonstrate through their scholarship, public advocacy, and lives that recovery from serious psychiatric illness is possible. A key aspect of SMI/SED education is acquainting trainees about these efforts by psychologists working to improve the public welfare, and helping trainees make linkages with relevant groups, such as Division 18, Psychologists in Public Service, should the trainee wish to affiliate with them.

A final issue with regard to public interest is the prominent role psychologists with expertise in SMI/SED can and do play in understanding and intervening around violence related to serious psychiatric illnesses. Large scale reviews confirm that individuals diagnosed with SMI/SED are more likely to be victims of all forms of violence than the general population, with victimization prevalence in the order of 15–45% in the last year, and 40–90% over a lifetime (Choe, Teplin, & Abram, 2008; Maniglio, 2009). Individuals diagnosed with an SMI/SED are also more likely to be victims rather than perpetrators of violence (Choe, Teplin, & Abram, 2008; Desmarais, Van Dorn, Johnson, Grimm, Douglas, & Swartz, 2014). However, those diagnosed with SMI/SED are more likely, compared to the general population, to perpetrate violence as well (Fazel, Gulati, Linsell, Geddes, & Grann, 2009), and comorbid substance use significantly increases the risk of perpetration (Fazel, Gulati, Linsell, Geddes, & Grann, 2009). In addition to substance abuse, both psychological and pharmacological treatment non-adherence are significant risk factors for violence in this population (Witt, van Dorn, & Fazel, 2013). Mental health professionals, and especially psychologists with expertise in schizophrenia and other psychotic disorders, can play a key role in identification of, supporting treatment adherence in, and developing preventive programming for individuals diagnosed with SMI/SED who are at increased risk for physical aggression, thus resulting in an overall reduced rate of community violence (Mullen, 2006).

g. Continuing Professional Development

As advances in our understanding and treatment of SMI/SED continue apace, so too have the efforts of the Specialty Council and individual members of the Specialty to translate those advances into clinically useful and relevant practices for the field. This has occurred in multiple ways evidencing the growth of the Specialty over the past several years. We have described these elsewhere in this petition and provide information about them below as well.

Several years ago the initial work of the Specialty was led by the APA Task Force on SMI and SED. In 1999 and 2000, the Task Force presented two mini-conventions at the annual APA convention. Since then, the Task Force and other Specialty Council members have organized convention symposia, discussion sessions and full day CE workshops designed to enhance the practice skills of psychologists working with persons with SMI/SED. For example:

- For more than 14 consecutive years, the Specialty has coordinated several APA convention CE offerings including five full day CE workshops and several symposia offered for CE credit. Beginning in 2004, and continuing to the present, members of the Council have offered symposia on SMI/SED. Interest in these offerings has been substantial, garnering between 100 and 150 attendees each year, with some of the symposia attendance topping 200 attendees. Beginning in 2012, the SMI/SED Section of Division 18 also began sponsoring symposia; more recently, other divisions have followed suit and as a result, the number of convention offerings on SMI/SED topics has increased considerably. Feedback has consistently indicated that training is needed to help psychologists work more competently with persons with SMI/SED and these symposia have sought to meet this need. In addition to the many symposia offered by members of the Specialty Council, beginning in 2010 and continuing through 2018, the Specialty Council has presented five full day CE workshops; these have also been highly rated, receiving ratings above 4.5 each time workshops were presented. Workshop titles are:

- New Interventions and Perspectives for Practitioners Treating Those with Serious Mental Illnesses, August, 2010.
- Treating Adults and Adolescents with Serious Mental Illness: Using EBPs in Clinical Practice, August, 2011.
- New and Emerging Clinical Practices for Treating People with Serious Mental Illness, August, 2012.
- Recent Advances in Evidence Based Practices to Help People Recover from Serious Mental Illnesses August, 2014.

- Evidence Based Interventions for First Episode Psychosis - RAISE-ETP & Beyond, August, 2018.
- In addition to yearly presentations at the APA convention, members of the Council also routinely present at other national and international research and training conferences such as the Association of Behavioral and Cognitive Therapies (ABCT), the Psychiatric Rehabilitation Association (PRA), the International Congress on Schizophrenia Research of the Schizophrenia International Research Society (SIRS), among others. Many of these sessions are offered for CE credit, both for psychologists and for members of other disciplines.
- Similarly, as noted in this Criterion and elsewhere in this petition, Specialty Council members publish regularly in highly respected journals in the Specialty and are very much respected in this field; sometimes these papers can be read for continuing education credits as well.
- Additionally, the APA Task Force and the APA Office of Continuing Education collaborated on the development of a four part CE series on SMI/SED entitled “APA CE Webinar Series on Serious Mental Illness and Severe Emotional Disturbance”; this four part CE webinar was presented by Council members. Each of the four parts can be taken for CE credit individually or the full series can be taken for CE credit. The webinars are available for a nominal fee; the series is available on the APA CE on-line portal and has been highlighted on the CE website. The series may be found under the topical headings of Clinical Psychology or Professional Resources for Practice. As listed on the APA CE website, the four titles are:
 - Webinar I: Assessment, Engagement, and Ethical Considerations
 - Webinar II: Clinical Interventions and Ethical Issues
 - Webinar III: Interventions for Special Populations - Specialized Training for Ethical Practice
 - Webinar IV: Interventions for Management & Policy Positions – Ethical Responsibilities, Training the Next Generation of Psychologists
- In 2010, APA received funding from SAMHSA to develop a Curriculum to train psychologists for work with individuals with SMI/SED. The Curriculum is entitled *Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders* and was completed and published in 2014 (American Psychological Association & Jansen, 2014) and is posted on the APA website <http://www.apa.org/pi/mfp/psychology/recovery-to-practice/training.aspx> and on the Specialty Council website (www.psychtrainingsmi.com). Since publication of the Curriculum, the leaders of the Specialty Council (the APA Task Force, Division 18, the Division 18 Section on SMI/SED, and the ABCT SIG) have been instrumental in promoting its use at the APA convention, at meetings of the various psychology training councils, and within graduate-level training programs. Specialty Council members have also given presentations at non-APA meetings, sparking interest in the curriculum among other professional groups as well. Most recently, material from the APA Curriculum was presented (and very well received) in a year-long series of webinars for mental health professionals from a wide range of disciplines who work in behavioral health settings across the US. These presentations were sponsored by Advocates for Human Potential via a contract from SAMHSA. Through this contract, presentations were given at several national and international meetings and at APA conventions and Division meetings. Another example of the Curriculum’s reach is its promotion by the Texas based Hogg Foundation which to date, has sponsored two statewide conferences for psychology training directors and their students. Most of these presentations have been offered for CE credit, both for psychologists and for providers in other disciplines. Work is underway for additional presentations at various regional and national psychology meetings and conferences – these would be offered for CE credit as well.

There are also several other resources for psychologists with a Specialty in SMI Psychology to continue to develop their knowledge and skills. These include attending professional workshops and

presentations at meetings of organizations such as those mentioned above (the American Psychiatric Association, the American Association of Community Psychiatrists, the Association for the Advancement of Behavioral and Cognitive Therapies, the Psychiatric Rehabilitation Association, the Schizophrenia International Research Association, and the International Early Psychosis Association); joining these organizations is also very valuable. The VA, SAMHSA, and APA Division 18 all provide webinars of interest to those with a Specialty in SMI Psychology.

Important SMi/SED articles found in journals such as:

- *British Journal of Psychiatry*
- *British Journal of Psychology*
- *Early Intervention in Psychiatry*
- *Journal of Abnormal Child Psychology*
- *Journal of Abnormal Psychology*
- *Journal of Affective Disorders*
- *Journal of Clinical Child and Adolescent Psychology*
- *Journal of Consulting and Clinical Psychology*
- *Psychiatric Rehabilitation Journal*
- *Psychiatric Services*
- *Psychological Medicine*
- *Psychological Services*
- *The Rochester Symposium on Developmental Psychopathology*
- *Schizophrenia Bulletin*
- *Schizophrenia Research*
- *World Psychiatry*

Other training curricula are also available such as:

- *Person-centered Care: From Theory to Practice (Tondora, 2011)*
- *Practice Guidelines for Recovery-Oriented Behavioral Health Care (Tondora & Davidson, 2006)*
- *Project GREAT Recovery Based Training Procedures Manual (Mabe & Fenley, 2008).*

3. Identify professional practice activities associated with the specialty in each of the following domains and how they differentiate and where they might overlap with other specialties.

The specific practices developed in a post-doctoral Major Area of Study Specialty in SMI Psychology are grounded in the general health service psychology skills gained in a doctoral program and clinical internship. For example, Rogers (1951) has spoken eloquently about the value of practitioner genuineness (openness and self-disclosure), acceptance (being seen with unconditional positive regard), and empathy (being listened to and understood) as a foundation for client growth. However, these factors, while necessary, are typically insufficient when working with a consumer who is manic, delusional (possibly paranoid), or preoccupied with internal stimuli. Here, additional skills, such as implementing strategies to enhance and focus attention to the interviewer, using Socratic questioning and being non-confrontational about points of disagreements, scheduling briefer but more frequent meetings, involving

supportive others in sessions and treatment, relaxing out-of-session assignment expectations, and permitting more limit-testing and bizarre behavior during face-to-face encounters, may all be appropriate. Thus, both shared and distinctive practices have a role in work with this population. The distinctive skills and competencies are only gained with focused, intensive, didactic and experiential training provided in a uniquely designed and supervised post-doctoral residency program with a Major Area of Study in SMI Psychology.

Members of the SMI Psychology Specialty have met and reviewed the expansive literature on appropriate Specialty practices for this population, and have generated and categorized distinctive practices and those shared by other specialties. Though the lists are not exhaustive, the council has worked diligently to capture the practices *considered of most relevance* here. These are shown below in table format:

Professional Practice Activities/Functional Competencies

I. Assessment	Essential to SMI/SED	Important to SMI/SED	Distinctive to SMI/SED	Shared with Generalists or Other Specialties
Assess for internalized stigma, recovery orientation, and level of insight in individuals with SMI/SED	X		X	
Utilize specialty interview assessments (e.g. the Positive and Negative Syndrome Scale, the Brief Psychiatric Rating Scale) to assess and monitor the symptoms commonly associated with SMI/SED (i.e. psychosis, mania, and negative symptoms)	X		X	
Assess presence of social network and family attitudes (e.g. expressed emotion) and burden in the family members/loved ones/caregivers of individuals with SMI/SED	X		X	
Recognize the complexity of and demonstrate competence in assessing late onset psychosis in old age and differentiate it from dementia	X		X	
Identify factors that may contribute (e.g. metabolic syndrome) to the shortened lifespan and health risks of individuals with SMI/SED	X		X	
Assess and evaluate contribution of trauma expression and PTSD to SMI psychotic symptoms	X		X	
Integrate the intersection of diversity related to age, cultural, spiritual/religious beliefs, etc. specifically related to the presentation of symptoms unique to SMI/SED	X		X	

Identify barriers (psychological, legal, financial, etc.) to community re-integration after hospitalization, jail, or residential placement	X		X	
Recognize and screen for potential cognitive deficits that are core areas of dysfunction for people with SMI/SED including processing speed, verbal memory, and attention using specialized assessment techniques	X			X
Diagnose each SMI accurately in spite of shared symptomatology and SUD comorbidities	X			X
Utilize a strengths-based approach to assessment	X			X
Assess for medication side effects, medication adherence, and barriers to adherence	X			X
Assess community and social functioning	X			X
Assess psychosocial capacity for education and employment as part of the completion of disability applications	X			X
Elicit accurate information from consumers with anosognosia or who are reluctant to disclose symptoms	X			X
Assess for suicide and violence risk; utilize more structured assessments measures (e.g. Historical, Clinical, Risk Management-20) as appropriate	X			X
Incorporate biological, social/cultural, and psychological variables in an individual's case conceptualization and demonstrate an understanding of how these factors impact the development and maintenance of SMI/SED	X			X

II. Intervention	Essential	Important	Distinctive	Shared
Demonstrate comprehensive knowledge of schizophrenia PORT recommended evidence-based (e.g. Assertive Community Treatment, Supported Employment) and promising practices (e.g. Cognitive Remediation, Peer Support Services)	X		X	

Appropriately match individuals with SMI/SED to PSR services based on the person's goals and preferences	X		X	
Provide schizophrenia PORT recommended psychological interventions (e.g. CBT for Psychosis) and other promising practices (e.g. cognitive remediation) for individuals with SMI/SED at the individual and the group level competently and with fidelity	X		X	
Adapt existing empirically supported treatments to accommodate the cognitive deficits associated with SMI/SED at both the individual and the group level	X		X	
Increase motivation in individuals who are highly symptomatic (e.g. experiencing positive and negative symptoms) and reluctant to engage in treatment	X		X	
Address the internalized stigma commonly associated with a diagnosis of SMI/SED and promote hope and a sense of empowerment at both the individual and the group level	X		X	
Address the effects of trauma in individuals with SMI/SED given the high rates of trauma and posttraumatic stress disorder in this population and the need for specialized treatment	X		X	
Address the increased health risks and early mortality of individuals with SMI/SED using interventions tailored to the population (e.g. specialized interventions for smoking cessation and obesity)	X		X	
Provide illness education and specialized evidence-based family-based interventions (e.g. behavioral family therapy) to individuals with SMI/SED and their family members/loved ones/caregivers	X		X	
Facilitate reintegration into the community by addressing barriers to community reintegration in partnership with individuals with SMI/SED and other disciplines	X		X	
Implement evidence-based first-episode of psychosis interventions	X		X	
Demonstrate an ability to competently	X		X	

provide interpersonal and social rhythm therapy (IPSRT) and Family Focused Treatment (FFT) for bipolar disorder				
Promote and support use of peer-based interventions such as the Wellness Recovery Action Program (WRAP)		X	X	
Build therapeutic rapport and compensate for lack of insight when providing evidence-based practices in various settings, including mandated treatment settings	X			X
Use shared-decision making in designing comprehensive and effective treatment plans	X			X
Address risk for violence towards self and others	X			X
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	X			X
Collaboratively explore the benefits and drawbacks of psychiatric medication and promote insight and medication adherence when appropriate	X			X
Integrate all information into a case formulation that uses psychosocial interventions designed to promote recovery and attainment of the goals articulated by each person	X			X
Provide 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		X		X

III. Consultation	Essential	Important	Distinctive	Shared
Provide consultation and training to staff at various levels of an organization on PSR principles	X		X	
Provide consultation and training to other members of an interprofessional team on assessment results, treatment progress, and	X		X	

the role of psychology in PSR				
Consult with the appropriate disciplines (e.g. physicians, dieticians) to address the early mortality of individuals with SMI/SED	X		X	
Provide education and training for mental health staff on all aspects of the recovery paradigm and PSR practices	X		X	
Assess an organization's barriers to implementing PSR services	X		X	
Design and implement PSR programs and services at the systems level	X		X	
Integrate the knowledge, values, and attitudes critical for successful work with people with SMI/SED into interprofessional team settings to facilitate shared decision making	X		X	
Provide psychoeducation to family members/loved ones/caregivers of individuals with SMI/SED	X		X	
Provide consultation to community agencies on step-down processes for the reintegration of individuals with SMI/SED into community settings		X	X	
Provide mental health training (e.g., Crisis Intervention Training) to first responders (e.g., police and public safety, emergency medical technicians) to crisis situations involving individuals with SMI/SED		X	X	
Provide consultation and training to staff at various levels of an organization on behavioral management and de-escalation techniques for individuals who are acutely psychotic and/or manic		X	X	
Provide psychoeducation to family members/loved ones/caregivers of individuals with SMI/SED	X		X	
Present information and develop treatment recommendations that are understandable to the person, his or her support team, and in accord with his or her goals	X			X

IV. Supervision	Essential	Important	Distinctive	Shared
------------------------	-----------	-----------	-------------	--------

Supervise graduate students, interns, and postdoctoral fellows in the assessment and treatment of individuals with SMI/SED using PSR principles	X		X	
Supervise non-psychology staff with varying levels of education and from various disciplines in the provision of PSR services	X		X	
Impart knowledge of the phenomenology of the disorders of SMI/SED (e.g., auditory hallucinations, negative symptoms such as diminutions of basic drives, etc.)	X		X	
Supervise staff at multiple levels of an organization from various disciplines in the process of community reintegration of individuals with SMI/SED	X		X	
Help trainees use self-disclosure to normalize SMI experience with clients	X		X	
Promote self-examination of fear and pre-conceptualization of people with SMI/SED including stigma and self-efficacy		X	X	
Supervise peer specialists with understanding of their unique role in PSR and the challenges they face (e.g. co-optation)		X	X	
Supervise graduate students, interns, and postdoctoral fellows in risk mitigation	X			X
Train trainees in use of standardized tools for fidelity measures and ability to supervise trainees in their use	X			X
Impart an understanding of the pace and non-linear process for recovery and ability to develop positive expectations for the person's progress despite the combination of social, functional, and cognitive impairments that are commonly observed	X			X

V. Research & Inquiry	Essential	Important	Distinctive	Shared
Incorporate individuals with lived experience of SMI/SED into all aspects of research and evaluation from conception to publication	X		X	
Incorporate family members/loved ones/caregivers of persons with lived experience and of SMI/SED into all aspects of	X		X	

research and evaluation from conception to publication				
Assess the decisional capacity of individuals with SMI/SED to provide informed consent, or obtain informed consent from legal guardians	X		X	
Apply for research funding with knowledge of effective recruitment strategies and ethical considerations specific to this population		X	X	
Inform and educate IRBs about the type of intervention research common with SMI/SED populations such as psychosocial interventions		X	X	
Demonstrate knowledge of and ensure additional protections for prisoner populations, who are psychiatric inpatients, in research projects	X			X
Recognize the needs of vulnerable populations vis a vis their participation in research efforts; protect as warranted	X			X
Identify appropriate outcomes for program evaluation efforts due to broad nature of quality of life, psychosocial functioning, and recovery		X		X

VI. Public Interest	Essential	Important	Distinctive	Shared
Advocate for and alongside individuals with SMI/SED to other health professionals, family members/loved ones/caregivers, organizations/institutions, and the public in order for individuals with SMI/SED to engage in meaningful activities (e.g. to work, go to school, be in relationships, etc.) without unnecessary restrictions	X		X	
Demonstrate knowledge of community resources and ability to reach out to these as a means of expanding access to services for people with SMI/SED	X		X	
Demonstrate knowledge of the Americans with Disabilities Act and its amendments and application to those with SMI/SED	X		X	
Demonstrate knowledge of laws that affect individuals with SMI/SED negatively and may lead to human rights violations (e.g., laws	X		X	

about competency to stand trial, not guilty by reason of insanity, etc.)				
Contribute to the de-stigmatization of SMI/SED through advocacy efforts	X		X	
Create opportunities for people with SMI/SED to meet and interact with others with and without SMI/SED, build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion		X	X	
Provide consumers with opportunities to do advocacy work or join the consumer recovery movement		X	X	
Serve on risk review committees to manage the risk posed by individuals with SMI/SED and a history of violence		X		X

VII. Continuing Professional Development	Essential	Important	Distinctive	Shared
Affiliate with professional organizations whose mission it is to advance knowledge and practice in PSR	X		X	
Demonstrate knowledge and understanding of the APA Recovery to Practice Curriculum, the NICE Clinical Practice Guidelines and other professional practice research and materials necessary to remain current with the Specialty		X	X	
Engage in continuing education and life-long learning activities to strengthen existing competencies and add new competencies in the assessment and treatment of individuals with SMI/SED	X			X

References

- Accurso, E. C., Taylor, R. M., & Garland, A. F. (2011). Evidence-based practices addressed in community-based children's mental health clinical supervision. *Training and Education in Professional Psychology*, 5, 88-96.
- Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. (2006). *Women, Mental Health and Mental Illness and Addiction in Canada: An Overview*. Canadian Women's Health Network and the Centres of Excellence for Women's Health. Winnipeg, MB: Author.

- Adams, J. R. & Drake, R. E. (2006). Shared decision-making and evidence-based practice. *Community Mental Health Journal*, 42, 87–105.
- Adams, J. R., Drake, R. E. & Wolford, G. L. (2007). Shared decision-making preferences of people with severe mental illness. *Psychiatric Services*, 58, 1219–1221.
- Addington, D., Addington, J., & Maticka-Tyndale, E. (1993). Assessing depression in schizophrenia: The Calgary Depression Scale. *British Journal of Psychiatry*, 163 (Suppl 22), 39-44.
- Addington, D., Addington, J., & Maticka-Tyndale, E. (1994). Specificity of the Calgary Depression Scale for schizophrenics. *Schizophrenia Research*, 11, 239-244.
- Addington, J., El-Guebaly, N., Campbell, W., Hodgins, D. C., & Addington, D. (1998). Smoking cessation treatment for patients with schizophrenia. *American Journal of Psychiatry*, 155, 974-975.
- Amador, X. F., Flaum, M., Andreasen, N. C., Strauss, D. H., Yale, S. A., Clark, S. C., & Gorman, J. M. (1994). Awareness of illness in schizophrenia and schizoaffective and mood disorders. *Archives of General Psychiatry*, 51, 826-836.
- American Psychological Association. (2017). Public description of clinical psychology. Retrieved from <http://www.apa.org/ed/graduate/specialize/clinical.aspx>.
- American Psychological Association. (2017). Public description of forensic psychology. Retrieved from <http://www.apa.org/ed/graduate/specialize/forensic.aspx>.
- American Psychological Association, & Jansen, M. A. (2014). *Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders*. Washington, DC: American Psychological Association.
- Andreasen, N. C. (1989). The Scale for the Assessment of Negative Symptoms (SANS): Conceptual and theoretical foundations. *The British Journal of Psychiatry*, 155, 49-52.
- Angold, A., & Costello, E. J. (2000). The child and adolescent psychiatric assessment (CAPA). *Journal of the American Academy of Child & Adolescent Psychiatry*, 39, 39-48.
- Anthony, W. A., Cohen, M. R., Farkas, M. D. & Gagne, C. (2002). *Psychiatric Rehabilitation*, 2nd ed. Boston (MA): Boston University, Center for Psychiatric Rehabilitation.
- Anthony, W. A. & Farkas, M. D. (2009). *A Primer on the Psychiatric Rehabilitation Process*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.
- Anthony, W. A., Howell, J. & Danley, K. S. (1984). Vocational Rehabilitation of the Psychiatrically Disabled. In M. Mirabi (Ed.). *The Chronically Mentally Ill: Research and Services*. Jamaica, NY: Spectrum Publications.
- Anthony, W., Rogers, E. S. & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, 39, 101–114.

- Appelbaum, P. S. (2006). Decisional capacity of patients with schizophrenia to consent to research: Taking stock. *Schizophrenia Bulletin*, 32, 22–25.
- Armando, M., Pontillo, M., & Vicari, S. (2015). Psychosocial interventions for very early and early-onset schizophrenia: A review of treatment efficacy. *Current Opinion in Psychiatry*, 28, 321-323.
- Arnold, L. M., Keck Jr, P. E., Collins, J., Wilson, R., Fleck, D. E., Corey, K. B., ... & Strakowski, S. M. (2004). Ethnicity and first-rank symptoms in patients with psychosis. *Schizophrenia Research*, 67, 207-212.
- Bahorik, A. L., Newhill, C. E., Queen, C. C., & Eack, S. M. (2014). Under-reporting of drug use among individuals with schizophrenia: Prevalence and predictors. *Psychological Medicine*, 44, 61-69.
- Baltieri, D. A., & De Andrade, A. G. (2009). Schizophrenia modifying the expression of gender identity disorder. *The Journal of Sexual Medicine*, 6, 1185-1188.
- Barker, S., Barron, N., McFarland, B. H., & Bigelow, D. A. (1994). A community ability scale for chronically mentally ill consumers: Part I. Reliability and validity. *Community Mental Health Journal*, 30, 363-383.
- Barker, S., Barron, N., McFarland, B., & Bigelow, D. (1994). *Multnomah Community Ability Scale: User's Manual*. Portland, OR: Western Mental Health Research Center, Oregon Health Sciences University.
- Barnes, A. (2008). Race and hospital diagnoses of schizophrenia and mood disorders. *Social Work*, 53, 77-83.
- Bartels, S. J. (2004). Caring for the whole person: Integrated health care for older adults with severe mental illness and medical comorbidity. *Journal of the American Geriatrics Society*, 52, 249-257.
- Bartels, S. J., Coakley, E. H., Zubritsky, C., Ware, J. H., Miles, K. M., Arean, P. A., ... PRISM-E Investigators. (2004). Improving access to geriatric mental health services: A randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *American Journal of Psychiatry*, 161, 8, 1455-1462.
- Baumeister, D., Sedgwick, O., Howes, O., & Peters, E. (2017). Auditory verbal hallucinations and continuum models of psychosis: A systematic review of the healthy voice-hearer literature. *Clinical Psychology Review*, 51, 125-141.
- Becker, D. R., & Drake, R. E. (2003). *A working life for people with severe mental illness*. Oxford University Press.
- Becker, D.R., Smith, J., Tanzman, B., Drake, R.E., & Tremblay T. (2001), Fidelity of supported employment programs and employment outcomes. *Psychiatric Services*, 52, 834–836.

- Bell, M., Fiszdon, J., Richardson, R., Lysaker, P., & Bryson G. (2007). Are self-reports valid for schizophrenia patients with poor insight? Relationship of unawareness of illness to psychological self-report instruments. *Psychiatry Research*, 151, 1-2, 37–46.
- Bellack, A. S., Green, M. F., Cook, J. A., Fenton, W., Harvey, P. D., Heaton, R. K., ... & Patterson, T. L. (2006). Assessment of community functioning in people with schizophrenia and other severe mental illnesses: A white paper based on an NIMH-sponsored workshop. *Schizophrenia Bulletin*, 33, 805-822.
- Bellack, A. S., Mueser, K. T., Gingerich, S., & Agresta, J. (2013). *Social skills training for schizophrenia: A step-by-step guide*. Guilford Publications.
- Bellonci, C., Jordan, P. E., Massey, O. T., Zubritsky, C. & Edwall, G. (2012). Reframing mental health practice for children, youth, and families: In search of developmental competencies to improve functioning across life domains (Issue Brief). Outcomes roundtable for children and families. Retrieved from http://familyinvolvementcenter.org/phocadownloadpap/Articles_and_Research/Prevention_Roundtable.pdf
- Bently, K. J. (2005). Women, mental health, and the psychiatric enterprise: A review. *Health Social Work*, 30, 56-63.
- Blackwell, B., Eilers, K. & Robinson, Jr. D. (2000). The Consumer's Role in Assessing Quality. In: G. Stricker & W. G. Troy, (Eds.). *Handbook of Quality Management in Behavioral Health: Issues in the Practice of Psychology*. Dordrecht, Netherlands: Kluwer Academic Publishers; 375-386.
- Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician- administered PTSD scale. *Journal of Traumatic Stress*, 8, 75-90.
- Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health*, 13, 493-505.
- Boyd, J. E., Graunke, B., Frese, F. J., Jones, J. T., Adkins, J. W., & Bassman, R. (2016). State psychology licensure questions about mental illness and compliance with the Americans with Disabilities Act. *American Journal of Orthopsychiatry*, 86, 620-631.
- British Psychological Society's Center for Outcomes Research and Effectiveness (CORE) (2016). Underpinning supervision competences for working with people with psychosis and bipolar disorder. Retrieved on 11/13/2016 at https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/pdfs/Supervision_of_Psychological_Therapies/all-client-populations
- Brown, G. W., Birley, J. L. T., & Wing, J. K. (1972). Influence of family life on the course of schizophrenic disorders: A replication. *British Journal of Psychiatry*, 121, 241-258.
- Brown, G. W., Monck, E. M., Carstairs, G. M., & Wing, J. K. (1962). Influence of family life on the course of schizophrenic illness. *British Journal of Preventive and Social Medicine*, 16, 55-68.

- Buck, K. D., Roe, D., Yanos, P., Buck, B., Fogley, R. L., Grant, M., ... & Lysaker, P. H. (2013). Challenges to assisting with the recovery of personal identity and wellness for persons with serious mental illness: Considerations for mental health professionals. *Psychosis*, 5, 134-143.
- Burns, J. K., Tomita, A., & Kapadia, A. S. (2014). Income inequality and schizophrenia: Increased schizophrenia incidence in countries with high levels of income inequality. *International Journal of Social Psychiatry*, 60, 185-196.
- Butzlaff, R. L., & Hooley, J. M. (1998). Expressed emotion and psychiatric relapse. *Archives of General Psychiatry*, 55, 547-552.
- Caplan, G., & Caplan, R. B. (1999). *Mental Health Consultation and Collaboration: Concepts and Applications*. Waveland Press.
- Cañas, F., Alptekin, K., Azorin, J. M., Dubois, V., Emsley, R., García, A. G., ... & Papageorgiou, G. (2013). Improving treatment adherence in your patients with schizophrenia. *Clinical Drug Investigation*, 33, 97-107
- Carr, E. R., & Miller, R. (2017). Expanding our reach: Increasing the role of psychologists in public and community mental health. *Psychological Services*, 14, 352-361.
- Carr, E. R., Bhagwat, R., Miller, R., & Ponce, A. N. (2014). Training in mental health recovery and social justice in the public sector. *The Counseling Psychologist*, 42, 1108-1135.
- Carpenter Jr, W. T., Heinrichs, D. W., & Wagman, A. M. (1988). Deficit and nondeficit forms of schizophrenia: The concept. *The American Journal of Psychiatry*, 145, 578-583.
- Cavelti, M., Kvrjic, S., E.-M. Beck, E.-M., Kossowsky, J., & Vauth, R. (2012). Assessing recovery from schizophrenia as an individual process. A review of self-report instruments. *European Psychiatry*, 27, 19-32.
- Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry*, 13, 153-160.
- Chien, W. T., Leung, S. F., Yeung, F. K., & Wong, W. K. (2013). Current approaches to treatments for schizophrenia spectrum disorders, part II: Psychosocial interventions and patient-focused perspectives in psychiatric care. *Neuropsychiatric Disease and Treatment*, 9, 1463-1481.
- Chinman, M., McInnes, D. K., Eisen, S., Ellison, M., Farkas, M., Armstrong, M., & Resnick, S. G. (2017). Establishing a research agenda for understanding the role and impact of mental health peer specialists. *Psychiatric Services*, 68, 955-957.
- Choe, J. Y., Teplin, L. A., & Abram, K. M. (2008). Perpetration of violence, violent victimization, and severe mental illness: Balancing public health concerns. *Psychiatric Services*, 59, 2, 153-164.
- Chu, J. P., Emmons, L., Wong, J., Goldblum, P., Reiser, R., Barrera, A. Z., & Byrd-Olmstead, J. (2012). Public psychology: A competency model for professional psychologists in community mental health. *Professional Psychology: Research and Practice*, 43, 39-49.
- Chu, J. P., Emmons, L., Wong, J., Goldblum, P., Reiser, R., Barrera, A. Z., & Byrd-Olmstead, J. (2012). The Public Psychology Doctoral Training Model: Training clinical psychologists in

- community mental health competencies and leadership. *Training and Education in Professional Psychology*, 6, 76-83.
- Clemmensen, L., Vernal, D. L., Steinhausen, H.C. (2012). A systematic review of the long-term outcome of early onset schizophrenia. *BMC Psychiatry*, 12, 150. Retrieved from <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/1471-244X-12-150>
- Corbière, M., Crocker, A. G., Lesage, A. D., Latimer, E., Ricard, N., & Mercier, C. (2002). Factor structure of the Multnomah Community Ability Scale. *Journal of Nervous and Mental Disease*, 190, 399-406.
- Cohen, A. N., Hamilton, A. B., Saks, E. R., Glover, D. L., Glynn, S. M., Brekke, J. S., & Marder, S. R. (2016). How occupationally high-achieving individuals with a diagnosis of schizophrenia manage their symptoms. *Psychiatric Services*, 68, 324-329.
- Cohen, J. L., Abraham, K. M., Burk, J. P., & Stein, C. H. (2012). Emerging opportunities for psychologists: Joining consumers in the recovery-oriented care movement. *Professional Psychology: Research and Practice*, 43, 24-31.
- Coleman, K. J., Stewart, C., Waitzfelder, B. E., Zeber, J. E., Morales, L. S., Ahmed, A. T., ... & Hunkeler, E. M. (2016). Racial-ethnic differences in psychiatric diagnoses and treatment across 11 health care systems in the Mental Health Research Network. *Psychiatric Services*, 67, 749-757.
- Corrigan, P. W. (2014). *The stigma of disease and disability: Understanding causes and overcoming injustices*. American Psychological Association.
- Corrigan, P. W., & Kosyluk, K. A. (2014). Mental illness stigma: Types, constructs, and vehicles for change. In P. W. Corrigan (Ed.). *The stigma of disease and disability: Understanding causes and overcoming injustices* (pp. 35-56). Washington, DC, American Psychological Association.
- Corrigan, P. W., Larson, J. E., Michaels, P. J., Buchholz, B. A., Del Rossi, R., Fontecchio, M. J., ... & Rüsçh, N. (2015). Diminishing the self-stigma of mental illness by coming out proud. *Psychiatry Research*, 229, 148-154.
- Corrigan, P. W., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation: An Empirical Approach*. New York, NY: Guilford Press.
- Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*, 25, 875-884.
- Crowley, R. A., & Kirschner, N. (2015). The integration of care for mental health, substance abuse, and other behavioral health conditions into primary care: executive summary of an American College of Physicians position paper. *Annals of Internal Medicine*, 163, 298-299.
- Cuesta, M. J., Pino, O., Guilera, G., Rojo, J. E., Gómez-Benito, J., Purdon, S. E., ... & Vieta, E. (2011). Brief cognitive assessment instruments in schizophrenia and bipolar patients, and healthy control subjects: a comparison study between the Brief Cognitive Assessment Tool for Schizophrenia (B-CATS) and the Screen for Cognitive Impairment in Psychiatry (SCIP). *Schizophrenia Research*, 130, 137-142.

- Cuijpers, P., & Smit, F. (2002). Excess mortality in depression: A meta-analysis of community studies. *Journal of Affective Disorders*, 72, 227-236.
- Darves-Bornoz, J. M., Lemperiere, T., Degiovanni, A. & Gaillard, P. (1995). Sexual victimization in women with schizophrenia and bi-polar disease. *Social Psychiatry and Psychiatric Epidemiology*, 30, 78-84.
- David, A. S. (2018). Insights on insight. *Schizophrenia Research*, 197, 61-62.
- Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry*, 11, 123-128.
- Davidson, L. & Chan, K. K. S. (2014). Common factors: Evidence-based practice and recovery. *Psychiatric Services*, 65, 675-677.
- Davidson, L., Rowe, M., Tondora, J., O'Connell, M. J., & Lawless, M.S. (2008). *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*. New York: Oxford University Press.
- Davidson, L., & Stayner, D. (1997). Loss, loneliness, and the desire for love: Perspectives on the social lives of people with schizophrenia. *Psychiatric Rehabilitation Journal*, 20, 3-12.
- De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Pakmas, M., Cohen, D., Asai, I. ... & Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, 10, 1, 52-77.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11, 11-19.
- Deegan, P. E. & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services*, 57, 1636-1639.
- Desmarais, S. L., van Dorn, R. A., Johnson, K. L., Grimm, K. J., Douglas, K. S., & Swartz, M. S. (2014). Community violence perpetration and victimization among adults with mental illnesses. *American Journal of Public Health*, 104, 12, 2342-2349.
- Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). HCR-20V3: Assessing risk for violence: User guide. *Mental Health, Law, and Policy Institute*, Simon Fraser University.
- Epperson, M., Wolff, N., Morgan, R., Fisher, W., Frueh, B. C. & Huening, J. (2011). *The Next Generation of Behavioral Health and Criminal Justice Interventions: Improving Outcomes by Improving Interventions*. New Brunswick, NJ: Rutgers University, Center for Behavioral Health Services & Criminal Justice Research.
- Elklit, A. & Shevlin, M. (2011). Female sexual victimization predicts psychosis: A case-control study based on the Danish registry system. *Schizophrenia Bulletin*, 37, 1305-1310.
- Elliott, L. (2003). *The National Mental Health Project: A Community-based Program Aimed at Reducing Mental Disorders Amongst Refugees in Western Australia*. North Parramatta, NSW: Multicultural Mental Health Australia

- Ellison, M. L., Belanger, L. K., Niles, B. L., Evans, L. C., & Bauer, M. S. (2018). Explication and definition of mental health recovery: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*, 45, 91-102.
- Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976). The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry*, 33, 766-771.
- Evans, B. A., Bedson, E., Bell, P., Hutchings, H., Lowes, L., Rea, D., ... & Thomas, M. (2013). Involving service users in trials: developing a standard operating procedure. *Trials*, 14, 1-7.
- Farkas, M. & Anthony, W. A. (2010). Psychiatric rehabilitation interventions: A review. *International Review of Psychiatry*, 22, 114–129.
- Farkas, M. & Anthony, W. A. (1989). *Psychiatric Rehabilitation Programs: Putting Theory into Practice*. Baltimore, MD: Johns Hopkins University Press.
- Farkas, M., Jansen, M. A. & Penk, W. E. (2007). Psychosocial rehabilitation: The approach of choice for those with serious mental illnesses. *Journal of Rehabilitation Research and Development*, 44, vii–xxi.
- Farkas, M., Sullivan Soydan, A. & Gagne, C. (2000). *Introduction to Readiness*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.
- Farrelly, S., Clement, S., Gabbidon, J., Jeffery, D., Dockery, L., Lassman, F., ... & Thornicroft, G. (2014). Anticipated and experienced discrimination amongst people with schizophrenia, bipolar disorder and major depressive disorder: A cross sectional study. *BMC Psychiatry*, 14, 157-164.
- Fazel, S., Gulati, G., Linsell, L., Geddes, J. R., & Grann, M. (2009). Schizophrenia and violence: Systematic review and meta-Analysis. *PLoS Med* 6(8): e1000120.
- Fearon, P., Kirkbride, J. B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., ... & Mallett, R. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: Results from the MRC AESOP Study. *Psychological Medicine*, 36, 1541-1550.
- Fischer, B. A., McMahon, R. P., Meyer, W. A., Slack, D. J., Appelbaum, P. S., & Carpenter, W. T. (2013). Participants with schizophrenia retain the information necessary for informed consent during clinical trials. *The Journal of Clinical Psychiatry*, 74, 622–627.
- Fisher, W. H., Geller, J. L., & Pandiani, J. A. (2009). The changing role of the state psychiatric hospital. *Health Affairs*, 28, 676-684.
- Fisher, A., Sharpe, L., Anderson, J., Manicavasagar, V., & Juraskova, I. (2018). Development and pilot of a decision-aid for patients with bipolar II disorder and their families making decisions about treatment options to prevent relapse. *PloS One*, 13, 1-22.
- First, M. B., Williams, J. B. W., Karg, R. S., & Spitzer, R. L. (2015a). *Structured Clinical Interview for DSM-5 Disorders, Clinician Version (SCID-5-CV)*. Arlington, VA: American Psychiatric Association.

- First, M. B., Williams, J. B. W., Karg, R. S., & Spitzer, R. L. (2015b). Structured Clinical Interview for DSM-5—Research Version (SCID-5 for DSM-5, Research Version; SCID-5-RV). Arlington, VA: American Psychiatric Association.
- Forte, A., Baldessarini, R. J., Tondo, L., Vázquez, G. H., Pompili, M., & Girardi, P. (2015). Long-term morbidity in bipolar-I, bipolar-II, and unipolar major depressive disorders. *Journal of Affective Disorders*, 178, 71-78.
- Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., ... & Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology*, 3, S5-S26.
- Frank, E., Swartz, H. A., & Kupfer, D. J. (2000). Interpersonal and social rhythm therapy: Managing the chaos of bipolar disorder. *Biological psychiatry*, 48(6), 593-604.
- Frese, F. J. (2015). Advocacy, Stigma, and Self-Disclosure. Long-Term Outcomes in Psychopathology Research: Rethinking the Scientific Agenda, In Bromet, E. J. (Ed.), Long-term Outcomes in Psychopathology Research: Rethinking the Scientific Agenda. (227-237). New York, NY: Oxford University Press.
- Frese III, F. J., Knight, E. L., & Saks, E. (2009). Recovery from schizophrenia: With views of psychiatrists, psychologists, and others diagnosed with this disorder. *Schizophrenia Bulletin*, 35, 370-380.
- Fristad, M.A. & MacPherson, H. (2014). Evidence-based psychosocial treatments for bipolar disorder in youth. *Journal of Clinical Child and Adolescent Psychology*, 43, 339-55.
- Frost, B. G., Tirupati, S., Johnston, S., Turrell, M., Lewin, T. J., Sly, K. A., & Conrad, A. M. (2017). An Integrated Recovery-oriented Model (IRM) for mental health services: Evolution and challenges. *BMC Psychiatry*, 17, 22-36.
- Fung, K. M. T., Tsang, H. W. H., & Corrigan, P. W. (2008). Self-stigma of people with schizophrenia as predictor of their adherence to psychosocial treatment. *Psychiatric Rehabilitation Journal*, 32, 95-104.
- Forchuk, C., Jensen, E., & Csiernik, R. (2009). Exploring differences between community-based women and men with a history of mental illness. *Issues in Mental Health Nursing*, 30, 495-502.
- Gaskin, C. J. (2015). On the potential for psychological researchers and psychologists to promote the social inclusion of people with disability: A review. *Australian Psychologist*, 50, 445-454.
- Gater, A., Rofail, D., Tolley, C., Marshall, C., Abetz-Webb, L., Zarit, S. H., & Berardo, C. G. (2014). "Sometimes it's difficult to have a normal life": Results from a qualitative study exploring caregiver burden in schizophrenia. *Schizophrenia research and treatment*, vol. 2014, 13 pp. doi: 10.1155/2014/368215.

- Gearon, J. S., Bellack, A. S., & Tenhula, W. N. (2004). Preliminary reliability and validity of the Clinician-Administered PTSD Scale for schizophrenia. *Journal of Consulting and Clinical Psychology, 72*, 121-125.
- Geddes, J. R., & Miklowitz, D. J. (2013). Treatment of bipolar disorder. *The Lancet, 381*, 1672-1682.
- Gibson, L. E., Alloy, L. B., & Ellman, L. M. (2016). Trauma and the psychosis spectrum: a review of symptom specificity and explanatory mechanisms. *Clinical Psychology Review, 49*, 92-105.
- Giffort, D., Schmook, A., Woody, C., Vollendorf, C., & Gervain, M. (1995). Construction of a Scale to Measure Consumer Recovery. Springfield, IL: Illinois Office of Mental Health.
- Glynn, S. M., & Mueser, K. T. (2018). Schizophrenia. Hunsley, J., & Mash, E. J. (Eds.), *A Guide to Assessments that Work (Second Edition)*. New York: Oxford University Press.
- Goff, D. C., Henderson, D. C., & Amico, E. (1992). Cigarette smoking in schizophrenia: Relationship to psychopathology and medication side effects. *American Journal of Psychiatry, 149*, 1189-1194.
- Goodwin, F. K., & Jamison, K. R. (2007). *Manic-depressive illness: Bipolar disorders and recurrent depression (Vol. 1)*. Oxford: Oxford University Press.
- Goldberg, J. F., & Harrow, M. (2011). A 15-year prospective follow-up of bipolar affective disorders: Comparisons with unipolar nonpsychotic depression. *Bipolar Disorders, 13*, 155-163.
- Goldman, H. H., & Karakus, M. C. (2014). Do not turn out the lights on the public mental health system when the ACA is fully implemented. *The Journal of Behavioral Health Services & Research, 41*, 429-433.
- Goldman, H. H., Skodol, A. E., & Lave, T. R. (1992). Revising axis V for DSM-IV: R review of measures of social functioning. *American Journal of Psychiatry, 149*, Retrieved from <https://ssrn.com/abstract=2143992>
- Goldstein, B. I., Carnethon, M. R., Matthews, K. A., McIntyre, R. S., Miller, G. E., Raghuvver, G., ... & McCrindle, B. W. (2015). Major depressive disorder and bipolar disorder predispose youth to accelerated atherosclerosis and early cardiovascular disease. *Circulation, 132*, 965-986.
- Goode-Cross, D. T. (2011). Those who learn have a responsibility to teach: Black therapists' experiences supervising Black therapist trainees. *Training and Education in Professional Psychology, 5*, 73-80.
- Goodman, L. A., Rosenberg, S. D., Mueser, K. T., & Drake, R. E. (1997). Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin, 23*, 685-696.
- Goodwin, F. W. & Jamison K. R. (2007). *Manic-Depressive Illness: Bipolar Illness and Recurrent Depression, Vol 1*. New York: Oxford University Press.
- Granholt, E., McQuaid, J. R., McClure, F. S., Auslander, L. A., Perivoliotis, D., Pedrelli, P., ... & Jeste, D. V. (2005). A randomized, controlled trial of cognitive behavioral social skills training

- for middle-aged and older outpatients with chronic schizophrenia. *American Journal of Psychiatry*, 162, 520-529.
- Green, C. A., Perrin, N. A., Leo, M. C., Janoff, S. L., Yarborough, B. J. H., & Paulson, R. I. (2013). Recovery from serious mental illness: Trajectories, characteristics, and the role of mental health care. *Psychiatric Services*, 64, 1203-1210.
- Green, M. F. (1996). What are the functional consequences of neurocognitive deficits in schizophrenia? *The American Journal of Psychiatry*, 153, 321-330
- Green, M. F., Horan, W. P., & Lee, J. (2015). Social cognition in schizophrenia. *Nature Reviews Neuroscience*, 16, 620-631.
- Greenfield, S., Kaplan, S. H., Ware, J. E., Yano, E. M., & Frank, H. J. (1988). Patients' participation in medical care: Effects on blood sugar control and quality of life in diabetes. *Journal of General Internal Medicine*, 3, 348-457.
- Grisso, T., Appelbaum, P. S. & Hill-Fotouhi C. (1997). The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions. *Psychiatric Services*, 48, 11, 1415-1419.
- Grubaugh, A. L., Zinzow, H. M., Paul, L., Egede, L. E., & Frueh, B. C. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review*, 31, 883-899.
- Gupta, U. C., & Kharawala, S. (2012). Informed consent in psychiatry clinical research: A conceptual review of issues, challenges, and recommendations. *Perspectives in Clinical Research*, 3, 8-15.
- Haddock, G., McCarron, J., Tarrier, N., & Faragher, E. B. (1999). Scales to measure dimensions of hallucinations and delusions: The psychotic rating scales (PSYRATS). *Psychological Medicine*, 29, 879-889.
- Hamm, J. A., Buck, K. D., Vohs, J., Westerlund, R. J., & Lysaker, P. H. (2016). Interpersonal stance and dialogue in psychotherapy for schizophrenia: A supervisory approach. *The Clinical Supervisor*, 35, 42-62.
- Hamm, J. A., Hasson-Ohayon, I., Kukla, M., & Lysaker, P. H. (2013). Individual psychotherapy for schizophrenia: Trends and developments in the wake of the recovery movement. *Psychology Research and Behavior Management*, 6, 45-54.
- Harris, M. & Bachrach, L. (1990). Perspectives on homeless mentally ill women. *Hospital and Community Psychiatry*, 41, 253-254.
- Harris, J. I., Leskela, J., & Hoffman-Konn, L. (2016). Provider lived experience and stigma. *American Journal of Orthopsychiatry*, 86, 604-609.
- Hartz, S. M., Pato, C. N., Medeiros, H., Cavazos-Rehg, P., Sobell, J. L., Knowles, J. A., ... & Pato, M. T. (2014). Comorbidity of severe psychotic disorders with measures of substance use. *JAMA Psychiatry*, 71, 3, 248-254.

- Harvey, P. D. (2005). *Schizophrenia in late life: Aging effects on symptoms and course of illness*. Washington DC: American Psychological Association.
- Heinrichs, R. W. (2005). The primacy of cognition in schizophrenia. *American Psychologist*, 60, 229-242.
- Heinssen, R. K., Goldstein, A. B., & Azrin, S. T. (2016). Evidence-based treatment for first-episode psychosis: Components of coordinated specialty care. National Institutes of Health website.
- Hendryx, M., Dyck, D. G., McBride, D., & Whitbeck, J. (2001). A test of the reliability and validity of the Multnomah Community Ability Scale. *Community Mental Health Journal*, 37, 157-168.
- Henriksen, M. G., & Parnas, J. (2013). Self-disorders and schizophrenia: A phenomenological reappraisal of poor insight and noncompliance. *Schizophrenia Bulletin*, 40, 542-547.
- Hiroeh, U., Kapur, N., Webb, R., Dunn, G., Mortensen, P. B., & Appleby, L. (2007). Deaths from natural causes in people with mental illness: A cohort study. *Journal of Psychosomatic Research*, 64, 275-283.
- Hoang, U., Goldacre, M. J., & Stewart, R. (2013). Avoidable mortality in people with schizophrenia or bipolar disorder in England. *Acta Psychiatrica Scandinavica*, 127, 195-201.
- Hodgins, S., Hiscoke, U. L., & Freese, R. (2003). The antecedents of aggressive behavior among men with schizophrenia: A prospective investigation of patients in community treatment. *Behavioral Sciences & the Law*, 21, 523-546.
- Hooley, J. M., & Parker, H. A. (2006). Measuring expressed emotion: An evaluation of the shortcuts. *Journal of Family Psychology*, 20, 386-396.
- Hurford, I. M., Marder, S. R., Keefe, R. S., Reise, S. P., & Bilder, R. M. (2009). A brief cognitive assessment tool for schizophrenia: Construction of a tool for clinicians. *Schizophrenia Bulletin*, 37, 538-545.
- Iasevoli, F., Giordano, S., Balletta, R., Latte, G., Formato, M. V., Prinzivalli, E., ... & de Bartolomeis, A. (2016). Treatment resistant schizophrenia is associated with the worst community functioning among severely-ill highly-disabling psychiatric conditions and is the most relevant predictor of poorer achievements in functional milestones. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, 65, 34-48.
- Insel, T. R. (2010). Rethinking schizophrenia. *Nature*, 468 (7321), 187-193.
- Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of consumers' recovery narratives. *Psychiatric Rehabilitation Journal*, 24, 248-256.
- Janssen, E. M., McGinty, E. E., Azrin, S. T., Juliano-Bult, D., & Daumit, G. L. (2015). Review of the evidence: Prevalence of medical conditions in the United States population with serious mental illness. *General Hospital Psychiatry*, 37, 199-222.
- Jeste, D. V., Palmer, B. W., & Saks, E. R. (2017). Why we need positive psychiatry for schizophrenia and other psychotic disorders. *Schizophrenia Bulletin*, 43, 227-229.

- Jewell, T. C., Smith, A. M., Hoh, B., Ladd, S., Evinger, J., Lamberti, J. S., ... & Salerno, A. J. (2012). Consumer centered family consultation: New York State's recent efforts to include families and consumers as partners in recovery. *American Journal of Psychiatric Rehabilitation*, 15, 44-60.
- Joint Centre for Bioethics. (undated). Aid To Capacity Evaluation (ACE). http://www.jcb.utoronto.ca/tools/ace_download.shtml
- Jones, N., & Corrigan, P. W. (2014). Understanding stigma. In P. W. Corrigan (Ed.), *The stigma of disease and disability: Understanding causes and overcoming injustices* (pp. 9-34). Washington, DC, US: American Psychological Association.
- Jones, N., & Shattell, M. (2016). Taking stock of the challenges and tensions involved in peer leadership in participatory research about psychosis and a call to do better. *Issues in Mental Health Nursing*, 37, 440-442.
- Jonikas, J. A., Laris, A., & Cook, J. A. (2003). The passage to adulthood: Psychiatric rehabilitation service and transition-related needs of young adult women with emotional and psychiatric disorders. *Psychiatric Rehabilitation Journal*, 27, 114-121.
- Joukamaa, M., Heliövaara, M., Knekt, P., Aromaa, A., Raitasalo, R., & Lehtinen, V. (2001). Mental disorders and cause-specific mortality. *British Journal of Psychiatry*, 179, 498-502.
- Judd, L. L., Akiskal, H. S., Schettler, P. J., Endicott, J., Leon, A. C., Solomon, D. A., ... & Keller, M. B. (2005). Psychosocial disability in the course of bipolar I and II disorders: A prospective, comparative, longitudinal study. *Archives of General Psychiatry*, 62, 1322-1330.
- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... & Marcy, P. (2015). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173, 362-372.
- Kara, H. (2013). Mental health service user involvement in research: where have we come from, where are we going? *Journal of Public Mental Health*, 12, 122-135.
- Karlin, B. E., & Cross, G. (2014). From the laboratory to the therapy room: National dissemination and implementation of evidence-based psychotherapies in the US Department of Veterans Affairs Health Care System. *American Psychologist*, 69, 19-33.
- Karow, A., Wittmann, L., Schöttle, D., Schäfer, I., & Lambert, M. (2014). The assessment of quality of life in clinical practice in patients with schizophrenia. *Dialogues in Clinical Neuroscience*, 16, 185-195.
- Kaslow, N. J., Graves, C. C., & Smith, C. O. (2012). Specialization in psychology and health care reform. *Journal of Clinical Psychology in Medical Settings*, 19, 12-21.
- Kay, S. R., Opler, L. A., & Fiszbein, A. (1987). The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, 13, 261-276.
- Kendall, T., Morriss, R., Mayo-Wilson, E., & Marcus, E. (2014). Assessment and management of bipolar disorder: Summary of updated NICE guidance. *Bmj*, 349, 1-5.

- Khalifeh, H., Johnson, S., Howard, L. M., Borschmann, R., Osborn, D., Dean, K., ... & Moran, P. (2015). Violent and non-violent crime against adults with severe mental illness. *The British Journal of Psychiatry*, 206, 275-282.
- King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Passeti, F., ... & Serfaty, M. (2007). The Stigma Scale: Development of a standardised measure of the stigma of mental illness. *The British Journal of Psychiatry*, 190, 248-254.
- Kingdon, D. G., & Turkington, D. (1994). *Cognitive-behavioral therapy of schizophrenia*. New York, NY: Guilford Press.
- Kirkbride, J. B. (2017). Migration and psychosis: Our smoking lung?. *World Psychiatry*, 16, 119-120.
- Kirkpatrick, B., Strauss, G. P., Nguyen, L., Fischer, B. A., Daniel, D. G., Cienfuegos, A., & Marder, S. M. (2011). The brief negative symptom scale: Psychometric properties. *Schizophrenia Bulletin*, 37, 300-305.
- Kirmayer, L. J., Hayton, B.C., Malus, M., DuFour, R., Jimenez, V., Ternar, ... & Yu, T. (1993). *Suicide Among Canadian Aboriginal Peoples: Emerging Trends in Research and Intervention*. Culture and Mental Health Research Unit Report No. 1. Montreal, QC: McGill University.
- Kirmayer, L. J., Macdonald, M. E. & Brass, G. M. (2000). *The Mental Health of Indigenous Peoples: Proceedings of the Advanced Study Institute*. Culture and Mental Health Research Unit Report No.10. Montreal, QC: McGill University.
- Kisely, S., Smith, M., Lawrence, D., Cox, M., Campbell, L. A., & Maaten, S. (2007). Inequitable access for mentally ill patients to some medically necessary procedures. *Canadian Medical Association Journal*, 176, 779-784.
- Klein, C. C., Jolson, M. B., Lazarus, M., Masterson, B., Blom, T. J., Adler, C. M., ... & Strakowski, S. M. (2019). Capacity to provide informed consent among adults with bipolar disorder. *Journal of Affective Disorders*, 242, 1-4.
- Kooyman, I., Dean, K., Harvey, S., & Walsh, E. (2007). Outcomes of public concern in schizophrenia. *The British Journal of Psychiatry*, 191 (S50), s29-s36.
- Kopelowicz, A., Zarate, R., Wallace, C. J., Liberman, R. P., Lopez, S. R., & Mintz, J. (2012). The ability of multifamily groups to improve treatment adherence in Mexican Americans with schizophrenia. *Archives of General Psychiatry*, 69, 265-273.
- Kopelowicz, A., Zarate, R., Wallace, C. J., Liberman, R. P., Lopez, S. R., & Mintz, J. (2015). Using the theory of planned behavior to improve treatment adherence in Mexican Americans with schizophrenia. *Journal of Consulting and Clinical Psychology*, 83, 985-993.
- Kraepelin, E. (1919/1971). *Dementia Praecox and Paraphrenia* (R. M. Barclay, Trans.). New York, NY: Krieger.
- Kreisman, D., Blumenthal, R., Borenstein, M., Woerner, M., Kane, J., Rifkin, A., & Reardon, G. (1988). Family attitudes and patient social adjustment in a longitudinal study of outpatient schizophrenics receiving low-dose neuroleptics: The family's view. *Psychiatry*, 51, 3-13.

- Kreisman, D. E., Simmens, S. J., & Joy, V. D. (1979). Rejecting the patient: preliminary validation of a self-report scale. *Schizophrenia Bulletin*, 5, 220-222.
- Kring, A. M., Gur, R. E., Blanchard, J. J., Horan, W. P., & Reise, S. P. (2013). The clinical assessment interview for negative symptoms (CAINS): Final development and validation. *American Journal of Psychiatry*, 170, 165-172.
- Kreyenbuhl, J., Buchanan, R.W., Dickerson, F. B. & Dixon, L. B. (2010). The schizophrenia patient outcomes research team (PORT): Updated treatment recommendations 2009. *Schizophrenia Bulletin*, 36, 94-103.
- Krupa, T., Chen, S. P., & Carter, G. (2015). Serious mental illness, vocational rehabilitation, and employment. In *Handbook of Vocational Rehabilitation and Disability Evaluation* (pp. 335-354). Springer, Cham.
- Kumari, S., Malik, M., Florival, C., Manalai, P., & Sonje, S. (2017). An assessment of five (PANSS, SAPS, SANS, NSA-16, CGI-SCH) commonly used symptoms rating scales in schizophrenia and comparison to newer scales (CAINS, BNSS). *Journal of Addiction Research & Therapy*, 8, 1-14.
- Kuniyoshi, J. & McClellan, J. M. (2014). Early-onset Schizophrenia. In E. J. Mash & R. A. Barkley (Eds.), *Child Psychopathology*, Third Edition (pp. 573-592), New York, NY: Guilford.
- Lawrence, D., Hancock, K. J., & Kisely, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in western Australia: Retrospective analysis of population based registers. *The BMJ*, 346, f2539.
- Lawrence, D., Mitrou, F., & Zubrick, S. R. (2009). Smoking and mental illness: Results from population surveys in Australia and the United States. *BMC Public Health*, 2009 9:285, 1-14.
- Leclerc, E., Mansur, R. B., & Brietzke, E. (2013). Determinants of adherence to treatment in bipolar disorder: A comprehensive review. *Journal of Affective Disorders*, 149, 247-252.
- Leff, J., & Vaughn, C. (Eds.). (1985). *Expressed Emotion in Families*. New York, NY: Guilford Publications.
- Levant, R. F., Reed, G. M., Ragusea, S. A., DiCowden, M., Murphy, M. J., Sullivan, F., ... & Stout, C. E. (2001). Envisioning and accessing new roles for professional psychology. *Professional Psychology: Research and Practice*, 32, 79-87.
- Lieberman, J. A., Stroup, T. S., & Perkins, D. O. (Eds.). (2007). *The American psychiatric publishing textbook of schizophrenia*. Washington DC: American Psychiatric Association Publishing.
- Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Lutzman, R. D. (2013). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review*, 33, 883-900.
- Lincoln, T. M., Ziegler, M., Lüllmann, E., Müller, M. J., & Rief, W. (2010). Can delusions be self-assessed? Concordance between self- and observer-rated delusions in schizophrenia. *Psychiatry Research*, 178, 2, 249–253.

- Lopez, S. R., Kopelowicz, A., & Canive, J. M. (2002). Strategies in developing culturally congruent family interventions for schizophrenia: The case of Hispanics. *Family Interventions in Mental Illness: International Perspectives*, 61-90.
- Lukoff, D., Nuechterlein, K. H., & Ventura, J. (1986). Manual for the expanded brief psychiatric rating scale (BPRS). *Schizophrenia Bulletin*, 12, 594-602.
- Lyman, E. R., Braude, L., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Consumer and family psychoeducation: Assessing the evidence. *Psychiatric Services*, 65, 4, 416–428.
- Lynch, S. M., DeHart, D. D., Belknap, J. E., Green, B. L., Dass-Brailsford, P., Johnson, K. A., & Whalley, E. (2014). A multisite study of the prevalence of serious mental illness, PTSD, and substance use disorders of women in jail. *Psychiatric Services*, 65, 670-674.
- Lysaker, P. H., & Leonhardt, B. L. (2012). Agency: its nature and role in recovery from severe mental illness. *World Psychiatry*, 11, 165-166.
- Mabe, P. A., Ahmed, A. O., Duncan, G. N., Fenley, G., & Buckley, P. F. (2014). Project GREAT: Immersing physicians and doctorally-trained psychologists in recovery-oriented care. *Professional Psychology: Research and Practice*, 45, 347-356.
- Mabe, P. A. & Fenley, G. (2008). Project Great Recovery Based Training Procedures Manual: A Guide to Teaching Professionals the Recovery Model of Mental Health Care. Augusta, GA: Department of Psychiatry and Health Behavior, Medical College of Georgia.
- MacPherson, H. A., Fristad, M.A., & Leffler, J. M. (2014). Implementation of multi-family psychoeducational psychotherapy for childhood mood disorders in an outpatient community setting. *Journal of Marital and Family Therapy*, 40, 193–211.
- Majumder, R. K., Walls, R. T. & Fullmer, S. L. (1998). Rehabilitation client involvement in employment decisions. *Rehabilitation Counseling Bulletin*, 42, 162-73.
- Malinovsky, I., Lehrer, P., Silverstein, S. M., Shankman, S. A., O'Brien, W., Samuelson, T., & Van Nostrand, G. (2013). An empirical evaluation of recovery transformation at a large community psychiatric rehabilitation organization. *Psychological Services*, 10, 428-441.
- Maniglio, R. (2009). Severe mental illness and criminal victimization: A systematic review. *Acta Psychiatrica Scandinavica*, 119, 3, 180-191.
- Marwaha, S., Durrani, A., & Singh, S. (2013). Employment outcomes in people with bipolar disorder: A systematic review. *Acta Psychiatrica Scandinavica*, 128, 179-193.
- McCannon, S. L. (2012). Systems of care as asset-building communities: Implementing strengths-based planning and positive youth development. *American Journal of Community Psychology*, 49, 556-565.
- McClellan, J., Kowatch, R., & Findling, R. L. (2007). Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46, 107-125.

- McClellan, J., Stock, S., & the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2013). Practice parameter for the assessment and treatment of children and adolescents with schizophrenia, *Journal of the American Academy of Child & Adolescent Psychiatry*, 52, 976-990.
- McGinty, E. E., Baller, J., Azrin, S. T., Juliano-Bult, D., & Daumit, G. L. (2015). Quality of medical care for persons with serious mental illness: A comprehensive review. *Schizophrenia Research*, 165, 2-3, 227-235.
- McGuire, A. B., Stull, L. G., Mueser, K. T., Santos, M., Mook, A., Rose, N., ... & Salyers, M. P. (2012). Development and reliability of a measure of clinician competence in providing illness management and recovery. *Psychiatric Services*, 63, 772-778.
- McGuire, A. B., White, D. A., Bartholomew, T., Flanagan, M. E., McGrew, J. H., Rollins, A. L., ... & Salyers, M. P. (2017). The relationship between provider competence, content exposure, and consumer outcomes in illness management and recovery programs. *Administration and Policy in Mental Health and Mental Health Services Research*, 44, 81-91.
- MDMBAMA, N. K. A., Hinton, L., & MDFRCPC, L. J. K. (Eds.). (2015). *DSM-5® handbook on the cultural formulation interview*. Washington, DC: American Psychiatric Publishing.
- Mead, S. & Copeland, M.E. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal*, 36, 315–328.
- Meijer, J. H., Eekhout, G. M., van Vlerken, R. H., & de Vries, A. L. (2017). Gender dysphoria and co-existing psychosis: Review and four case examples of successful gender affirmative treatment. *LGBT Health*, 4, 106-114.
- Merikangas, K. R., Jin, R., He, J. P., Kessler, R. C., Lee, S., Sampson, N. A., ... & Ladea, M. (2011). Prevalence and correlates of bipolar spectrum disorder in the world mental health survey initiative. *Archives of General Psychiatry*, 68, 241-251.
- Miller, C. J., Johnson, S. L., & Eisner, L. (2009). Assessment tools for adult bipolar disorder. *Clinical Psychology: Science and Practice*, 16, 188–201.
- Mistler, L. A., Brunette, M. F., Ferron, J. C., & Ziedonis, D. M. (2012). Shared decision making and behavioral support interventions for people with severe mental illness and tobacco dependence. *Journal of Dual Diagnosis*, 8, 99-103.
- Mitchell, J. E., & Dahlgren, L. A. (1986). Prevalence of smoking among psychiatric outpatients. *American Journal of Psychiatry*, 143, 993-997.
- Monahan, J., Vesselinov, R., Robbins, P. C., & Appelbaum, P. S. (2017). Violence to others, violent self-victimization, and violent victimization by others among persons with a mental illness. *Psychiatric Services*, 68, 516-519.
- Montgomery, A. E., Metraux, S., & Culhane, D. (2013). Rethinking homelessness prevention among persons with serious mental illness. *Social Issues and Policy Review*, 7, 58-82.
- Morin, L., & Franck, N. (2017). Rehabilitation interventions to promote recovery from schizophrenia: A systematic review. *Frontiers in Psychiatry*, 8, 100-112.

- Mueser, K. T. (2012). Evidence-based practices and recovery-oriented services: Is there a relationship? Should there be one? *Psychiatric Rehabilitation Journal*, 35, 287–288.
- Mueser, K. T., Bellack, A. S., Wade, J. H., Sayers, S. L., Tierney, A., & Haas, G. (1993). Expressed emotion, social skill, and response to negative affect in schizophrenia. *Journal of Abnormal Psychology*, 102, 339-351.
- Mueser, K. T., & Cook, J. A. (2014). Rising to the challenge of first episode psychosis: The NIMH Recovery After Initial Schizophrenia Episode (RAISE) initiative. *Psychiatric Rehabilitation Journal*, 37, 267-269.
- Mueser, K. T., Deavers, F., Penn, D. L., & Cassisi, J. E. (2013). Psychosocial treatments for schizophrenia. *Annual Review of Clinical Psychology*, 9, 465-497.
- Mueser, K. T., & Glynn, S. M. (1995). *Behavioral family therapy for psychiatric disorders*. Boston, MA: Allyn & Bacon.
- Mueser, K. T., Gottlieb, J. D., Xie, H., Lu, W., Yanos, P. T., Rosenberg, S. D., ... & McHugo, G. J. (2015). Evaluation of cognitive restructuring for post-traumatic stress disorder in people with severe mental illness. *The British Journal of Psychiatry*, 206, 501-508.
- Mueser, K. T. & Jeste, D. V. (Eds.). (2008). *Clinical Handbook of Schizophrenia*. New York, NY: Guilford Press.
- Mueser, K. T., Meyer-Kalos, P. S., Glynn, S. M., Lynde, D. W., Robinson, D. G., Gingerich, S., ... & Wiseman, J. L. (2018). Implementation and fidelity assessment of the NAVIGATE treatment program for first episode psychosis in a multi-site study. *Schizophrenia research*. Advance online publication. doi.org/10.1016/j.schres.2018.08.015
- Mueser, K. T., Penn, D. L., Addington, J., Brunetter, M. F., Gingerich, S., Glynn, S. M., ... & Kane, J. M. (2015). The navigate program for first-episode psychosis: Rationale, overview, and description of psychosocial components. *Psychiatric Services*, 66, 680-690.
- Mueser, K. T., Silverstein, S. M., & Farkas, M. D. (2013). Should the training of clinical psychologists require competence in the treatment and rehabilitation of individuals with a serious mental illness? *Psychiatric Rehabilitation Journal*, 36, 54.
- Mullen, P. E. (2006). Schizophrenia and violence: From correlations to preventive strategies. *Advances in Psychiatric Treatment*, 12, 4, 239-248.
- Nadal, K. L. (2017). "Let's get in formation": On becoming a psychologist–activist in the 21st century. *American Psychologist*, 72, 935-946.
- National Health Policy Forum. (2009). *Children's mental health: Prevalence, illness burden, and efforts at prevention and early intervention*. Forum session presented November, 20, 2009, Washington, DC.
- National Institute of Mental Health. (2012). *Improving health and reducing premature mortality in people with severe mental illness*. Washington, DC: Author.

- O'Connell, M., Tondora, J., Croog, G., Evans, A., & Davidson, L. (2005). From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal*, 28, 4, 378-366.
<http://dx.doi.org/10.2975/28.2005.378.386>
- Olfson, M., Gerhard, T., Huang, C., Crystal, S. & Stroup, T. S. (2015). Premature mortality among adults with schizophrenia in the United States. *JAMA Psychiatry*, 72, 1172-81.
- Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research*, 40, 384-399.
- Paris, Jr., M., Silva, M. A., Diaz, E., Bedregal, L. E., Cole, R. A., & Añez-Nava, L. M. (2016). The Connecticut Latino behavioral health system: A culturally informed community-academic collaboration. *Psychological Services*, 13, 140-147.
- Patel, S. R., Bakken, S. & Ruland, C. (2008). Recent advances in shared decision making for mental health. *Current Opinion in Psychiatry*, 21, 606-612.
- Pescosolido, B. A. (2013). The public stigma of mental illness: What do we think; what do we know; what can we prove?. *Journal of Health and Social behavior*, 54, 1-21.
- Pinkham, A.E., Mueser, K.T., Penn, D.L., Glynn, S.M., McGurk, S.R., Addington, J. (2012). Social and functional impairments. In: Lieberman, J. A., Stroup, T. S., & Perkins, D. O. (Eds.). *Essentials of schizophrenia*. Washington, DC: American Psychiatric Publishing, Inc, 93-130.
- Pratt, C. W., Gill, K. J., Barrett, N. M., & Roberts, M. M. (2007). *Psychiatric Rehabilitation*. Burlington MA: Elsevier Academic Press.
- Pratt, S. I., Bartels, S. J., Mueser, K. T., & Forester, B. (2008). Helping older people experience success: An integrated model of psychosocial rehabilitation and health care management for older adults with serious mental illness. *American Journal of Psychiatric Rehabilitation*, 11, 41-60.
- Pratt, S. I. & Mueser, K. T. (2002). Schizophrenia. In: M. M. Anthony & D. H. Barlow (Eds.). *Handbook of Assessment and Treatment Planning for Psychological Disorders*. New York, NY: The Guilford Press.
- Purdon, S. E. (2005). *The Screen for Cognitive Impairment in Psychiatry (SCIP): Instructions and three alternate forms*. PNL Inc, Edmonton, Alberta.
- Rajkumar, R. P. (2014). Gender identity disorder and schizophrenia: neurodevelopmental disorders with common causal mechanisms?. *Schizophrenia Research and Treatment*, 1-8.
- Ralph, R. O., Kidder, K., & Phillips, D. (2000). *Can We Measure Recovery? A Compendium of Recovery and Recovery-related Instruments*. Cambridge, MA: The Evaluation Center @ Human Services Research Institute.
- Razzano, L. A., Jonikas, J. A., Goelitz, M. A., Hamilton, M. M., Marvin, R., Jones-Martinez, N., ... & Cook, J. A. (2010). *The Recovery Education in the Academy Program: Transforming*

- academic curricula with the principles of recovery and self-determination. *Psychiatric Rehabilitation Journal*, 34, 130-136.
- Reddy, F., Spaulding, W. D., Jansen, M. A., Menditto, A. A., & Pickett, S. (2010). Psychologists' roles and opportunities in rehabilitation and recovery for serious mental illness: A survey of Council of University Directors of Clinical Psychology (CUDCP) clinical psychology training and doctoral education. *Training and Education in Professional Psychology*, 4, 254-263.
- Reich, W. (2000). Diagnostic interview for children and adolescents (DICA). *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 59-66.
- Reinhard, S. C., Gubman, G. D., Horwitz, A. V., & Minsky, S. (1994). Burden assessment scale for families of the seriously mentally ill. *Evaluation and Program Planning*, 17, 261-269.
- Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, 60, 748-756.
- Ridgway, P. A. (2001). Re-storying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*, 24, 335-343.
- Ritsher, J. B., Otilingam, P. G., & Grajales, M. (2003). Internalized stigma of mental illness: Psychometric properties of a new measure. *Psychiatry Research*, 121, 31-49.
- Roberts, M. C. (2006). Essential tension: Specialization with broad and general training in psychology. *American Psychologist*, 61, 862-870.
- Rodolfa, E., Bent, R., Eisman, E., Nelson, P., Rehm, L., & Ritchie, P. (2005). A cube model for competency development: Implications for psychology educators and regulators. *Professional Psychology: Research and Practice*, 36, 347-354.
- Rodrigues, R., & Anderson, K. K. (2017). The traumatic experience of first-episode psychosis: A systematic review and meta-analysis. *Schizophrenia Research*, 189, 27-36.
- Roe, D., Yanos, P. T., & Lysaker, P. H. (2006). Overcoming barriers to increase the contribution of clinical psychologists to work with persons with severe mental illness. *Clinical Psychology: Science and Practice*, 13, 376-383.
- Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. London: Constable.
- Rooney, M. T., Fristad, M. A., Weller, E. B. & Weller, R. A. (1999). *Children's Interview for Psychiatric Syndromes: Administration Manual*. Arlington, VA: American Psychiatric Press, Inc.
- Rosenheck, R., Leslie, D., Sint, K., Lin, H., Robinson, D. G., Schooler, N. R., & Kane, J. M. (2016). Cost-effectiveness of comprehensive, integrated care for first episode psychosis in the NIMH RAISE early treatment program. *Schizophrenia Bulletin*, 42, 896-906.
- Rosenheck, R., Mueser, K. T., Sint, K., Lin, H., Lynde, D. W., Glynn, S. M., ... & Kane, J. M. (2017). Supported employment and education in comprehensive, integrated care for first episode psychosis: Effects on work, school, and disability income. *Schizophrenia Research*, 182, 120-128.

- Rosenthal, E., & Rubenstein, L. S. (1993). International human rights advocacy under the "Principles for the Protection of Persons with Mental Illness." *International Journal of Law and Psychiatry*, 16, 257-300.
- Rousseau, D. M., & Gunia, B. C. (2016). Evidence-based practice: The psychology of EBP implementation. *Annual Review of Psychology*, 67, 667-692.
- Roy, L., Crocker, A. G., Nicholls, T. L., Latimer, E. A., & Ayllon, A. R. (2014). Criminal behavior and victimization among homeless individuals with severe mental illness: A systematic review. *Psychiatric Services*, 65, 739-750.
- Rozensky, R. H., Grus, C. L., Nutt, R. L., Carlson, C. I., Eisman, E. J., & Nelson, P. D. (2015). A taxonomy for education and training in professional psychology health service specialties: Evolution and implementation of new guidelines for a common language. *American Psychologist*, 70, 1, 21-32.
- Sarteschi, C. M. (2013). Mentally ill offenders involved with the US criminal justice system: A synthesis. *Sage Open*, 3(3), Retrieved from <https://doi.org/10.1177/2158244013497029>
- Schizophrenia Working Group of the Psychiatric Genomics Consortium. (2014). Biological insights from 108 schizophrenia-associated genetic loci. *Nature*, 511, 421–427.
- Schooler, N., Hogarty, G., & Weissman, M. (1979). Social Adjustment Scale II (SAS-II). Resource Materials for Community Mental Health Program Evaluations, 290-303.
- Schroeder, S. A. & Morris, C. D. (2010). Confronting a neglected epidemic: Tobacco cessation for persons with mental illnesses and substance abuse problems. *Annual Review of Public Health*, 31, 297–314.
- Seeman, M. & Seeman, T. E. (1983). Health behavior and personal autonomy: A longitudinal study of the sense of control in illness. *Journal of Health and Social Behavior*, 24, 144–160.
- Sekar, A., Bialas, A. R. de Rivera, H., Davis, A., Hammond, T. R., Kamitaki, N., ... & Handsaker, R. E. (2016). Schizophrenia risk from complex variation of complement component 4. *Nature* 530, 177–183.
- Shevlin, M. & Dorahy M., & Adamson, G. (2007). Trauma and psychosis: An analysis of the National Comorbidity Survey. *American Journal of Psychiatry*, 164, 1, 166-169.
- Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge University Press.
- Smith, J. D., Mittal, D., Chekuri, L., Han, X., & Sullivan, G. (2017). A comparison of provider attitudes toward serious mental illness across different health care disciplines. *Stigma and Health*, 2, 4, 327-337.
- Society of Pediatric Psychology. (2017). Bylaws of Division 54 of the American Psychological Association, Society of Pediatric Psychology. (Retrieved from <http://www.societyofpediatricpsychology.org/sites/default/files/files/Division%2054%20BYLAW%20January%202016%5B1%5D.pdf>)

- Spaulding, W. & Deogun, J. (2011). A pathway to personalization of integrated treatment: Informatics and decision science in psychiatric rehabilitation. *Schizophrenia Bulletin*, 37 (suppl 2), 129–137.
- Staley, K., Kabir, T., & Szmukler, G. (2013). Service users as collaborators in mental health research: less stick, more carrot. *Psychological Medicine*, 43, 1121–1125.
- Staley, K., Kabir, T., & Szmukler, G. (2013). Service users as collaborators in mental health research: Less stick, more carrot. *Psychological Medicine*, 43, 1121–1125.
- Staring, A. B., ter Huurne, M. A. B., & van der Gaag, M. (2013). Cognitive Behavioral Therapy for negative symptoms (CBT-n) in psychotic disorders: A pilot study. *Journal of Behavior Therapy and Experimental Psychiatry*, 44, 300-306.
- Steel, C., Hardy, A., Smith, B., Wykes, T., Rose, S., Enright, S., ... & Rose, D. (2017). Cognitive-behaviour therapy for post-traumatic stress in schizophrenia: A randomized controlled trial. *Psychological Medicine*, 47, 43-51.
- Steenkamp, M. M., Litz, B. T., Hoge, C. W., & Marmar, C. R. (2015). Psychotherapy for military-related PTSD: A review of randomized clinical trials. *Jama*, 314, 489-500.
- Strachan, A. M., Leff, J. P., Goldstein, M. J., Doane, J. A., & Burt, C. (1986). Emotional attitudes and direct communication in the families of schizophrenics: A cross-national replication. *British Journal of Psychiatry*, 149, 279-287.
- Strauss, G. P., Morra, L. F., Sullivan, S. K., & Gold, J. M. (2015). The role of low cognitive effort and negative symptoms in neuropsychological impairment in schizophrenia. *Neuropsychology*, 29, 282-291.
- Strauss, J. S. (2014). Psychological interventions for psychosis: Theme and variations. *The American Journal of Psychiatry*, 171, 479-481.
- Stroul, B. A., Blau, G. M., & Friedman, R. M. (2010). *Updating the System of Care Concept and Philosophy*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
- Stewart, M. & Brown, J. (2001). Patient-Centeredness in Medicine. In G. Elwyn & A. Edwards (Eds.) *Evidence-based Patient Choice: Inevitable or Impossible?* New York: Oxford University Press.
- Subica, A. M. (2013). Psychiatric and physical sequelae of childhood physical and sexual abuse and forced sexual trauma among individuals with serious mental illness. *Journal of Traumatic Stress*, 26, 588-596.
- Substance Abuse and Mental Health Services Administration. (2009). *Illness Management and Recovery: Practitioner Guides and Handouts*. HHS Pub. No. SMA-09-4462, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Swanson, K. A., Bastani, R., Rubenstein, L. V., Meredith, L. S., & Ford, D. E. (2007). Effect of mental health care and shared decision making on patient satisfaction in a community sample of patients with depression. *Medical Care Research Review*, 64, 416–430.

- Tandon, R., Nasrallah, H. A., & Keshavan, M. S. (2009). Schizophrenia, "just the facts" 4. Clinical features and conceptualization. *Schizophrenia Research*, 110, 1-23.
- Takeuchi, H., Fervaha, G., & Remington, G. (2016). Reliability of a patient-reported outcome measure in schizophrenia: Results from back-to-back self-ratings. *Psychiatry Research*, 244, 415-419.
- Tessler, R., & Gamache, G. (1996). *Toolkit for Evaluating Family Experiences with Severe Mental Illness*. Amherst, MA: The Evaluation Center at HSRI.
- Thornicroft, G. (2011). Physical health disparities and mental illness: the scandal of premature mortality. *The British Journal of Psychiatry*, 199, 441-442.
- Tiffin, P. A., & Welsh, P. (2013). Practitioner review: Schizophrenia spectrum disorders and the at-risk mental state for psychosis in children and adolescents—evidence-based management approaches. *Journal of Child Psychology and Psychiatry*, 54(11), 1155-1175.
- Tlach, L., Wüsten, C., Daubmann, A., Liebherz, S., Härter, M., & Dirmaier, J. (2015). Information and decision-making needs among people with mental disorders: A systematic review of the literature. *Health Expectations*, 18, 1856-1872.
- Tondora, J. (2011). Person-centered care: From theory to practice. Training curriculum and tools. Retrieved from: <http://www.ct.gov/dmhas/cwp/view.asp?a=2913&q=456036>.
- Tondora, J. & Davidson, L. (2006). *Practice guidelines for recovery-oriented behavioral health care*. Hartford, CT: Connecticut Department of Mental Health and Addiction Services.
- Topor, A., Andersson, G., Denhov, A., Holmqvist, S., Mattsson, M., Stefansson, C. G., & Bülow, P. (2014). Psychosis and poverty: Coping with poverty and severe mental illness in everyday life. *Psychosis*, 6, 117-127.
- Toporek, R. L., & Vaughn, S. R. (2010) Social justice in the training of professional psychologists: Moving forward. *Training and Education in Professional Psychology*, 4, 177-182.
- Tse, S., Tsoi, E. W., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., ... & Petrakis, M. (2016). Uses of strength-based interventions for people with serious mental illness: A critical review. *International Journal of Social Psychiatry*, 62, 281-291.
- Tsoi, D. T., Porwal, M., & Webster, A. C. (2013). Interventions for smoking cessation and reduction in individuals with schizophrenia. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD007253. DOI: 10.1002/14651858.CD007253.pub3.
- Turner, D. T., van der Gaag, M., Karyotaki, E., & Cuijpers, P. (2014). Psychological interventions for psychosis: A meta-analysis of comparative outcome studies. *American Journal of Psychiatry*, 171, 523-538.
- Usall, J., Araya, S., Ochoa, S., Busquets, E., Gost, A., Marquez, M., & Assessment Research Group in Schizophrenia (NEDES). (2001). Gender differences in a sample of schizophrenic outpatients. *Comprehensive Psychiatry*, 42, 4, 301-305.

- U.S. Department of Health and Human Services. (2006). National Consensus Conference Statement on Mental Health Recovery and Systems Transformation. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- U. S. Department of Health and Human Services. (2010). Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions. HHS Publication No. SMA-09-4371. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Varese, F., Smeets, F., Drukker, M., Lieveerse, R., Lataster, T., Viechtbauer, W. ... & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective-and cross-sectional cohort studies. *Schizophrenia Bulletin*, 38, 661-671.
- Vasiliadis, H. M., Lesage, A., Adair, C., & Boyer, R. (2005). Service use for mental health reasons: Cross-provincial differences in rates, determinants, and equity of access. *Canadian Journal of Psychiatry*, 50, 10, 614-619.
- Ventura, J., Liberman, R. P., Green, M. F., Shaner, A., & Mintz, J. (1998). Training and quality assurance with the Structured Clinical Interview for DSM-IV (SCID-I/P). *Psychiatry Research*, 79, 163-173
- Vieta, E., Pacchiarotti, I., Valentí, M., Berk, M., Scott, J., & Colom, F. (2009). A critical update on psychological interventions for bipolar disorders. *Current Psychiatry Reports*, 11, 494-502.
- Viggiano, T., Pincus, H. A., & Crystal, S. (2012). Care transition interventions in mental health. *Current Opinion in Psychiatry*, 25, 551-558.
- Vöhringer, P. A., Barroilhet, S., Amerio, A., Reale, M. L., Vergne, D., Alvear, K. P., & Ghaemi, S. N. (2013). Cognitive impairment in bipolar disorder and schizophrenia: A systematic review. *Frontiers in Psychiatry*, 4, 1-11.
- Wallace, C. J., Lecomte, T., Wilde, J., & Liberman, R. P. (2001). CASIG: A consumer-centered assessment for planning individualized treatment and evaluating program outcomes. *Schizophrenia Research*, 50, 105-109.
- Walker, E. R., McGee, R. E., Druss, B. G. (2015). Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis. *JAMA Psychiatry*, 72, 4, 334-341.
- Warner, R. (2013). *Recovery from schizophrenia: Psychiatry and political economy*. London, UK: Routledge.
- Warner, R. (2010). Does the scientific evidence support the recovery model? *The Psychiatrist Online*, 34, 3-5.
- Watson, A. C., & Fulambarker, A. J. (2012). The crisis intervention team model of police response to mental health crises: A primer for mental health practitioners. *Best Practices in Mental Health*, 8, 71-81.

- Weisman de Mamani, A., Weintraub, M. J., Gurak, K., & Maura, J. (2014). A randomized clinical trial to test the efficacy of a family-focused, culturally informed therapy for schizophrenia. *Journal of Family Psychology*, 28, 800-810.
- Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry*, 33, 1111-1115.
- Weller, E. B., Weller, R. A., Fristad, M. A., Rooney, M., T., & Schechter, J. (2000). Children's Interview for Psychiatric syndromes (ChIPS). *Journal of the American Academy of Child & Adolescent Psychiatry*, 39, 76-84.
- Williams, J., Leamy, M., Bird, V., Harding, C., Larsen, J., Le Boutillier, C., Oades, L., & Slade, M. (2012). Measures of the recovery orientation of mental health services: systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 47, 11, 1827-1835.
DOI: <https://doi.org/10.1007/s00127-012-0484-y>
- Wirshing, D. A., Wirshing, W. C., Marder, S. R., Liberman, R. P., & Mintz, J. (1998). Informed consent: Assessment of comprehension. *American Journal of Psychiatry*, 155, 1508-1511.
- Wisdom, J. P., Bruce, K., Saedi, G. A., Weis, T., & Green, C. A. (2008). Stealing me from myself: Identity and recovery in personal accounts of mental illness. *Australian & New Zealand Journal of Psychiatry*, 42, 489-495.
- Witt, K., Hawton, K., & Fazel, S. (2014). The relationship between suicide and violence in schizophrenia: Analysis of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) dataset. *Schizophrenia Research*, 154, 61-67.
- Witt, K., van Dorn, R., & Fazel, S. (2013). Risk factors for violence in psychosis: Systematic review and meta-regression analysis of 110 Studies. *PLoS ONE* 8(2): e55942.
- Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A. M., & Bauer, M. S. (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: Systematic review and meta-analysis. *American Journal of Psychiatry*, 169, 790-804.
- Wright, E. R., Wright, D. E., Perry, B. L., & Foote-Ardah, C. E. (2007). Stigma and the sexual isolation of people with serious mental illness. *Social Problems*, 54, 1, 78-98.
<https://doi.org/10.1525/sp.2007.54.1.78>.
- Yerushalmi, H. & Lysaker, P. H. (2014). The recovery approach to rehabilitation: implementation in supervision. *Journal of Social Work Practice*, 28, 59-73.
- Young, M. E., Bell, Z. E., & Fristad, M. (2016). Validation of a brief structured interview: The children's interview for psychiatric syndromes (ChIPS). *Journal of Clinical Psychology in Medical Settings*, 23, 327-340.
- Young, S. L., & Bullock, W. A. (2005). Mental Health Recovery Measure (MHRM). In T. Campbell-Orde, J. Chamberlin, J. Carpenter, & H. S. Leff (Eds.), *Measuring the Promise: A Compendium of Recovery Measures* (Vol. II, pp. 36-41). Cambridge, MA: Evaluation Center @ Human Services Research Institute.

- Yung, A. R., Yuen, H. P., McGorry, P. D., Phillips, L. J., Kelly, D., Dell'olio, M., ...& Buckby, J. (2005). Mapping the onset of psychosis: The comprehensive assessment of at-risk mental states. *Australian and New Zealand Journal of Psychiatry*, 39, 964-971.
- Zarit, S., Reever, K., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. *The Gerontologist*, 20, 649-655.
- Zipursky, R. B., Reilly, T. J. & Murray, R. M. (2012). The myth of schizophrenia as a progressive brain disease. *Schizophrenia Bulletin*, 39, 1363–1372.
- Zuehlke, J. B., Kotecki, R. M., Kern, S., Sholty, G., & Hauser, P. (2016). Transformation to a recovery-oriented model of care on a veterans administration inpatient unit. *Psychiatric Rehabilitation Journal*, 39, 361-363.

Criterion V. Advanced Scientific and Theoretical Preparation

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

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

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

The Specialty is designed to be based on a Major Area of Study at the post-doctoral level. We recognize that students may well have an opportunity to have an Exposure, Experience, or even an Emphasis in working with the SMI/SED population at the graduate and/or internship level of learning; but, given the specialized scientific and clinical competencies required of this Specialty, we believe that the 80%+ time available during the post-doctoral experience is what is required to complete the required training in this Specialty.

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

We strongly believe that at the doctoral level, including internship, students should have at least an Experience, Exposure or Emphasis opportunity with the SMI population that is truly broad and general training with a major population that can be seen by all psychologists. Students from programs that provide a Major Area of Study at the doctoral and or internship level with the SMI population are even better prepared to embark on the specialized training of the post-doctoral year(s).

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

This is a post-doctoral specialty. We note that in a post-doctoral Major Area of Study that at least 80% of a learners time is within the scientific and clinical areas of the Specialty. The details of the training for this Specialty are described in this Criterion (V), in Criteria IV, VI and VII and in our Training Guidelines for Post-Doctoral Psychology Residency Programs in SMI Psychology, attached as Appendix I and available on our Specialty Council website (<http://www.psychtrainingsmi.com>).

In addition to the requirements of the Standards of Accreditation for Health Service Psychology (American Psychological Association, Commission on Accreditation, 2015), i.e., completion of doctoral and internship training, post-doctoral residency programs in SMI/SED require official transcripts from the doctoral or re-specialization program (if the applicant did not graduate from an accredited program in Health Service Psychology) and from the internship program, a cover letter indicating previous clinical experience with persons with SMI/SED or in settings where persons with SMI/SED are seen, commitment to a career working with those diagnosed with SMI/SED, statement of future goals as they relate to SMI/SED, letters of recommendation, and the applicant's CV. Programs may also have other requirements such as submission of a work sample, etc.

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

Advanced scientific and theoretical knowledge specifically focused on the SMI/SED population is acquired via specialized didactic and experiential training at the post-doctoral level that builds on and extends the broad and general preparation in health service psychology and is based on the empirical literature. The specialized training needed to develop competence to treat persons with SMI/SED builds on, and expands doctoral level foundational and functional competencies, and includes:

- Additional, specialized assessment methods that assess strengths and functional capability rather than primarily symptomatology and deficits,
- Evidence-based and promising practices designed specifically for this population,
- Interventions modified and found to be effective with people in this population within the forensic mental health system,
- Research methods adapted for populations such as this, and
- Systems transformation methods specific to large mental health systems that serve this population, to name but a few – these are some of the major areas of specialized training needed by psychologists to work with individuals with SMI/SED.

This specialized training for post-doctoral residents in this Specialty takes place via several principal avenues, all of which are based on the latest science. These avenues are:

- Primary and secondary placements,
- Seminars, didactics, and workshops,
- Research,
- Supervision,
- Consultation,
- Teaching, and
- Administration.

While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training and scientific experiences should exist with the SMI/SED population (at least 80% of a resident's time) across all programs; as we make clear in the description of each of the avenues listed above, all aspects of residency training must be based on the most current scientific literature. The content of residency training should be focused on learning how to apply the scientific literature to develop the competencies necessary to conduct research, evaluation, clinical assessments and interventions with, and on behalf of, those with SMI/SED and to assist them to recover and attain their full functional capability.

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

Each resident's training plan should be individually created to meet the specific training needs of the resident and to develop competence in a full range of mental health and PSR skills, including competence in research and scientific inquiry for working with this population, based on the scientific

literature and specifically designed for individuals with SMI/SED. Training activities include attention to advancing development of core skills such as: specialized assessments, treatment interventions developed and researched specifically for this population, consultation and interprofessional teamwork, research and scientific inquiry, supervision and teaching, ethics, program management and administration, and understanding and valuing individual and cultural diversity. Residents leave their residency well-prepared to function successfully as independent scientist-practitioners and work effectively with persons with SMI/SED. Another goal of the residency is to train residents to function in leadership positions working with persons with SMI/SED. As a result, the resident should also be prepared to transition to practice with an interprofessional team, promoting client-centered, recovery oriented care and interprofessional collaboration for specialized assessment and treatment of persons with SMI/SED.

A developmental training approach is to be used in which learning objectives are achieved through didactic and experiential clinical placements under observation, supervision and mentoring by one or more supervisors. Each resident's training plan is individually created to meet the specific training needs of the resident and to develop competence in a full range of community mental health and PSR skills. Competence is evaluated through components of knowledge, skills, and attitudes/values. An evaluation tool adapted specifically for SMI Psychology training and competence evaluation has been piloted and is in use at post-doctoral training sites. 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)*, and is included at Attachment III. Generally, a resident's training will follow a progression from observation by a 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 (Falendar & Shafranske, 2004) or an integrative developmental model (Stoltenberg & McNeill, 2010)

Required Education and Training and Other Experiences

Primary and Secondary Placements

Across all placements, the post-doctoral resident should be the primary psychologist responsible for several individual clients. Residents should conduct a range of EBPs and promising practices, with fidelity to the models measured when fidelity criteria exist. Residents should also oversee at least one or more skills training group(s). Post-doctoral residents also conduct several assessments that include cultural, strengths-based, and functional assessments, and use those assessments to develop treatment plans or recommendations from those assessments. Residents should also work provide psychoeducation for several families or support systems of their clients. Given that much of the PSR work focuses on community integration, residents should have at least one ongoing experience outside the clinic (ACT, home-based interventions, etc.).

1. Required Primary Placement

Residents should expect to spend at least 80% time in the Major Area of Study with approximately 20 hours per week in a supervised, primary placement setting that is focused on the scientific understanding and treatment of the SMI/SED population. A secondary rotation, also focused on the SMI/SED population (see below), and grounded in the latest science, will be part of the post-doctoral leaning opportunity to broaden the experience of settings and patient types. As residents increase their competencies, confidence, and levels of responsibility, they should receive more complex cases, provide more independent clinical work, pursue their own training goals, and take on additional roles if desired. Residents also typically work with pre-doctoral interns and practicum students, and are involved with the hierarchical supervision of these interns and students along with their clinical responsibilities on their rotations. The intensity and level of these activities would be determined in a collaborative nature between trainee, supervisors, and the Directors of Training.

Residents' competence 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. This 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. Further, 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 colleagues, behavioral observation, structured observation checklist ratings, and ratings based on record or chart review. 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. Evaluation feedback needs to be given early enough in the program to serve as a basis for correction and should include documentation about intended corrective actions. Subsequent feedback involves the extent to which these corrective actions are, or are not successful in addressing any areas of concern.

The primary placement could take place in an outpatient program or on an in-patient unit. The focus of the team should be on recovery-oriented PSR for those with SMI/SED. Residents would conduct screening, provide diagnostic clinical and strength based functional and resource assessments, work on initial goal-setting, provide psychoeducation to meet the person's expressed needs, help motivate individuals to engage in treatment, provide evidence-based and promising practices specific to persons with SMI/SED, and assist in data collection, program evaluation, and quality improvement. Residents will also participate in individual (and possibly group) supervision regarding specialized PSR and related clinical activities for the SMI/SED population in an appropriate and effective manner. Residents should be expected to offer case presentations that include a cultural case formulation, and residents and other trainees also typically meet to review cases and process their experiences. Residents learn about recovery-driven systems and the kinds of services provided and are members of interprofessional teams. A post-doctoral residency in SMI Psychology is fully focused on the SMI/SED population. Though doctorally prepared psychologists may have had some exposure and experience with individuals in this population, post-doctoral training in this Specialty is intense and concentrated; this concentration is required to develop the competencies needed to manage the complexities of the illnesses within the SMI/SED population. The activities mentioned above (screening, assessments, interventions, etc.) are accomplished using specialized methods and tools developed and tested specifically for this population; these require highly trained and skilled psychologists to undertake them responsively and complete them effectively.

Residents and other trainees also typically meet with peers, teams, and training faculty to review cases and process their experiences. They would also have the opportunity to lead rounds and facilitate discussions, offering supervision and team leading experiences.

The empirical literature (cited throughout this petition) drives all aspects of the SMI Psychology post-doctoral residency and is the foundation on which each component of the residency is built. This includes all clinical placements, didactic instruction, seminars, consultation, and supervision. It is this scientific literature that serves as the basis for all aspects of treatment of persons with SMI/SED, from engagement, through to assessment, goal setting/service planning, interventions, consultation, etc., and which supports research and development of new clinical measures and methods for this population.

Core components that PSR and recovery oriented units/teams for persons with SMI/SED would include (each residency program would determine which are best suited for the program):

Integration of Science and Practice

- Understands and uses evidence-based approaches to working with the SMI/SED population and how practice integrates the best available research, clinical expertise, and new and

emerging assessment and treatment approaches with the SMI/SED population.

- Demonstrates the ability to formulate and test empirical questions informed by clinical problems encountered, clinical services provided, and the clinical settings within which the resident works with the range of SMI/SED patients
- Each of the components is based on the empirical literature; residents must be familiar with and be able to demonstrate competency in the concepts and practices of that literature

NOTE: The citations we provide below are a sampling of important references. An attempt was made to avoid duplication with the extensive review and listing in Criteria IV and VI although there may be some overlap; newer citations are also incorporated below. Please see Criteria IV and VI for additional information and references. Each post-doctoral residency program will choose the SMI/SED specific scientific literature that best meets their needs.

Individualized assessment/re-assessment focused on the cognitive deficits experienced by persons with SMI/SED and that lead to the functional deficits experienced by those treated by psychologists in this Specialty including:

- Strengths based and culturally informed assessments
- Diagnostic clarifications
- Cognitive screening
- Functional assessment
- Rehabilitation readiness assessment
- Goal setting and recovery/treatment planning

See for example: Bora, Yucel & Pantelis, 2010; Cavelti, Kvrjic, Beck, Kossowsky, & Vauth, 2012; Cohen, Farkas & Cohen, 2007; Cramer, et al., 2016; Davidson, 2010; Farkas, Cohen, McNamara, Nemecek, & Cohen, 2000; Glynn & Mueser, 2018; Khanam, McDonald, & Neils, 2013; Kirkpatrick, Buchanan, McKenney, Alphas, & Carpenter, 2013; Kring, Gur, Blanchard, Horan, & Reise, 2013; Mueser, 2012; Nuechterlein, et al., 2008; Oliveira-Maia, Mendonça, Pessoa, Camacho, & Gago, 2016; Pratt & Mueser, 2011; Shankman, et al., 2017; Sklar, Groess, O'Connell, Davidson, & Aarons, 2013; Wallace, Lecomte, Wilde, & Liberman, 2001; Wong & Gordon, 2006; Wu, Dagg, & Molgat, 2014; Zisman-Ilani, Barnett, Harik, Pavlo, & O'Connell, 2017.

Assessments specific to SMI/SED

Please Note: See Criterion VI for more comprehensive information and detail concerning many of the following assessments, especially those designated as culturally informed, the strength based assessments, and some of the functional capability assessments. For an excellent overview of assessments, see the chapter by Glynn and Mueser (2018) which presents a comprehensive review of the many instruments available along with information about their psychometric properties. See Criteria IV and VI for a more comprehensive review of the scientific literature.

The assessment instruments below are examples of a listing of the most widely known and used assessment instruments in a wide array of categories. These are specific to SMI/SED and could not all be covered in depth in a one year post-doctoral residency program. Residents should be made aware of the breadth of assessments available and become competent in at least one or two from each major category. A good overview reference is APA's curriculum (American Psychological Association & Jansen, 2014) which provides information about many relevant recovery-oriented assessments and most of the evidence-based and promising PSR practice interventions. Each residency program would decide which

of the following would be required and/or emphasized.

Comprehensive assessment is essential to any recovery service plan. Residents should be able to appropriately assess, evaluate and then develop practical interventions for individuals with severe and persistent mental illnesses, including those with complicated mental, substance abuse, and medical comorbidities, often with histories of trauma. Residents should achieve competence in conducting a cultural formulation interview; the DSM-5 Cultural Formulation Interview (American Psychiatric Association, 2013) is recommended for use in training programs in this Specialty.

- **Culturally informed assessment**

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).

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) (Andreasen, 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).

Self-Stigma of Mental Illness Scale (SSMI) (Corrigan, Watson, & Barr, 2006),

Internalized Stigma of Mental Illness Scale (ISMI) (Ritsher et al., 2003),

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, 2006).

- **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, 2011).

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** – Note: the predictive accuracy of instruments in this category “remains a source of considerable uncertainty” (Fazel, Singh, Doll, & Grann, 2012).

Hare Psychopathy Checklist-Revised (PCL-R) (Hare, 1991).

Historical, Clinical, Risk Management-20 V3 (HCR-20) (Douglas, Hart, Webster, & Belfrage, 2013).

- **Recovery based assessments 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).

Interventions specific to SMI/SED

Please Note: We have tried to avoid repeating the detailed information presented in Criteria IV and VI. For comprehensive information, details and citations concerning the scientific basis of **each** of the evidence based and promising practices, please see Criteria IV and VI.

- **Evidence-based and promising practices for this population:**

Family psychoeducation

Assertive community treatment

Supported education and supported employment particularly the individual placement and support model

CBT for psychosis (CBTp) and Cognitive Behavioral Therapy (CBT) for select problems

Co-occurring disorders treatment

Social cognition and cognitive remediation

Early intervention and PSR treatments for recent onset psychosis

Cognitive behavioral social skills training (CBSST)

Weight management and smoking interventions,

Trauma informed and trauma specific care

Illness management

Issues and interventions for those in criminal justice and forensic settings

Interventions for bipolar disorder including Interpersonal and Social Rhythm Therapy (IPSRT) and Family Focused Treatment (FFT)

Note that there is no one seminal reference for any of the EBPs or promising practices listed above as each has been the subject of multiple clinical trials, some of which have incorporated other interventions. For this reason, the following are provided as evidence of the robust literature for these interventions. See for example: American Psychological Association, 2015; Aschbrenner & Brunette, 2018; Barry, McGinty, Pescosolido, & Goldman, 2014; Bartels, 2018; Chinman, et al., 2014; Anthony, Morrison & Barratt, 2010; Bellack, Mueser, Gingerich, & Agresta, 2004; Compton, Daumit, & Druss, 2009; Cook & Newman, 2014; Correll, et al., 2018; Corrigan, et al., 2017; Dass-Brailsford & Myrick, 2010; DeHart, et al., 2013; Dickerson, et al., 2006; Dickerson, et al., 2018; Dixon, et al., 2010; Dixon, Goldman, Srihari, & Kane, 2018; Ellingrod, et al., 2012; Epperson, et al., 2014; Epstein. et al., 2015; Epstein, Fannesbeck, Potter, Rizzone, & McPheeters, 2015; Evins, Cather, & Laffer, 2015; Forman-Hoffman, et al., 2016; Frank, et al., 2005; Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2012; Granholm, McQuaid, & Holden, 2016; Hagen, Turkington, Berge & Grawe, 2011; Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010; Lecomte, Samson, Naeem, Schachte, & Farhall, 2018; Leonhardt, et al., 2017; Lu, et al., 2013; Lynch, et al., 2014; McFarlane, 2002; Mitchell, et al., 2013; Mueser, Lu, Rosenberg & Wolfe, 2010; Naslund, et al., 2014; Naslund, Aschbrenner, Marsch & Bartels, 2016; Nossel, et al., 2018; Parks, Svendsen, Singer & Foti, 2006; Peters, Wexler, & Lurigio, 2015; Pettersen, Ruud, Ravndal, Havnes, & Landheim, 2014; Pratt, Sargent, Daniels, Santos, & Brunette, 2016; Priester, et al., 2016; Reisinger-Walker, McGee, & Druss, 2015; Roy, Crocker, Nicholls, Latimer & Ayllon, 2014; Schroeder & Morris, 2010; Siu, for the U.S. Preventive Services Task Force, 2015; Smith, et al., 2017; Stein, Celedonia, Kogan, Swartz, & Frank, 2013; Stobbe, 2014; U.S. Department of Health and Human Services, 2008; U.S. Department of Health and Human Services, 2009a; U.S. Department of Health and Human Services, 2009b; U.S. Department of Health and Human Services, 2009c; U.S. Department of Health and Human Services, 2009d; U.S. Department of Health and Human Services, 2011a; U. S. Department of Health and Human Services, 2011b; van Gestel-Timmermans, 2012; Wright, et al., 2014; Wright, Turkington, Kingdon, & Ramirez Basco, 2009.

- **Other interventions targeted to the principal problems faced by persons with SMI/SED**

- **Individual or group psychotherapy for**
 - Intensive case management
 - Anger management skills and Relationship skills
 - Interpersonal psychotherapy
- **Interventions for those who are homeless or at risk of homelessness**
- **Interventions to reduce stigma, social isolation, and community exclusion**
- **Interventions for suicide prevention**
- **Working with community partners (e.g., NAMI; libraries, community recreation centers, senior centers, legal clinics, etc.)**
- **Solution-focused approaches such as Wellness Recovery Action Planning (WRAP)**

For these interventions, see for example: Baillargeon, Hoge, & Penn, 2010; Barrowclough, et al., 2010; Biebel, Nicholson & Woolsey, 2014; Bonfils, Adams, Firmin, White, & Salyers, 2014; Cohen, Ferguson, Harms, Pooley, & Tomlinson, 2011; Cook, et al., 2013; Copeland, 2018; Davydov, Stewart, Ritchie, & Chaudieu, 2010; Elis, Caponigro, & Kring, 2013; Jochems, van der Feltz-Cornelis, van Dam, Duivenvoorden, & Mulder, 2015; Morris, Johns & Oliver, 2013; Murphy, Irving, Adams, & Waqar, 2015. National Academies of Sciences, Engineering, and Medicine, 2016; U.S. Department of Health and Human Services, 2010.

2. Secondary Placements and Other Training Experiences

During the remaining 20 hours of the week, residents participate in additional rotations, didactic seminars, supervisory sessions, and other experiences, all of which are focused on SMI/SED and designed to round out their scientific understanding and knowledge of SMI/SED and fully develop their competence in service provision for this population. We describe these below.

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

3. Topics and Concepts that Should be Covered

In addition to completing required primary and secondary placements, residents are also required to attend seminars, didactic presentations, and supervision sessions which are to be focused on issues related to SMI/SED. Contemporary research literature in each topic is used to facilitate the scientific and

theoretical discussion required for the Specialty and how to integrate critical, scientific thinking into the application and clinical work of each resident. The scientific literature also serves to enhance discussion during seminars. In order for residents to gain experience in teaching, participants would be encouraged to teach at least one session on an area of interest, and to submit abstracts for talks to be given at relevant conferences such as those of the Psychiatric Rehabilitation Association, Association of Behavioral and Cognitive Therapies, the American Psychological Association convention and/or local, state, or regional conferences with an interest in SMI/SED. If applicable, time is devoted to teaching the mechanics of giving PSR presentations, and providing feedback to participants as they rehearse these talks for presentation to larger audiences.

The Specialty Council has recognized the essential importance of developing guidelines to direct optimal training of new psychologists. Accordingly, the SMI Psychology Training Guidelines (Appendix I and available on the Specialty Council website (www.psychtrainingsmi.com)) outline the training requirements for Specialty programs in SMI Psychology. SMI/SED cultural competence is defined as a foundational competency and the Training Guidelines require post-doctoral trainees, at a minimum, to 1) participate in a yearly diversity seminar, 2) be placed at clinical sites where they will have exposure to diverse clients and supervisors, 3) learn to use the DSM-5 Cultural Formulation Interview, 4) and be assessed regularly on their competency in this area. As discussed in Criterion III, training programs with a Major Area of Study in SMI Psychology are also encouraged to develop site-specific activities to enhance cultural practice competency.

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

- **Principles of PSR:** This didactic seminar mirrors the training philosophy of the scientist-practitioner model and is designed to provide participants with a broad and thorough understanding of PSR interventions, principles, theories, and current research in clinical and community psychology as applied to persons with SMI/SED. Sessions focus on current evidence-based and promising practices designed, developed, and empirically validated for persons with SMI/SED, stigma, ethics and boundaries (and how they may differ from those in traditional mental health and or other health service psychology specialties), and other relevant topics (American Psychological Association & Jansen, 2014; Buonocore, et al., 2018; Corrigan, 2016; Corrigan, Mueser, Bond, Drake & Solomon, 2008; Davidson, Harding & Spaniol, 2005; Davidson, Harding & Spaniol, 2006; Glynn, 2014; Kern, Glynn, Horan, & Marder, 2009; Lim, Barrio, Hernandez, Barragan, & Brekke, 2017; Morin & Franck, 2017; Mueser, Glynn, & Meyer-Kalos, 2017; Onken, Craig, Ridgway, Ralph, & Cook. 2007; Pratt, Gill, Barrett & Roberts, 2007).

The goal of PSR is an individual's improved functioning, life satisfaction, and participation in environments of one's choice; symptom improvement may also occur. The majority of services provided are PSR interventions, although residents in this specialty also provide traditional treatments such as symptom management and supportive therapy. Embedded in this model is an interprofessional approach based on a recovery model that empowers individuals to develop personalized goals and choose from a menu of treatment program opportunities, including inpatient and outpatient services. The goal of services is to improve community functioning and quality of life for persons with SMI/SED. Ensuring an active partnership with consumers and community partners is an important element of this work.

Learning outcomes include:

- Ability to competently explain the underlying principles and theories of a recovery approach to services for persons with SMI/SED;
- Demonstrated ability to put into practice the essential elements that differentiate PSR methods from more traditional psychological approaches;

- Demonstrated ability to describe the elements of evidence-based and promising PSR practices including their fidelity measures;
- Demonstrated acceptance of the importance of partnering with persons with SMI/SED, their families, support partners, and community systems.
- **Research / Program Evaluation and Dissemination Seminar:** One of the most important ways that science is incorporated into the post-doctoral residency experience is that each resident would be expected to design, develop, and implement a research, evaluation, or academic project that can be presented at a relevant national, regional or local conference and that is specifically targeted to an issue or problem in the Specialty. The purpose of this project is to disseminate novel approaches to PSR for people with SMI/SED. Projects could include designing a new psycho-educational group or program, implementing a focus group, evaluating an existing treatment program, participating in an ongoing research study and presenting research findings, writing a literature review manuscript, submitting a grant application, developing an impact statement or a policy initiative, designing and evaluating a new group or program, etc.

This seminar is designed to assist in the formulation and execution of the project and would focus on topics such as overviews of research and evaluation of PSR assessment and intervention, research and evaluation methods, research dissemination, and critical reviews of research. The seminar focuses on research methodology that is particularly germane to SMI/SED, which may include qualitative and mixed method designs, case studies, and participatory action research. The seminar also promotes the integration of science and practice by including journal club readings and discussions about the latest research findings on clinical approaches to the assessment and treatment of persons with SMI/SED, including discussions about how these findings should shape residents' clinical services.

Residents should gain experience in identifying, reviewing, and contributing to the scientific literature and knowledge base in SMI/SED.

Learning outcomes include:

- Ability to locate evidence in the literature from scientific studies relevant to the SMI/SED population, apply knowledge of research design and statistical methods to the evaluation of study findings, and select appropriate evidence on diagnostic and therapeutic effectiveness to improve patient care;
- Demonstrate familiarity with current scientific literature in PSR and related clinical activities for SMI/SED population; evaluate the relevance of scientific literature relevant to specific questions or patients;
- Demonstrate familiarity with methods of integrating scientific literature and clinical information regarding PSR and related clinical activities for SMI/SED population in the service of patient care and program development;
- Demonstrate knowledge of resources available to locate information on PSR and related clinical activities for SMI/SED population relevant to patient care and program development;
- Demonstrate understanding of how to use knowledge of research design and statistical methods to identify the level of evidence in published information when applying to PSR and related clinical activities for SMI/SED population;
- Develop and implement research questions in PSR and related clinical activities, and in health-care systems to improve the organization, delivery and effectiveness of SMI/SED-driven care;

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

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

Sample readings include the following: Cabassa, et al., 2013; Chatterton, et al., 2017; Corrigan, et al, 2001; Davidson, et al., 1997; Ivankova, 2014; King, Lloyd, & Meehan, 2013; Kuipers, Yesufu-Udechuku, Taylor, & Kendall, 2014; Kukla, Whitesel, & Lysaker, 2016; Leonhardt, et al., 2017; McGurk, et al., 2017; Michalak, 2016; Moos, 2017; Patton, 2015; Rouse, Mutschler, McShane, & Habal-Brosek, 2017; Sin, & Spain, 2017; Wallcraft, Schrank, & Amering, 2009; Yin, 2017.

- **Interprofessional Case Assessment Seminar:** This seminar should focus on learning and applying the unique assessment skills of each discipline to effectively work in a collaborative manner to create and provide assessments that are comprehensive, recovery-focused, culturally informed and diversity respectful, holistic and offer an interprofessional approach to treatment for persons with SMI/SED. In order to facilitate this learning, residents would be paired with other disciplines to conduct assessments outside of the seminar meetings. Residents would be expected to work collaboratively with each other throughout the entire process of the assessment, which includes selecting assessment tools, scheduling times to conduct the assessment, writing the assessment report and presenting feedback to the treatment team, the individual, family members and other stakeholders. Residents would be assigned at least one case, and preferably two or more, as part of the interprofessional team (Barry & Crosby, 1996; MacDonald-Wilson, Rogers, & Anthony, 2001; Mueser, et al., 2001).

Note that case assessment is different from case management which is a specific PSR intervention that occurs in the context of a therapeutic relationship and flows from an understanding of the unique problems experienced by the individual as well as of the particular types of assistance needed to overcome the problem, and might more aptly be titled clinical case management, requiring specialized training in order to maintain faithful implementation and fidelity to the model.

Learning outcomes include:

- Recognizing and demonstrating ability to appreciate the value of assessments from other disciplines/professionals;
- Ability to work collaboratively with professionals from other disciplines involved with each case.
- **Systems Change Seminar:** A didactic seminar using seminal research literature to guide discussions about leadership, management styles and organizational development, this seminar draws heavily from the research literature on change management, organizational development, and systems design. Similarly to other disciplines, dissemination and implementation of new methods for working with persons with SMI/SED is challenging. The PSR literature is extensive and several special issues have been devoted to the issue. 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/SED Specialty's focus on person-centeredness.

Suggested readings include (Armenakis, Harris, & Mossholder, 1993; Battilana & Casciaro, 2012;

Cameron & McNaughtan, 2014; Carpinello, 2002; Chu, et al., 2012; Corrigan, et al., 2001; Corrigan, Steiner, McCracken, Blaser & Barr, 2001; Davidson, et al., 2007; Drake & Essock, 2009; Farkas & Anthony, 2007; Foster-Fishman, & Behrens, 2007; Gask & Coventry, 2012; Green, et al., 2014; Institute of Medicine, 2001; Kidd, McKenzie & Virdee, 2014; McFarlane, et al., 2001; McHugo, et al., 2007; Mueser, et al., 2003; Olmos-Gallo, Starks, DeRoche-Luszczakoski, Huff & Mock, 2011; Ramos, 2007; Resnick & Leddy, 2015; Rosenheck, 2001; Torrey, et al., 2001; U.S. Department of Health and Human Services, 2006; Weick & Quinn, 1999; Weick, 1984).

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

Residents should demonstrate an ability to:

- Understand the challenges in developing and maintaining an interprofessional workforce;
 - Demonstrate leadership through mentoring and supervision;
 - Recognize and negotiate the politics of organizations and the issues specific to systems that treat persons with SMI/SED.
- **Diversity Seminar:** Training in a Major area of Study in an SMI Psychology Specialty program must integrate both knowledge and practice to be useful. Applications of cultural knowledge acquired in the classroom take place during practice training experiences. Thus, diversity training when working with the SMI/SED population is primarily practical and applied, with cultural competence defined as a foundational competency. Practice training for post-doctoral residents in this Specialty occurs in several main areas: primary and secondary placements, seminars, didactics, research, supervision, consultation, teaching, and administration. While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training experiences should exist across all programs. With regard to diversity experience, in addition to participation in the diversity seminar, fellows should receive clinical training in at least one (and preferably more) clinical setting which 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.

The Diversity seminar itself will include journal club readings and discussion of contemporary research literature on diversity and cultural competency issues in SMI/SED, such as the following topics: clinician reasoning in the use of cultural formulation to resolve uncertainty in the diagnosis of psychosis (Adeponle, Groleau, & Kirmayer, 2015; Evans, et al., 2015; Keval, 2015; Whitley, 2016), cultural adaptation and treatment (Maura, & de Mamani, 2017; Rathod, et al., 2017).

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

Learning outcomes include:

- Fully understanding psychiatric disability as part of diversity;

- Recognition of ethical issues and development of skill in resolving these, development of understanding and respectful attitudes, current knowledge and skills in relation to all aspects of human diversity;
- Residents are expected to make a substantial effort to recognize, understand, appreciate and discuss topics such as age, sex, gender, ability/disability/illness, culture, ethnicity, race, language/culture of origin, sexual orientation, socioeconomic status, and religious/spiritual beliefs and attitudes, among others, as well as the intersection of these and how they are considered and integrated in provision of services and design of evaluation and research, with regard to persons with SMI/SED.

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

- Poor attention to physical health complaints by health care providers, misattributions of legitimate health concerns to psychotic symptoms, discriminatory practices including failure to follow treatment guidelines when people of color and diverse cultural backgrounds are seen, and need for attention to language barriers, traditional beliefs about mental illness, and religious/cultural issues;
- The exploration of power differentials, dynamics, and privilege should be at the core of understanding issues of diversity and impact on social structures and institutionalized forms of discrimination that may influence the person's perception of her/his potential for improved quality of life.
- **Laws and Ethics Seminar:**

Mental health recovery for those with SMI/SED raises important ethical issues regarding competence and safety while balancing with 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 (Atterbury, 2014; Lukens & Solomon, 2013; Rudnick, 2011), use of restraints and seclusion (Know & Holloman, 2012; Ashcraft & Anthony, 2009), culture and diversity (Hoop, DiPasquale, Hernandez & Roberts, 2008) and even family involvement (Bellesheim, 2016; Lukens & Solomon, 2013) in working with persons with SMI/SED. 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 (Corey, Corey & Corey, 2018). Ethically, health care providers should focus on the rights of the person to self-determination in making choices that affect each individual. Shared decision making is a process to facilitate self-determination and is recommended to be integrated with other recovery-supporting interventions (Davidson, Tondora, Pavlo & Stanhope, 2017; Slade, 2017; Anthony, 2010). Shared decision making is considered to be an ethical imperative in providing general health care (Elwyn, 2011) and, more specifically, specialty mental health care (Del Piccolo & Gross, 2012).

Learning outcomes include:

- Ability to balance the need for competent decision making with self-autonomy in light of risks to self and others;
- Knowledge of the emergent literature on the dangers of seclusion and restraint and ability to know if, when, and under what circumstances such procedures can be used;
- Understanding of the biases surrounding culture, race, gender and other diversity issues and the impact of those biases on decisions made by professionals in the mental health system. Ability to

recognize those biases within oneself and refrain from making decisions based by those biases.

- **Consultation Seminar:**

Mental health recovery is often facilitated by a team of clinicians working collaboratively towards the client's goals. Learning the unique interprofessional competencies (Interprofessional Education Collaborative, 2016) and how to apply them is critical in providing optimal patient-centered care (Fox & Reeves, 2015; Links, 2014; Bainbridge & Wood, 2012; Legare, et al., 2011). This extends beyond general health care, specifically to specialty mental health care (Maranzan, 2016; Johnson & Freeman, 2014; Kinnair, et al., 2014; Chong, et al., 2013; Kinnair, Anderson & Thorpe, 2012; Priest et al., 2011, 2008). Of note, although interprofessional efforts span across many professions, psychology recognizes the importance of interprofessional efforts (American Psychological Association, 2016) and psychologists are well-suited to be leaders on interprofessional teams and direct implementation and evaluation of outcomes (Ward, Zagaloff, Rieck, & Robiner, 2018).

Using contemporary research and clinical literature, this seminar is designed to provide didactic training and opportunities to discuss issues pertaining to consultation at the individual, team, and system levels (Chu, et al., 2012; Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Hutton, & Williams, 2001; Liebowitz, & Blattner, 2015; McFarlane, Dixon, Lukens, & Lucksted, 2003; Saillant, Hudelson, Dao, & Perron, 2016; Stirman, et al., 2017; Ziedonis, Williams, & Smelson, 2003). The seminar emphasizes the need for feedback and intervention recommendations to be data-driven. Residents provide feedback to each other about their consultation efforts. Leaders, faculty, and staff from other disciplines should be involved to serve as discussants to provide multiple perspectives. In all cases, the discussion is focused on how to apply what was learned to the SMI/SED PSR setting.

Residents should demonstrate competence in the following:

- Within the bounds of confidentiality and privacy, residents must be able to listen, understand, communicate, and display excellent rapport and proficiency with relevant stakeholders including: persons with SMI/SED, family members, relevant community members, interprofessional staff and other healthcare providers within and outside of the system, and community agencies and partners;
- Residents must demonstrate an ability to effectively present information and develop treatment recommendations that are understandable to the person with SMI/SED, his or her support team, and in accord with the individual's goals;
- Residents are able to competently work with an interprofessional team and present information about persons with SMI/SED so that team members can understand and learn from the presentation;
- Residents regularly provide consultation to interprofessional teams within the medical and or academic setting on how to implement EBPs for SMI/SED, best practices in PSR and community integration, and recovery-oriented mental health care for persons with SMI/SED;
- Consultation services include the provision of educational trainings on SMI/SED topics, the principles and strategies of PSR and recovery-oriented services for staff, partner agencies, organizations, and trainees from psychology and other disciplines;
- Residents provide consultation to community providers working with individuals with SMI/SED (examples may include providing training, technical assistance, case consultation, etc.).

4. Teaching and Supervision

Residents receive training in providing competency-based clinical supervision based on the Falender & Shafranske (2004; 2007; 2008) model, and training in supervision for specific clinical modalities follows evidence-based models (e.g., Milne & Riser, 2017 and Reiser et al., 2018 for cognitive behavioral therapy supervision). Residents should perform clinical supervision of pre-doctoral practicum students and doctoral interns (where the residency setting also has interns and pre-doctoral students), be supervised themselves by experienced clinical trainers, and take part in workshops or other training opportunities to develop their own supervisory skills, with reference to the population of persons with SMI/SED. They should also have the opportunity to present talks and seminars.

Residents should be able to:

- Demonstrate knowledge of methods of teaching specific to PSR and related clinical activities for the SMI/SED population, e.g., in case conferences, seminars, didactics, and journal clubs. Effectively translate knowledge of specialized PSR and related clinical activities for the SMI/SED population to interprofessional audiences;
- Demonstrate knowledge of methods of providing supervision to other psychology trainees that emphasizes skill building in providing patient care, consulting with other professionals, identifying relevant scientific data and conducting research, practice management and related clinical activities specific to PSR for the SMI/SED population. Residents demonstrate capability to competently supervise trainees in the full range of clinical activities. Demonstrated knowledge of, and ability to supervise implementation, of EBPs and fidelity scales where these exist. Topics include models of supervision, clinical competency, goals of supervision, reducing anxiety in supervision, silence, countertransference, supervision and ethics, risk management, self-care for the therapist and supervisor, and diversity awareness.

5. Supervision Meetings

- **Group Supervision Meetings.** These meetings incorporate the scientific literature cited throughout this petition to provide residents opportunities to learn more about how to work with those who have SMI/SED and can include processing past group or individual sessions, reviewing skills, role playing exercises, and learning more about various theories as well as practice tools and techniques. Residents learn to critically examine the empirical literature and to apply the evidence from the literature to their professional activities.

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

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

6. Professional Development Seminar

This seminar is typically a monthly meeting for all psychology post-doctoral residents at the site that focuses on professional development. Topics could include: applying for a career development award, general licensure requirements, both broadly and specific to the jurisdiction of the residency, studying for the EPPP, obtaining employment, managing a research and clinical career, and other timely topics of interest to professional psychologists.

7. Additional didactic content specific to SMI/SED to be covered

- **Etiology / epidemiology** – see for example: Kessler, Chiu, Demler, & Walters, 2005; U.S.

Department of Health and Human Services, 2015a; U.S. Department of Health and Human Services, 2015b.

- **Stress-vulnerability model of SMI/SED** (Cairns, Reid, Murray, & Weatherhead, 2015; Corrigan, Mueser, Bond, Drake & Solomon, 2008; Nuechterlein & Dawson, 1984; Opler, et al., 2013).
- **Premorbid / prodrome** - The period before onset of full blown psychosis is known as the prodromal period, and those in this state have been said to be at ultra-high-risk, or to be experiencing an attenuated psychosis syndrome (Alvarez-Jimenez, et al., 2018; Yung, et al., 2012); the rate of onset of a psychotic disorder has been shown to be thirty six percent within three years (Fusar-Poli, Bonoldi, Yung, Borgwardt, Kempton, et al., 2012). For those at this stage, early intervention with a combination of interventions has been shown in multiple trials to be effective and is critical for reducing the duration of untreated psychosis and improving outcomes (Alameda, et al., 2018; Álvarez-Jiménez, et al. 2011; Alvarez-Jimenez, et al., 2018; Bertelsen, et al., 2008; Bird, et al., 2010; Fisher, et al., 2018; Friis, et al., 2011 Kane et al., 2015; Shihari, et al., 2017).
- **Neurobiological/neurophysiological/neurocognitive phenomena** (Beck, Rector, Stolar, & Grant, 2011; Galderisi, et al., 2002; Green & Harvey, 2014; McDonald & Carter, 2002; Palmer, Dawes, & Heaton, 2009; Raglund, 2007; Schretlen, 2007).
- **Biopsychosocial model / physical health problems/behaviors** – It is well documented that persons with SMI die, on average, considerably earlier than those without SMI; estimates range between 10 – 30 years of premature death (Cairns, Reid, Murray, & Weatherhead, 2015; De Hert, et al., 2011; Kotsiubinskii, 2002; Lawrence, Hancock, & Kisely, 2013; National Institute of Mental Health, 2012; Olfson, Gerhard, Huang, Crystal, & Stroup, 2015; Thornicroft, 2011). The World Health Organization (WHO) reported the range to be between 10 - 26 years and reported the mortality rate for schizophrenia as 2 – 2.5 times higher and thirty-five – fifty percent higher for those with bipolar disorder than for those in the general population (World Health Organization, undated) and some investigators believe the mortality gap between those with SMI and the general population is widening (Cuijpers & Smit, 2002; Hiroeh, et al., 2007; Joukamaa, et al., 2001; Kisely, et al., 2007; Lawrence, Holman, & Jablensky, 2001; Lawrence, Mitrou, & Zubrick, 2009).
- **Older adult/aging** – Schizophrenia in late life is emerging as a major public health concern worldwide and impacts on persons affected, their families and caregivers, public health systems, and the public as costs escalate (Becker & Mehra, 2005; Cohen, 2000; Folsom, et al., 2006; Jeste & Liebowitz, 1997). There are different symptoms and unique challenges associated with SMI in (Harvey, 2005) older adults; the central issue is that of age-related changes in the clinical features of schizophrenia, which include delusions, hallucinations, emotional changes, cognitive impairments, and adaptive life skills (Harvey, 2005), along with social issues stigma, such as loneliness, homelessness, and comorbidities (Bartels, 2004; Bartels, et al., 2004; Loebach Wetherell & Jeste, 2004; Molinari, et al., 2013).

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

Through interdisciplinary rounds, clinical supervision, and educational seminars, SMI Psychology residents learn about psychopharmacology, pharmacokinetics, and pharmacodynamics, as they relate to clients with SMI/SED. Trainees demonstrate the ability to speak with physicians and other prescribers about medication regimens and adjustments, understand the normal range for therapeutic dose of common medications, provide education about the mind-body connection, and de-stigmatize and demystify pharmacotherapy. Residents also have an understanding of, and ability to communicate to clients and families about the medications and their potential benefits, side effects, and contraindications. Residents are also aware of the consequences of polypharmacy. This is particularly important for SMI Psychologists who work with clients who often have multiple co-morbid physical issues, are taking

multiple medications, and have varying levels of engaging in a medication regimen. SMI Psychologists are specifically educated about medications that are prevalent in these populations such as antipsychotics, mood stabilizers, antidepressants, and anxiolytics. Residents are also familiar with how various individual differences influence pharmacological treatment including age, gender, pregnancy/breastfeeding status, and religious or cultural perspectives on psychiatric medications. Residents are aware of how pharmacogenetics are increasingly part of the conversation of individual differences and medication prescription.

Selected readings include: Baldessarini, 2014; Baldessarini, Tondo, & Vazquez, 2010; Baldessarini, 2013; Muse & Moore, 2012; National Institute of Mental Health (website); Nussbaum & Sammons, (online course); Zandi & Judy, 2011.

History/community advocacy

- History of treatment of persons with SMI/SED
Deinstitutionalization, history of coercion, clubhouse model, empowerment movement
- Advocacy groups/community resources
- Violence and aggression – by persons with SMI/SED and against persons with SMI/SED
- Systems and settings for care provision

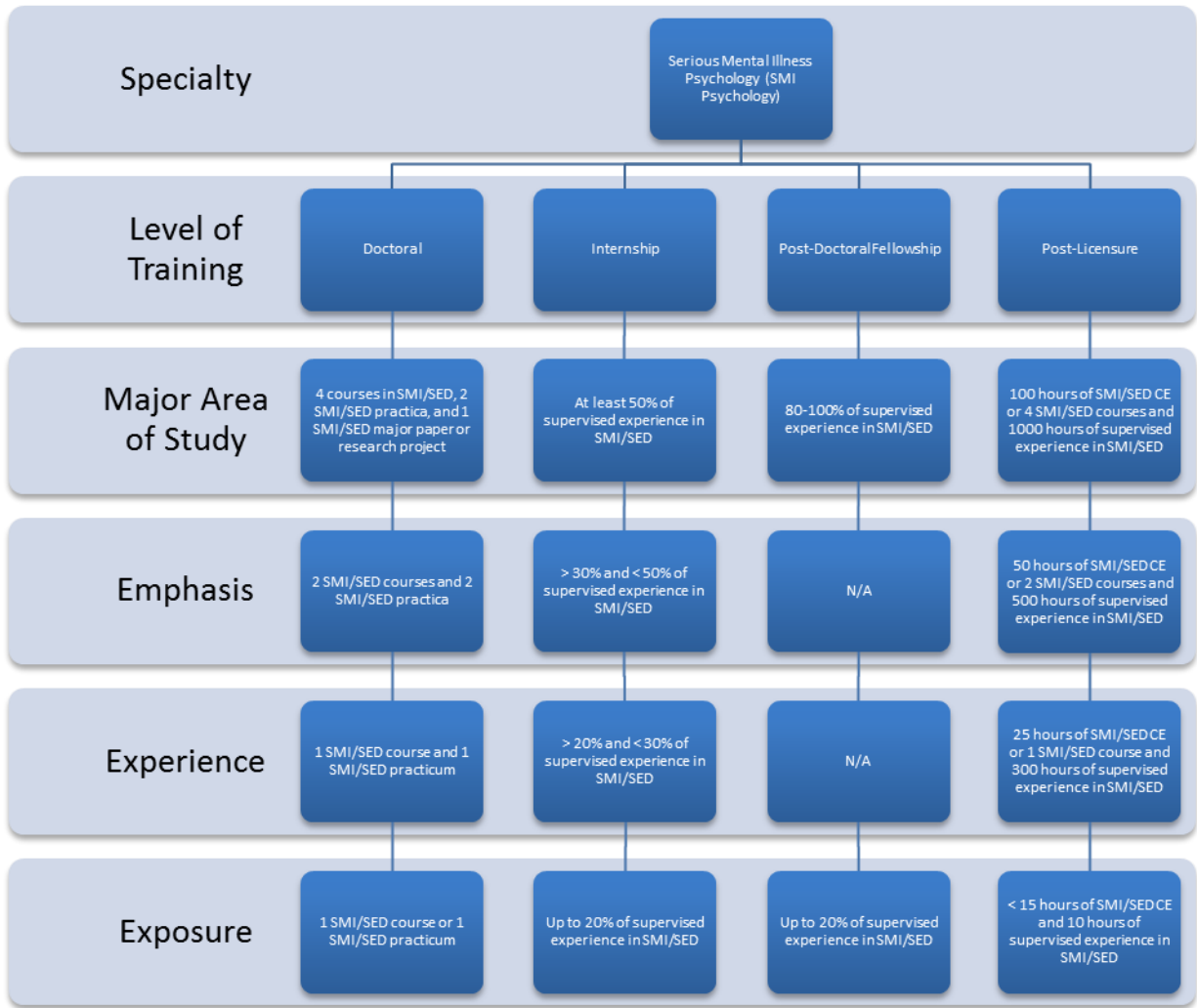
The scientific literature for these topics has been covered in several other criteria in this petition. Some additional citations, especially those that are highly important, seminal references and are required to cover the topics below are the following: (Baranowski, 2016; Chamberlin, 1977; Charland, 2011; Collison, et al., 1998; Constantine, Hage, Kindaichi, & Brynat, 2007; Corrigan, 2002; Cross, 2011; Deegan, 1996; Frese & Davis, 1997; Kuruvilla, & Jacob, 2007; Lefley, 2005; Linhorst, 2006a; Linhorst, 2006b; Lyons, et al., 2015; Mallinckrodt, Miles, & Levy, 2014; Meade & Copeland, 2005; Mosher & Hendrix, 2004; Myers & Sweeney, 2004; Neugeboren, 1999; Ridgway, 2001; Rowe, et al., 2009; Rowe, & Pelletier, 2012; Whitaker, 2002; Winerip, 1994).

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

Specialty training for the Specialty in SMI Psychology should occur at the post-doctoral level. It is expected that those learners seeking a position in the SMI/SED Specialty will have received their education and training in APA accredited doctoral and internship programs and pass their state licensing exam as soon as they accrue sufficient supervised hours to meet state requirements, which would typically happen during or soon after their first year of their post-doctoral residency. Thus, a psychologist desiring this specialized training would complete a post-doctoral specialization to obtain the didactic and experiential training described in this petition via a post-doctoral level Major Area of Study with the SMI/SED population in order to be fully competent to work effectively, ethically, and competently with people with SMI/SED and in preparation for seeking board certification in the Specialty.

For licensed, practicing psychologists who seek to become board certified in the Specialty, a minimum completion of 100 hours of APA approved CE credits or 4 academic courses didactic and experiential training in the concepts of recovery from SMI/SED and training in the assessments specific to this population along with training in the PSR evidence based and promising practices designed and researched for this population plus 1000 hours of supervised experience working with persons with SMI/SED are required to ensure competency. This is shown below in the Taxonomy for SMI Psychology.

Taxonomy for Education and Training in Serious Mental Illness Psychology (SMI Psychology)



SMI/SED Course – Each course must have predominant content specific to the recovery paradigm and/or psychosocial rehabilitation for persons with SMI/SED and be taken for at least 3 hours of credit.

SMI/SED Practicum – Minimum experience of 9 months of applied, clinical supervised experience for at least 10 hours per week working with persons with SMI/SED.

Applied, Clinical Supervised Experience – Must include at least 80% clinical contact with persons with SMI/SED and pertain to assessment, treatment, and/or consultation. If offered, seminar attendance, interdisciplinary team participation, readings, and research may count as part of the supervised experience for interns and postdoctoral fellows. Supervision must be provided by a psychologist meeting requirements for Major Area of Study in SMI/SED at the post-licensure stage.

CE coursework – Must be approved by the American Psychological Association and have content specific to SMI/SED.

Post-doctoral specialization in SMI/SED is intended to follow broad and general training in clinical, counseling or school psychology.

References

- Adeponle, A. B., Groleau, D., & Kirmayer, L. J. (2015). Clinician reasoning in the use of cultural formulation to resolve uncertainty in the diagnosis of psychosis. *Culture, Medicine, and Psychiatry*, 39, 1, 16-42.
- Alameda, L., Fournier, M., Khadimallah, I., Baumann, P. S., Cleusix, M., Griffa, A., ... Do, K. (2018). Childhood trauma engages oxidative stress, hippocampus alterations and poorer clinical outcome in early psychosis patients. *Schizophrenia Bulletin*, 44, Suppl 1, 1, S25–S26.
- Álvarez-Jiménez, M., Gleeson, J. F., Rice, S., Bendall, S., D'Alfonso, S., Eleftheriadis, D., ... Nelson, B. (2018). Enhancing social functioning and long-term recovery in young people with first episode psychosis (FEP) and young people at ultra high risk (UHR) for psychosis: A novel online social therapy approach. *Schizophrenia Bulletin*, 44, Suppl 1, S4–S5.
- Álvarez-Jiménez, M., Parker, A. G., Hetrick, S. E., McGorry, P. D., Gleeson, J. F. (2011). Preventing the second episode: A systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis. *Schizophrenia Bulletin*, 37, 3, 619–630.
- American Psychiatric Association. (2013). Cultural formulation. In: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, pps 749-759. Washington, DC: American Psychiatric Association.
- American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010 and January 1, 2017). Retrieved from <http://www.apa.org/ethics/code/index.aspx>
- American Psychological Association. (2015). Guidelines on Trauma Competencies for Education and Training. Washington, DC: Author. Retrieved from: <http://www.apa.org/ed/resources/trauma-competencies-training.pdf>
- American Psychological Association. (2016). APA joins interprofessional education collaborative. Retrieved August 13, 2017 from <http://www.apa.org/news/press/releases/2016/02/interprofessional-education.aspx>
- American Psychological Association & Jansen, M. A. (2014). *Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders*. Washington, DC: American Psychological Association.
- Anderson, K. K. & Kurdyak, P. (2016). Factors associated with timely physician follow-up after a first diagnosis of psychotic disorder. *The Canadian Journal of Psychiatry*, doi: 10.1177/0706743716673322.
- Andreason, N. C. (1986). Scale for the assessment of thought, language and communication disorders. *Schizophrenia Bulletin*, 12, 3, 473-482.
- Andreasen, N. C., Flaum, M., Swayze, V. W., et al. (1990). Positive and negative symptoms in schizophrenia: A critical reappraisal. *Archives of General Psychiatry*, 47, 7, 615-621.
- Anthony, W. (2010). Shared decision making, self-determination and psychiatric rehabilitation. *Psychiatric Rehabilitation Journal*, 34, 2, 87-88.
- Anthony P., Morrison, A. P. & Barratt, S. (2010). What are the components of CBT for Psychosis? A Delphi study. *Schizophrenia Bulletin*, 36, 1, 136–142.

- Armenakis, A. A., Harris, S. G., & Mossholder, K. W. (1993). Creating readiness for organizational change. *Human Relations*, 46, 6, 681-703.
- Armstrong, N. P. & Steffen, J. J. (2009). The recovery promotion fidelity scale: Assessing the organizational promotion of recovery. *Community Mental Health Journal*, 45, 3, 163-170.
- Aron, L., Honberg, R., Duckworth, K., et al. (2009). Grading the States 2009: A report on America's health care system for adults with serious mental illness. Arlington, VA: National Alliance on Mental Illness.
- Aschbrenner, K., A., & Brunette, M. F. (2018). The role of peers in health interventions for serious mental illness. *Psychiatric Services* 69, 5, 497.
- Ashcraft, L. & Anthony, W. (2008). Eliminating seclusion and restraint in recovery-oriented crisis services. *Psychiatric Services*, 59, 10, 1198-1202.
- Atterbury, K. (2014). Preserving the person: The ethical imperative of recovery-oriented practices. *American Journal of Orthopsychiatry*, 84, 2, 182-189.
- Auther, A. M., Smith, C. W., & Cornblatt, B. A. (2006). *Global Functioning: Social Scale (GF: Social)*. Glen Oaks, NY: Zucker Hillside Hospital.
- Bainbridge, L. & Wood, V. I. (2012). The power of prepositions: Learning with, from and about others in the context of interprofessional education. *Journal of Interprofessional Care*, 26, 452-458.
- Baldessarini, R. J. (2014). The impact of psychopharmacology on contemporary psychiatry. *Canadian Journal of Psychiatry*, 59, 8, 401-405.
- Baldessarini, R., Tondo, L., & Vazquez, G. (2108). Pharmacological treatment of adult bipolar disorder. *Molecular Psychiatry*, doi: 10.1038/s41380-018-0044-2
- Baldessarini, R. J. (2013). *Chemotherapy in Psychiatry - Pharmacologic Basis of Treatments for Major Mental Illness, Third Edition*. New York, NY Springer.
- Baillargeon, J., Hoge, S. K., & Penn, J. V. (2010). Addressing the challenge of community reentry among released inmates with serious mental illness. *American Journal of Community Psychology*, 46, 3-4, 361-375.
- Baranowski, K. A., Bhattacharyya, S., Ameen, E. J., Herbst, R. B., Corrales, C., Gonzalez, L. M. C., ... & Miville, M. L. (2016). Community and public arena advocacy training challenges, supports, and recommendations in counseling psychology: A participatory qualitative inquiry. *Journal for Social Action in Counseling & Psychology*, 8, 2.
- Barrowclough, C., Haddock, G., Wykes, T., Beardmore, R., Conrod, P., Craig, T., ... Tarrier, N. (2010). Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: Randomised controlled trial. *BMJ*, 341:c6325.
- Barry, M. M., & Crosby, C. (1996). Quality of life as an evaluative measure in assessing the impact of community care on people with long-term psychiatric disorders. *The British Journal of Psychiatry*, 168, 2, 210-216.
- Barry, C. L., McGinty, E. E., Pescosolido, B. A., & Goldman, H. H. (2014). Stigma, discrimination, treatment effectiveness and policy: Public views about drug addiction and mental illness. *Psychiatric Services*, 65, 10, 1269-1272.

- Bartels, S. J. (2004). Caring for the whole person. Integrated health care for older adults with Severe Mental Illness and medical comorbidity. *Journal of the American Geriatrics Society*, 52, 249-257.
- Bartels, S. J., Aschbrenner, K. A., Pratt, S. I., Naslund, J. A., Scherer, E. A., Zubkoff, L., ... Brunette, M. F. (2018). Implementation of a lifestyle intervention for people with serious mental illness in state-funded mental health centers. *Psychiatric Services*, 69, 6, 664-670.
- Bartels, S. J., Coakley, E. H., Zubritsky, C., Ware, J. H., Miles, K. M., Arean, P. A., ... PRISM-E Investigators. (2004). Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *American Journal of Psychiatry*, 161, 8, 1455-1462.
- Battilana, J., & Casciaro, T. (2012). Change agents, networks, and institutions: A contingency theory of organizational change. *Academy of Management Journal*, 55, 2, 381-398.
- Beck, A. T., Baruch, E., Balter, J. M., Steer, R. A., & Warman, D. M. (2004). A new instrument for measuring insight: the Beck Cognitive Insight Scale. *Schizophrenia Research*, 68, 2-3, 319-29.
- Beck, A. T., Rector, N. A., Stolar, N. & Grant, P. (2011). (Eds.). *Biological Contributions. Schizophrenia: Cognitive Theory, Research, and Therapy*. New York, NY: Guilford Press.
- Becker, M. & Mehra, S. (2005). *Serious Mental Illness in Florida nursing homes: A study of resident, facility, cost, and quality of care characteristics (Report to Agency for Health Care Administration)*, Tampa, FL: University of South Florida.
- Bellack, A. S, Brown, C. H., & Thomas-Lorhman, S. (2006). Psychometric characteristics of role play assessments of social skill in schizophrenia. *Behavior Therapy*, 37, 4, 339-352.
- Bellack, A. S., Mueser, K. T., Gingerich, S. & Agresta, J. (2004). *Social skills training for schizophrenia: A step-by-step guide*. New York, NY: Guilford Press.
- Bellesheim, K. (2016). Ethical challenges and legal issues for mental health professionals working with family caregivers of individuals with serious mental illness. *Ethics and Behavior*, 26, 7, 607-620.
- Bergland, A., Meaas, I., Debesay, J., Brovold, T., Jacobsen, E. L., Antypas, K., & Bye, A. (2016). Associations of social networks with quality of life, health and physical functioning. *European Journal of Physiotherapy*, 18, 2, 78-88.
- Bertelsen, M., Jeppesen, P., Petersen, L., Thorup, A., Øhlenschlaeger, J. le Quach, P., ... Nordentoft, M. (2008). Five-year follow-up of a randomized multicenter trial of intensive early intervention vs standard treatment for patients with a first episode of psychotic illness: The OPUS Trial. *Archives of General Psychiatry*, 65, 7, 762-771.
- Biebel, K., Nicholson, J., & Woolsey, K. (2014). Implementing an intervention for parents with mental illness: Building workforce capacity. *Psychiatric Rehabilitation Journal*, 37, 3, 209-215.
- Birchwood, M., Smith, J., Cochrane, R., Wetton, S., & Copestake, S. (1990). The Social Functioning Scale. The development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenic patients. *British Journal of Psychiatry*, 157, 853-859.

- Bird, V., Premkumar, P., Kendall, C., Whittington, J., Mitchell, J., & Kuipers, E. (2010). Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: Systematic review. *The British Journal of Psychiatry*, 197, 350-356.
- Bonfils, K. A., Adams, E. L., Firmin, R. L., White, L. M., & Salyers, M. P. (2014). Parenthood and severe mental illness: Relationships With recovery. *Psychiatric Rehabilitation Journal*, 37, 3, 186-193.
- Bora, E., Yücel, M., & Pantelis, C. (2010). Cognitive impairment in affective psychoses: A meta-analysis. *Schizophrenia Bulletin*, 36, 1, 112-125.
- Buonocore, M., Bosia, M., Baraldi, M. A., Bechi, M., Spangaro, M., Cocchi, F., ... Cavallaro, R. (2018). Achieving recovery in patients with schizophrenia through psychosocial interventions: A retrospective study. *Psychiatry and Clinical Neurosciences*, 72, 28-34.
- Cabassa, L. J., Parcesepe, A., Nicasio, A., Baxter, E., Tsemberis, S., & Lewis-Fernández, R. (2013). Health and wellness photovoice project: Engaging consumers with serious mental illness in health care interventions. *Qualitative Health Research*, 23, 5, 618-630.
- Cairns, V. A., Reid, G. S., Murray, C. D., & Weatherhead, S. J. (2015). Experience of psychosocial formulation within a biopsychosocial model of care for first-episode psychosis. *International Journal of Psychosocial Rehabilitation*, 19, 2, 47-62.
- Cameron, K., & McNaughtan, J. (2014). Positive organizational change. *The Journal of Applied Behavioral Science*, 50, 4, 445-462.
- Carpinello, S. E., Rosenberg, L., Stone, J., Schwager, M., & Felton, C. J. (2002). Best practices: New York State's campaign to implement evidence-based practices for people with serious mental disorders. *Psychiatric Services*, 53, 2, 153-155.
- Cavelti, M., Kvrjic, S., Beck, E., Kossowsky, J., & Vauth, R. (2012). Assessing recovery from schizophrenia as an individual process. A review of self-report instruments. *European Psychiatry*, 27, 19-32.
- Certification Commission for Psychiatric Rehabilitation. September 28, 2012. Code of Ethics for Psychiatric Rehabilitation Practitioners. Psychiatric Rehabilitation Association. https://www.psychrehabassociation.org/sites/default/files/images/CPRP-Code_of_Ethics_REV.pdf
- Chamberlin, J. (1977). *On Our Own: Patient-Controlled Alternatives to the Mental Health System*. Lawrence, MA: The National Empowerment Center, Inc.
- Charland, L. (2011). Historical antecedents of contemporary person-centered approaches to serious mental illness: Moral treatment in the eighteenth and nineteenth centuries. In Rudnick, A. & Roe, D. (Eds.) *Serious Mental Illness: Person Centered Approaches*. London, United Kingdom: Radcliffe Publishing.
- Chatterton, M. L., Stockings, E., Berk, M., Barendregt, J. J., Carter, R., & Mihalopoulos, C. (2017). Psychosocial therapies for the adjunctive treatment of bipolar disorder in adults: Network meta-analysis. *The British Journal of Psychiatry*, 210, 5, 333-341.
- Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatric Services*, 65, 4, 429-441.

- Chong, W., Aslani, P., & Chen, T. (2013). Multiple perspectives on shared decision-making and interprofessional collaboration in mental healthcare. *Journal of Interprofessional Care*, 27, 223-230.
- Chu, J. P., Emmons, L., Wong, J., Goldblum, P., Reiser, R., Barrera, A. Z., & Byrd-Olmstead, J. (2012). The Public Psychology Doctoral Training Model: Training clinical psychologists in community mental health competencies and leadership. *Training and Education in Professional Psychology*, 6, 2, 76.
- Cohen, C. I. (2000). Directions for Research and Policy on Schizophrenia and Older Adults: Summary of the GAP Committee Report. *Psychiatric Services*, 51, 3, 299-302.
- Cohen, M., Farkas, M., & Cohen, B. (2007). *Psychiatric rehabilitation training technology: Functional assessment*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.
- Cohen, L., Ferguson, C., Harms, C., Pooley, J.A., & Tomlinson, S. (2011). Family systems and mental health issues: A resilience approach. *Journal of Social Work Practice*, 25, 1, 109–125.
- Collison, B. B., Osborne, J. L., Gray, L. A., House, R. M., Firth, J., & Lou, M. (1998). Preparing counselors for social action. In C. Lee & G. Walz (Eds.), *Social action: A mandate for counselors* (pp. 263-277). Alexandria, VA: American Counseling Association.
- Compton, M. T., Gaumit, G. L., & Druss, B. G. (2009). Cigarette smoking and overweight/obesity among individuals with serious mental illnesses: A preventive perspective. *Harvard Review of Psychiatry*, 14, 212-222.
- Constantine, M., Hage, S., Kindaichi, M. & Brynat, R. (2007). Social justice and multicultural issues: Implications for the practice and training of counselors and counseling psychologists. *Journal of Counseling and Development*, 85, 24-29.
- Cook, J. A., Jonikas, J. A., Hamilton, M. M., Goldrick, V., Steigman, P. J., Grey, D. D., ... & Copeland, M. E. (2013). Impact of Wellness Recovery Action Planning on service utilization and need in a randomized controlled trial. *Psychiatric Rehabilitation Journal*, 36, 4, 250.
- Cook, J. M. & Newman, E. (2014). A consensus statement on trauma mental health: The New Haven competency conference process and major findings. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6, 4, 300–307.
- Copeland, M. A. (2018). *Wellness Recovery Action Plan*. Sudbury, MA: Human Potential Press/Advocates for Human Potential.
- Corcoran, R., Mercer, G., Frith, C. D. (1995). Schizophrenia, symptomatology and social inference: Investigating “Theory of mind” in people with schizophrenia. *Schizophrenia Research* 17, 5–13.
- Corey, G., Corey, M., & Corey, C. (2018). *Issues and ethics in the helping professions*. 10th edition. Boston, MA: Cengage Learning.
- Correll, C. U., Galling, B., Pawar A., Krivko, A., Bonetto, C., Ruggeri, M. ... Kane, J. M. (2018). Comparison of early intervention services vs treatment as usual for early-phase psychosis: A systematic review, meta-analysis, and meta-regression. *JAMA Psychiatry*, 75, 6, 555-565.
- Correll, C. U., Olvet, D. M., Auther, A. M., Hauaser, M., Kishimoto, T., Carrión, R. E., Snyder, S. & Cornblatt, B. A. (2014). The Bipolar Prodrome Symptom Interview and Scale–Prospective (BPSS-P): description and validation in a psychiatric sample and healthy controls. *Bipolar Disorders*, 16, 5, 505–522.

- Corrigan, P. W. (2002). Empowerment and serious mental illness: Treatment partnerships and community opportunities. *Psychiatric Quarterly*, 73, 3, 217-228.
- Corrigan, P. W. (2016). *Principles and Practice of Psychiatric Rehabilitation: An Empirical Approach*, 2nd edition. New York, NY: Guildford Press.
- Corrigan, P. W., Kraus, D. J., Pickett, S. A., Schmidt, A., Stellan, E., Hantke, E., Lara, J. L. (2017). Using peer navigators to address the integrated health care needs of homeless African Americans with serious mental illness. *Psychiatric Services*, 68, 3, 264-270.
- Corrigan, P., McCracken, S., & Blaser, B. (2003). Disseminating evidence-based mental health practices. *Evidence-Based Mental Health*, 6, 1, 4-5.
- Corrigan, P. W., Mittal, D., Reaves, C. M., Haynes, T. F., Han, X., Morris, S., & Sullivan, G. (2015). Mental health stigma and primary health care decisions. *Psychiatry Research*, 218, 35-38.
- Corrigan, P. W., Mueser, K. T., Bond, G. R., Drake, R. E., & Solomon, P. (Eds.), (2008). *Principles and Practice of Psychiatric Rehabilitation: An Empirical Approach*. New York, NY: Guildford Press.
- Corrigan, P. W. & Rao, D. (2012). On the Self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, 57, 8, 464–469.
- Corrigan, P. W., Steiner, L., McCracken, S. G., Blaser, B., & Barr, M. (2001). Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. *Psychiatric Services*, 52, 12, 1598-1606.
- Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*, 25, 875-884.
- Cramer, A., Schuetz, C., Andreae, A., Koemeda, M., Schulthess, P., Tschuschke, V., & Von Wyl, A. (2016). The Brief Symptom Inventory and the Outcome Questionnaire-45 in the Assessment of the Outcome Quality of Mental Health Interventions. *Psychiatry Journal*, (Article ID 7830785), 1-14.
- Cross, L. (2011). Historical antecedents of contemporary person-centered approaches to serious mental illness: Rogerian and related psychotherapies in the twentieth century. In Rudnick, A. & Roe, D. (Eds.) *Serious Mental Illness: Person Centered Approaches*. London, United Kingdom: Radcliffe Publishing.
- Cuijpers, P., & Smit, F. (2002). Excess mortality in depression: A meta-analysis of community studies. *Journal of Affective Disorders*, 72, 227-236.
- Dass-Brailsford, P. & Myrick, A. C. (2010). Psychological trauma and substance abuse: The need for an integrated approach. *Trauma, Violence, & Abuse*, 11, 4, 202-213.
- Davidson, L. (2010). PORT through a recovery lens. *Schizophrenia Bulletin*, 36, 1, 107–108.
- Davidson, L., Harding, C., & Spaniol, L. (Eds.) (2005). *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice, Volume 1*. Boston, MA: The Center for Psychiatric Rehabilitation.
- Davidson, L., Harding, C., & Spaniol, L. (Eds.) (2006). *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice, Volume 2*. Boston, MA: The Center for Psychiatric Rehabilitation.

- Davidson, L., Stayner, D. A., Lambert, S., Smith, P., & Sledge, W. H. (1997). Phenomenological and participatory research on schizophrenia: Recovering the person in theory and practice. *Journal of Social Issues*, 53, 4, 767-784.
- Davidson, L., Tondora, J., O'connell, M. J., Kirk Jr, T., Rockholz, P., & Evans, A. C. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal*, 31, 1, 23.
- Davidson, L., Tondora, J., Pavlo, A., & Stanhope, V. (2017). Shared-decision making within the context of recovery-oriented care. *Mental Health Review Journal*, 22, 3, 179-190.
- Davydov, D. M., Stewart, R., Ritchie, K., & Chaudieu, I. (2010). Resilience and mental health. *Clinical Psychology Review*, 30, 5, 479–495.
- Deegan, P. (1996). Recovery and the conspiracy of hope. Presented at the Sixth Annual Mental Health Services Conference of Australia and New Zealand; Brisbane, Australia.
- DeHart, D., Lynch, S., Belknap, J., Dass-Brailsford, P., & Green B. (2013). Life history models of female offending: The roles of serious mental illness and trauma in women's pathways to jail. *Psychology of Women Quarterly*, 38, 1, 138-151.
- De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Pakmas, M., Cohen, D., Asai, I. ... Leucht, S . (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, 10, 1, 52–77.
- Del Piccolo, L & Gross, C. (2012). People-centered care: new research needs and methods in doctor-patient communication. *Challenges in mental health. Epidemiology and Psychiatric Sciences*, 21, 145-149.
- Dickerson, F. B., Brown, C. H., Kreyenbuhl, J. A., Fang, L., Goldberg, W., Wohlheiter, K., & Dixon, L. B. (2006). Obesity among individuals with serious mental illness. *Acta Psychiatrica Scandinavica*, 113, 4, 306–313.
- Dickerson, F., Schroeder, J., Katsafanas, E., Khushalani, S., Origoni, A. E., Savage, C., ... Yolken, R. H. (2018). Cigarette smoking by patients with serious mental illness, 1999-2016: An increasing disparity. *Psychiatric Services*, 69, 2, 154–160.
- Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., . . . Kreyenbuhl, J. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36, 1, 48-70.
- Dixon, L. B., Goldman, H. H., Srihari, V. H., & Kane, J. M. (2018). Transforming the Treatment of Schizophrenia in the United States: The RAISE Initiative. *Annual Review of Clinical Psychology*, 7, 14, 237-258.
- Docherty, N. M., DeRosa, M., & Andreason, N. C. (1996). Communication disturbances in schizophrenia and mania. *Archives of General Psychiatry*, 53, 358-364.
- Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). HCR-20V3: Assessing risk of violence – User guide. Burnaby, BC, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.
- Drake, R. E. & Essock, S. M. (2009). The science-to-service gap in real-world schizophrenia treatment: The 95% problem. *Schizophrenia Bulletin*, 35, 4, 677–678.

- Drake, R. E., Goldman, H. H., Leff, H. S., Lehman, A. F., Dixon, L., Mueser, K. T., & Torrey, W. C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services, 52*, 2, 179-182.
- Elis, O., Caponigro, J. M., & Kring, A. M. (2013). Psychosocial treatments for negative symptoms in schizophrenia: Current practices and future directions. *Clinical Psychology Review, 33*, 8, 914–928.
- Ellingrod, V. L., Taylor, S. F., Dalack, G., Grove, T. B., Bly, M. J., Brook, R. D., ... & Pop-Busui, R. (2012). Risk factors associated with metabolic syndrome in bipolar and schizophrenia subjects treated with antipsychotics: The role of folate pharmacogenetics. *Journal of Clinical Psychopharmacology, 32*, 2, 261.
- Elwyn, G. Salzberg statement on shared decision making. *British Medical Journal, 342*, d1745.
- Epperson, M. W., Wolff, N., Morgan, R. D., Fisher, W. H., Frueh, B. C., & Huening, J. (2014). Envisioning the Next Generation of Behavioral Health and Criminal Justice Interventions. *International Journal of Law and Psychiatry, 37*, 5, 427–438.
- Epstein, R. A., Fennesbeck, C., Potter, S., Rizzone, K. H., & McPheeters, M. (2015). Psychosocial Interventions for Child Disruptive Behaviors: A Meta-analysis. *Pediatrics, 136*, 5, 947-960.
- Epstein, R., Fennesbeck, C., Williamson, E., Kuhn, T., Lindegren, M. L., Rizzone, K., ... McPheeters, M. (2015, October). Psychosocial and Pharmacologic Interventions for Disruptive Behavior in Children and Adolescents. Comparative Effectiveness Review No. 154. (Prepared by the Vanderbilt Evidence based Practice Center under Contract No. 290-2012-00009-I.) AHRQ Publication No. 15(16)- EHC019-EF. Rockville, MD: Agency for Healthcare Research and Quality. www.effectivehealthcare.ahrq.gov/reports/final.cfm.
- Evans, T. S., Berkman, N., Brown, C., Gaynes, B., & Weber, R. P. (2016). Disparities Within Serious Mental Illness. Agency for Healthcare Research and Quality.
- Evins, A. E., Cather, C., & Laffer, A. (2015). Treatment of tobacco use disorders in smokers with serious mental illness: Toward clinical best practices. *Harvard Review of Psychiatry, 23*, 2, 90–98.
- Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.
- Falender, C. A., & Shafranske, E. P. (2007). Competence in competency-based supervision practice: Construct and application. *Professional psychology: Research and practice, 38*, 3, 232.
- Falender, C. A., & Shafranske, E. P. (2008). *Casebook for clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.
- Farkas, M., & Anthony, W. A. (2007). Bridging science to service: Using Rehabilitation Research and Training Center program to ensure that research-based knowledge makes a difference. *Journal of Rehabilitation Research & Development, 44*, 879–892.
- Farkas, M., Cohen, M., McNamara, S., Nemec, P., & Cohen, B. (2000). *Psychiatric rehabilitation training technology: Assessing readiness for rehabilitation*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.
- Farkas, M., Sullivan Soydan, A. & Gagne, C. (2000). *Introduction to Readiness*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.

- Fazel, S., Singh, J. P., Doll, H., & Grann, M. (2012). Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24 827 people: systematic review and meta-analysis. *BMJ*, 345:e4692 doi: 10.1136/bmj.e4692.
- Fisher, H., Marzi, S., Arseneault, L., Wong, C., Kandaswamy, R., Moffitt, T., ... Caspi, C. (2018). Epigenetic signatures of childhood and adolescent victimization using a genetically sensitive longitudinal cohort study. *Schizophrenia Bulletin*, 44, Suppl 1, 1, S25.
- Folsom, D. P., Lebowitz, B. D., Lindamer, L. A., Palmer, B. W., Patterson, T. L., & Jeste, D. V. (2006). Schizophrenia in late life: emerging issues. *Dialogues in Clinical Neuroscience*, 8, 1, 45–52.
- Forman-Hoffman, V. L., Cook Middleton, J., McKeeman, J. L., Stambaugh, L. F., Christian, R. B., Gaynes, B. N. ... Viswanathan, M. (2016, December). Strategies To Improve Mental Health Care for Children and Adolescents. Comparative Effectiveness Review No. 181. (Prepared by the RTI International–University of North Carolina Evidence-based Practice Center under Contract No. 290-2012- 00008-I.) AHRQ Publication No. 16(17)- EHC035-EF. Rockville, MD: Agency for Healthcare Research and Quality. www.effectivehealthcare.ahrq.gov/reports/final.cfm.
- Foster-Fishman, P. G., & Behrens, T. R. (2007). Systems change reborn: Rethinking our theories, methods, and efforts in human services reform and community-based change. *American Journal of Community Psychology*, 39, (3-4), 191-196.
- Fox, A. & Reeves, S. (2015). Interprofessional collaborative patient-centered care: A critical exploration of two related discourses. *Journal of Interprofessional Care*, 29, 2, 113-118.
- Frank, E., Kupfer, D. J., Thase, M. E., Mallinger, A. G., Swartz, H. A., Fagiolini, A. M. ... Monk, T. (September 2005). Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. *Archives of General Psychiatry*, 62, 9, 996–1004.
- Frese, F. J. & Davis. W. W. (1997). The consumer-survivor movement, recovery and consumer professionals. *Professional Psychology: Research and Practice*, 28, 3, 243-245.
- Friis, S., Evensen, J., Haahr, U., Hegelstad, W., Joa, I., Johannessen, O., Langeveld, H., ... McGlashan, T. H. et al. (2011). Early detection and intervention (EDI) in first episode psychosis: Can it increase the chance for full recovery? TIPS 10 year findings. *Schizophrenia Bulletin*, 37, (Supp 1), 273–274.
- Fusar-Poli, P., Bonoldi, I., Yung, A. R., Borgwardt, S., Kempton, M. J., Valmaggia, L., ... McGuire, P. (2012). Predicting psychosis: Meta-analysis of transition outcomes in individuals at high clinical risk. *Archives of General Psychiatry*, 69, 3, 220–229.
- Galderisi, S., Maj, M., Mucci, A., Cassano, G. B., Invernizzi, G., Rossi, A., ... Pini, S. (2002). Historical, psychopathological, neurological and neuropsychological aspects of deficit schizophrenia: A multicenter study. *American Journal of Psychiatry*, 159, 6, 983-990.
- Gask, L. & Coventry, P. (2012). Person-centred mental health care: The challenge of implementation. *Epidemiology and Psychiatric Sciences*, 21, 2, 139-44.
- Gearon, J. S., Bellack, A. S., & Tenhula, W. N. (2004). Preliminary reliability and validity of the Clinician-Administered PTSD Scale for schizophrenia. *Journal of Consulting and Clinical Psychology*, 72, 1, 121-125.
- Giffort, D., Schmook, A., Woody, C., Vollendorf, C., & Gervain, M. (1995). Construction of a Scale to Measure Consumer Recovery. Springfield, IL: Illinois Office of Mental Health.

- Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2012). Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. *Cochrane Database Systematic Review*, CD006726. doi: 10.1002/14651858.CD006726.pub2
- Glynn, S. M. (2014) Bridging psychiatric rehabilitation and recovery in schizophrenia: A life's work. *American Journal of Psychiatric Rehabilitation*, 17, 3, 214-224.
- Glynn, S. M. & Mueser, K. T. (2018). Schizophrenia. In Hunsley, J. & Mash, E. J. (Eds.). *A Guide to Assessments that Work (Second Edition)* pps. 391-412. New York, NY: Oxford University Press.
- Granholm, E. L., McQuaid, J. R., & Holden, J. L. (2016). *Cognitive Behavioral Social Skills Training (CBSST) for Schizophrenia: A Practical Treatment Guide*. New York, NY: Guilford Press.
- Green, C. A., Estroff, S. E., Yarborough, B. J. H., Spofford, M., Solloway, M. R., Kitson, R. S. & Perrin, N. A. (2014). Directions for future patient-centered and comparative effectiveness research for people with serious mental illness in a learning mental health care system. *Schizophrenia Bulletin*, 40, Supplement 1, S1 – S76.
- Green, M. F., & Harvey, P. D. (2014). Cognition in schizophrenia: Past, present, and future. *Schizophrenia Research. Cognition*, 1, 1, e1–e9.
- Grisso, T., Appelbaum, P. S. & Hill-Fotouhi C. (1997). The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions. *Psychiatric Services*, 48, 11, 1415-1419.
- Haddock, G., McCarron, J., Tarrier, N., & Faragher, E. B. (1999). Scales to measure dimensions of hallucinations and delusions: The psychotic rating scales (PSYRATS). *Psychological Medicine*, 29, 879-889.
- Hagen, R., Turkington, D., Berge, T. & Grawe, R. W. (2011). *CBT for Psychosis: A symptom-based approach*. New York, NY: Routledge/Taylor & Francis Group.
- Hann, M. C., Caporaso, E., Loeffler, G., Cuellar, A., Herrington, L., Marrone, L., & Yoon, J. (2018). Early interventions in a US military FIRST episode psychosis program. *Early Intervention in Psychiatry*. doi: 10.1111/eip.12709.
- Hare, R. D. (1991). *The Psychopathy Checklist—Revised manual* - Toronto, Ontario, Canada: Multi-Health Systems 1991
- Harvey, P. D. (2005). *Schizophrenia in late life; Aging effects on symptoms and course of illness*. Washington DC: American Psychological Association.
- Harvey, P. D., Davidson, M., Mueser, K. T., Parrella, M., White, L., & Powchik, P. (1997). Social-Adaptive Functioning Evaluation (SAFE): A rating scale for geriatric psychiatric patients. *Schizophrenia Bulletin*, 23, 1, 131-145.
- Hiroeh, U., Kapur, N., Webb, R., Dunn, G., Mortensen, P. B., & Appleby, L. (2007). Deaths from natural causes in people with mental illness: A cohort study. *Journal of Psychosomatic Research*, 64, 275-283.
- Hoop, J., DiPasquale, T., Hernandez, J., & Roberts, L. (2008). Ethics and culture in mental health care. *Ethics and Behavior*, 18, 4, 353-372.
- Horvitz-Lennon, M., Kilbourne, A. M., & Pincus, H. A. (2006). From silos to bridges: Meeting the general health care needs of adults with severe mental illnesses. *Health Affairs*, 25, 3, 659-669.

- Hurford, I. M., Marder, S. R., Keefe, R. S., Reise, S. P., & Bilder, R. M. (2009). A brief cognitive assessment tool for schizophrenia: Construction of a tool for clinicians. *Schizophrenia Bulletin*, 37, 538-545.
- Hutton, J. M., & Williams, M. (2001). Assessment of psychological issues and needs in the specialties of a large teaching hospital. *Psychology, Health & Medicine*, 6, 3, 313-319.
- Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press.
- Interprofessional Education Collaborative. (2016). *Core competencies for interprofessional collaborative practice: 2016 update*. Washington, DC: Interprofessional Education Collaborative.
- Ivankova, N. V. (2014). *Mixed Methods Applications in Action Research*. Thousand Oaks, CA: Sage Publications.
- Jaeger, J., Berns, S. M., & Czobor, P. (2003). The multidimensional scale of independent functioning: A new instrument for measuring functional disability in psychiatric populations. *Schizophrenia Bulletin*, 29, 1, 153-168.
- Jeste, D. V. & Lebowitz, B. D. (1997). Coming of age. *The Leifer Report, Special Edition*, 39–40.
- Jochems, E. C., van der Feltz-Cornelis, C. M., van Dam, A, Duivenvoorden, H. J., Mulder, C.L. (2015). The effects of motivation feedback in patients with severe mental illness: A cluster randomized controlled trial. *Neuropsychiatric Disease and Treatment*, 11, 3049-3064.
- Johnson, K. & Freeman, K. (2014). Integrating interprofessional education and collaboration competencies (IPEC) into mental health counselor education. *Journal of Mental Health Counseling*, 36, 4, 328-344.
- Joint Centre for Bioethics. (undated). *Aid To Capacity Evaluation (ACE)*.
http://www.jcb.utoronto.ca/tools/ace_download.shtml
- Joukamaa, M., Heliövaara, M., Knekt, P., Aromaa, A., Raitasalo, R., & Lehtinen, V. (2001). Mental disorders and cause-specific mortality. *British Journal of Psychiatry*, 179, 498-502.
- Joy, M., Clement, T., & Sisti, D. (2016). The ethics of behavioral health information technology: Frequent flyer icons and implicit bias. *JAMA*, published online September 08, 2016. doi:10.1001/jama.2016.12534.
- Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., Williamson, D. & Ryan, N. (1997). Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 7, 980-988.
- Kay, S. R., Fiszbein, A., & Opler, L. A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, 13, 2, 261-76.
- Keefe, R. S. E., Goldberg, T. E., Harvey, P. D., Gold, J. M., Poe, M. P., & Coughenour, L. (2004). The Brief Assessment of Cognition in Schizophrenia: reliability, sensitivity, and comparison with a standard neurocognitive battery. *Schizophrenia Research*, 68, 2-3, 283-297.
- Kern, R. S., Glynn, S. M., Horan, W. P., & Marder, S. R. (2009). Psychosocial treatments to promote functional recovery in schizophrenia. *Schizophrenia Bulletin*, 35, 2, 347–361.

- Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 6, 593–602. Retrieved June 24, 2015 <http://archpsyc.jamanetwork.com/article.aspx?articleid=208671>.
- Keval, H. (2015). Schizophrenia and psychosis: The magical and troubling disappearance of race from the debate. *Diversity and Equality in Health and Care*, 12, 1, 6-8.
- Khanam, D., McDonald, K., & Neils, C. (2013). *Measuring Recovery: A Toolkit for Mental Health Providers in New York City*. New York, NY: The Bureau of Mental Health, New York City Department of Health and Mental Hygiene.
- Kidd, S. A., McKenzie, K. J., & Virdee, G. (2014). Mental health reform at a systems level: Widening the lens on recovery-oriented care. *The Canadian Journal of Psychiatry*, 59, 5, 243-249.
- King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Pasetti, F., ... & Serfaty, M. (2007). The Stigma Scale: Development of a standardised measure of the stigma of mental illness. *The British Journal of Psychiatry*, 190, 248-254.
- King, R., Lloyd, C., & Meehan, T. (2013). *Handbook of Psychosocial Rehabilitation*. Hoboken, NJ: John Wiley & Sons.
- Kinnair, D., Anderson, E., van Diepen, H., & Poyser, C. (2014). Interprofessional education in mental health services: Learning together for better team working. *Advances in Psychiatric Treatment*, 20, 1, 61-68.
- Kinnair, D., Anderson, E., & Thorpe, L. (2012). Development of interprofessional education in mental health practice: Adapting the Leicester model. *Journal of Interprofessional Care*, 26, 189-197.
- Kirkpatrick, B., Buchanan, R. W., McKenney, P. D., Alphas, L. D., & Carpenter, W. T. (2013). The Schedule for the Deficit syndrome: An instrument for research in schizophrenia. *American Journal of Psychiatry*, 170, 2, 165-72.
- Kirkpatrick, B., Strauss, G. P., Nguyen, L., Fischer, B. A., Daniel, D. G., Cienfuegos, A., & Marder, S. R. (2011). The Brief Negative Symptom Scale: Psychometric properties. *Schizophrenia Bulletin*, 37, 2, 300–305.
- Kisely, S., Smith, M., Lawrence, D., Cox, M., Campbell, L. A., & Maaten, S. (2007). Inequitable access for mentally ill patients to some medically necessary procedures. *Canadian Medical Association Journal*, 176, 779-784.
- Knox, D., & Holloman, G. (2012). Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup. *Western Journal of Emergency Medicine*, 13, 1, 35-40.
- Kotsiubinskii, A. P. (2002). A biopsychosocial model of schizophrenia. *International Journal of Mental Health*, 31, 2, 51-60.
- Kreyenbuhl, J., Buchanan, R. W., Dickerson, F. B., & Dixon, L. B. (2010). The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2009. *Schizophrenia Bulletin*, 36, 1, 94–103.
- Kreisman, D. E., Simmens, S. J., & Joy, V. D. (1979). Rejecting the patient: preliminary validation of a self-report scale. *Schizophrenia Bulletin*, 5, 220-222.

- Kring, A. M., Gur, R. E., Blanchard, J. J., Horan, W. P., & Reise, S. P. (2013). The Clinical Assessment Interview for Negative Symptoms (CAINS): Final development and validation. *American Journal of Psychiatry*, 170, 2, 165–172.
- Kuipers, E., Yesufu-Udechuku, A., Taylor, C., & Kendall, T. (2014). Management of psychosis and schizophrenia in adults: summary of updated NICE guidance. *BMJ: British Medical Journal (Online)*, 348.
- Kukla, M., Whitesel, F., & Lysaker, P. H. (2016). An integrative psychotherapy approach to foster community engagement and rehabilitation in schizophrenia: A case study illustration. *Journal of Clinical Psychology*, 72, 2, 152-163.
- Kuruville, A., & Jacob, K. S. (2007). Poverty, social stress & mental health. *Indian Journal of Medical Research*, 126, 4, 273-278.
- Lawrence, D., Hancock, K. J., & Kisely, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: Retrospective analysis of population based registers. *The BMJ*, 346, 2539.
- Lawrence, D., Holman, C. D. J., & Jablensky, A. V. (2001). *Duty to care: Preventable physical illness in people with mental illness*. Perth, Australia: University of Western Australia.
- Lawrence, D., Mitrou, F., & Zubrick, S. R. (2009). Smoking and mental illness: Results from population surveys in Australia and the United States. *BMC Public Health*, 2009 9, 285, 1-14.
- Lecomte, T., Samson, C., Naeem, F., Schachte, L., & Farhall, J. (2018). Implementing cognitive behavioral therapy for psychosis: An international survey of clinicians' attitudes and obstacles. *Psychiatric Rehabilitation Journal*, 41, 2, 141-148.
- Leff, J. P. & Vaughn, C. (1985). *Expressed emotion in families*. New York: Guildford Press.
- Lefley, H. P. (2005). Advocacy, self-help, and consumer operated services. In Davidson, L., Harding, C. & Spaniol, L. (Eds.) *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice*. Volume 1. Boston, MA: Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University.
- Legare, F., Stacey, D., Pouliot, S., Gauvin, F., Desroche, S., et al. (2011). Interprofessionalism and shared decision-making in primary care: A stepwise approach towards a new model. *Journal of Interprofessional Care*, 25, 18-25.
- Leonhardt, B. L., Huling, K., Hamm, J. A., Roe, D., Hasson-Ohayon, I., McLeod, H. J., & Lysaker, P. H. (2017). Recovery and serious mental illness: a review of current clinical and research paradigms and future directions. *Expert Review of Neurotherapeutics*, 17, 11, 1117-1130.
- Liebowitz, B. & Blattner, J. (2015). On becoming a consultant: The transition for a clinical psychologist. *Consulting Psychology Journal: Practice and Research*, 67, 2, 144.
- Lim, C., Barrio, C., Hernandez, M., Barragan, A., & Brekke, J. S. (2017). Recovery from schizophrenia in community-based psychosocial rehabilitation settings: Rates and predictors. *Research on Social Work Practice*, 27, 5, 538-551.
- Linhorst, D. M. (2006a). A history of powerlessness. In Linhorst, D. M. (Ed). *Empowering people with severe mental illness: A practical guide*. New York, NY: Oxford University Press.
- Linhorst, D. M. (2006b). Individual rights, coercion, and empowerment. In Linhorst, D. M. (Ed). *Empowering people with severe mental illness: A practical guide*. New York, NY: Oxford University Press.

- Links, M. (2014). "Walking the walk"; Promoting competencies for interprofessional learning through team meetings – a case study. *Journal of Research in Interprofessional Practice and Education*, 4, 2, 1-16.
- Loebach Wetherell, J. & Jeste, D. V. (2004). Older adults with schizophrenia. *Elder Care*, 3, 2, 8-11.
- Lowe, M. R. & Cautela, J. R. (1978). A self-report measure of social skill. *Behavior Therapy*, 9, 4, 535-544.
- Lu, W., Yanos, P. T., Silverstein, S. M., Mueser, K. T., Rosenberg, S. D., Gottlieb, J. D., ... Giacobbe, G. (2013). Public mental health clients with severe mental illness and probable posttraumatic stress disorder: Trauma exposure and correlates of symptom severity. *Journal of Traumatic Stress*, 26, 266-273.
- Lukens, J. & Solomon, P. (2013). Thinking through recovery: Resolving ethical challenges and promoting social work values in mental health services. *Journal of Social Work Values and Ethics*, 10, 1, 61-71.
- Lynch, S. M., DeHart, D., Belknap, J. E., Green, B. L., Dass-Brailsford, P., Johnson, K. A. & Whalley, E. (2014). A multisite study of the prevalence of serious mental illness, PTSD, and substance use disorders of women in jail. *Psychiatric Services*, 65, 5, 670–674.
- Lyons, J. C., Webster, S. R., Friedman, B. L., Schiavoni, S. P., Lit, K. R., & Ralph, E. (Gene). (2015). A preliminary study exploring the efficacy of advocacy training. *Professional Psychology: Research and Practice*, 46, 6, 409 – 413.
- MacDonald-Wilson, K., Rogers, E. S., & Anthony, W. A. (2001). Unique issues in assessing work function among individuals with psychiatric disabilities. *Journal of Occupational Rehabilitation*, 11, 3, 217-232.
- Mallinckrodt, B., Miles, J. R., & Levy, J. J. (2014). The scientist-practitioner-advocate model: Addressing contemporary training needs for social justice advocacy. *Training and Education in Professional Psychology*, 8, 4, 303-311.
- Mancini, A. D., & Finnerty, M.T. (2005). Recovery Oriented Practices Index (ROPI). Unpublished manuscript, New York State Office of Mental Health.
- Maranzan, K. (2016). Interprofessional education in mental health: An opportunity to reduce mental illness stigma. *Journal of Interprofessional Care*, 30, 3, 370-377.
- Maura, J., & de Mamani, A. W. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings*, 24, 3-4, 187-210.
- Mazi-Kotwal, N. & Upadhyay, B. (2011). Physical health in schizophrenia. *Cutting Edge Psychiatry in Practice*, 1, 3, 74–77.
- McDonald, A. W. & Carter, C. S. (2002). Cognitive experimental approaches to investigating impaired cognition in schizophrenia: A paradigm shift. *Journal of Clinical and Experimental Neuropsychology*, 24(7), 873-882.
- McFarlane, W.R. Multifamily groups in the treatment of severe psychiatric disorders. New York, NY: The Guilford Press, 2002.
- McFarlane, W. R., Dixon, L., Lukens, E., & Lucksted, A. (2003). Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy*, 29, 2, 223-245.

- McFarlane, W. R., McNary, S., Dixon, L., Hornby, H., & Cimett, E. (2001). Predictors of dissemination of family psychoeducation in community mental health centers in Maine and Illinois. *Psychiatric Services*, 52, 7, 935-942.
- McGlashan, T. H., Walsh, B. C., & Woods, S. W. (2014). Structured Interview for Psychosis Risk Syndromes – English language, Version 5.5. New Haven, CT: PRIME Research Clinic, Yale School of Medicine
- McGurk, S. R., Drake, R. E., Xie, H., Riley, J., Milfort, R., Hale, T. W., & Frey, W. (2017). Cognitive predictors of work among social security disability insurance beneficiaries with psychiatric disorders enrolled in IPS supported employment. *Schizophrenia Bulletin*, 44, 1, 32-37.
- McHugo, G. J., Drake, R. E., Whitley, R., Bond, G. R., Campbell, K., Rapp, C. A., ... & Finnerty, M. T. (2007). Fidelity outcomes in the national implementing evidence-based practices project. *Psychiatric Services*, 58, 10, 1279-1284.
- Mead, S. & Copeland, M. E. (2005). What recovery means to us: Consumers' Perspectives. In Davidson, Harding & Spaniol (Eds.) *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice*. Volume 1. Boston, MA: Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University.
- Menditto, A. Wallace, C. P., Liberman, R., Vander Wal, J., Tuomi Jones, N., & Stuve, P. (1999). Functional assessment of independent living skills. *Psychiatric Rehabilitation Skills*, 3, 2, 200-219.
- Michalak, E. E., Jones, S., Lobban, F., Algorta, G. P., Barnes, S. J., Berk, L., ... & Milev, R. (2016). Harnessing the potential of community-based participatory research approaches in bipolar disorder. *International Journal of Bipolar Disorders*, 4, 1, 4.
- Milne, D. L., & Reiser, R. P. (2017). *A manual for evidence-based CBT supervision*. Hoboken, NJ: John Wiley & Sons.
- Mitchell, A. J., Delaffon, V., & Lord, O. (2012). Let's get physical: Improving the medical care of people with severe mental illness. *Advances in psychiatric treatment*, 18, 216–225.
- Mitchell, A. J., Vancampfort, D., Sweers, K., van Winkel, R., Yu, W. & de Hert, M. (2013). Prevalence of metabolic syndrome and metabolic abnormalities in schizophrenia and related disorders—A systematic review and meta-analysis. *Schizophrenia Bulletin*, 39, 2, 306-318.
- Molinari, V., Brown, L. M., Frahm, K., Schinka, J., & Casey, R. (2013). Factors that influence homelessness in older homeless veterans. *Journal of Health Care for the Poor and Underserved*, 24, 487-498.
- Moos, R. H. (2017). *Evaluating Treatment Environments: The Quality of Psychiatric and Substance Abuse Programs*. Abingdon, UK: Routledge.
- Moran, M. (2014). Overdiagnosis of schizophrenia said to be persistent among black patients. *Psychiatric Times*, December 29, 2014.
- Morin, L., & Franck, N. (2017). Rehabilitation interventions to promote recovery from schizophrenia: A systematic review. *Frontiers in Psychiatry*, 8, 100.
- Morris, Johns & Oliver (Eds.). (2013). *Acceptance and Commitment Therapy and Mindfulness for Psychosis*. West Sussex, UK: John Wiley & Sons.
- Morrison, A. P. & Barratt, S. (2010). What are the components of CBT for psychosis? A Delphi study. *Schizophrenia Bulletin*, 36, 1, 136-142.

- Mosher, L. R. & Hendrix, V. (2004). *Soteria: Through Madness to Deliverance*. Bloomington, IN: Xlibris.
- Mueser, K. T. (2012). Evidence-based practices and recovery-oriented services: Is there a relationship? Should there be one? *Psychiatric Rehabilitation Journal*, 35, 4, 287–288.
- Mueser, K. T., Glynn, S. M., & Meyer-Kalos, P. S. (2017). What are the key ingredients of optimal psychosocial treatment for persons recovering from a first episode of psychosis? *World Psychiatry*, 16, 3, 266-267.
- Mueser, K. T., Lu, W., Rosenberg, S. D. & Wolfe, R. (2010). The trauma of psychosis: Posttraumatic stress disorder and recent onset psychosis. *Schizophrenia Research*, 116, 2-3, 217-227.
- Mueser, K. T., Rosenberg, S. D., Fox, L., Salyers, M. P., Ford, J. D., & Carty, P. (2001). Psychometric evaluation of trauma and posttraumatic stress disorder assessments in persons with severe mental illness. *Psychological Assessment*, 13, 1, 110.
- Mueser, K. T., Torrey, W. C., Lynde, D., Singer, P., & Drake, R. E. (2003). Implementing evidence-based practices for people with severe mental illness. *Behavior Modification*, 27, 3, 387-411.
- Murphy, S., Irving, C. B., Adams, C. E., & Waqar, M. (2015). Crisis intervention for people with severe mental illnesses. *Cochrane Library*.
- Muse, M. & Moore, B. A. (Eds.) (2012). *Handbook of Clinical Psychopharmacology for Psychologists*. Hoboken, NJ: John Wiley & Sons.
- Myers, J. E., & Sweeney, T. J. (2004). Advocacy for the counseling profession: Results of a national survey. *Journal of Counseling & Development*, 82, 466 – 471.
- Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., & Bartels, S. J. (2016). The future of mental health care: Peer-to-peer support and social media. *Epidemiology and Psychiatric Sciences*, 25, 2, 113-122.
- Naslund, J. A., Grande, S. W., Aschbrenner, K. A., & Elwyn, G. (2014) Naturally occurring peer support through social media: The experiences of individuals with severe mental illness using YouTube. *PLoS ONE* 9, 10, e110171.
- National Academies of Sciences, Engineering, and Medicine. (2016). *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*. Washington, DC: The National Academies Press.
- National Institute of Mental Health. (2012). *Improving health and reducing premature mortality in people with severe mental illness*. Washington, DC: Author.
- National Institute of Mental Health (website). *Mental Health Medications*.
<https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml>
- Neugeboren, J. (1999). *Transforming Madness: New Lives for People Living with Mental Illness*. Los Angeles, CA: University of California Press.
- Niendam, T. A., Bearden, C. E., Johnson, J. K., & Cannon, T. D. (2006). *Global Functioning: Role Scale (GF: Role)*. Los Angeles, CA: University of California.
- Niv, N., Cohen, A. N., Sullivan, G., & Young, A. S. (2007). The MIRECC version of the Global Assessment of Functioning Scale: Reliability and validity. *Psychiatric Services*, 58, 529-535.

- Nossel, I., Wall, M. M., Scodes, J., Marino, L. A., Zilkha, S., Bello, I., ... Dixon, L. (2018). Results of a coordinated specialty care program for early psychosis and predictors of outcomes. *Psychiatric Services*, doi: 10.1176/appi.ps.201700436.
- Nuechterlein, K. H. & Dawson, M. E. (1984). Vulnerability and stress factors in the developmental course of schizophrenia disorders. *Schizophrenia Bulletin*, 10, 2, 158-159.
- Nuechterlein, K. H. & Green, M. F. (2006). *MATRICES Consensus Cognitive Battery Manual*. Los Angeles, CA: MATRICES Assessment, Inc.
- Nuechterlein, K. H., Green, M. F., Kern, R. S., Baade, L. E., Barch, D. M., Cohen, J. D., ... & Goldberg, T. (2008). The MATRICES Consensus Cognitive Battery, part 1: test selection, reliability, and validity. *American Journal of Psychiatry*, 165, 2, 203-213.
- Nussbaum, D. & Sammons, M. (online course). *A Psychologist's Guide to Psychopharmacology*. Canadian Psychological Association. <https://www.cpa.ca/professionaldevelopment/webcourses/catalogue>
- Olfson, M., Gerhard, T., Huang, C., Crystal, S. & Stroup, T. S. (2015). Premature mortality among adults with schizophrenia in the United States. *JAMA Psychiatry*, 72, 12, 1172-1181.
- Oliveira-Maia, A. J., Mendonça, C., Pessoa, M. J., Camacho, M., & Gago, J. (2016). The Mental Health Recovery Measure Can Be Used to Assess Aspects of Both Customer-Based and Service-Based Recovery in the Context of Severe Mental Illness. *Frontiers in Psychology*, 7, 1679.
- Olmos-Gallo, P. A., Starks, R., DeRoche Luszczakoski, K. Huff, S. & Mock, K. (2011). Seven key strategies that work together to create recovery based transformation. *Community Mental Health Journal*, 47, 1–8.
- Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, 31, 9-22.
- Onken, S., Dumont, J. M., Ridgway, P., Dornan, D. H. & Ralph, R. O. (2007). *The Recovery Oriented System Indicators (ROSI) Measure*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center (NTAC).
- Opler, M., Charap, J., Greig, A., Stein, V., Polito, S., & Malaspina, D. (2013). Environmental risk factors and schizophrenia. *International Journal of Mental Health*, 42, 1, 23-32.
- Palmer, B. W., Dawes, S. E., & Heaton, R. K. (2009). What do we know about the neuropsychological aspects of schizophrenia? *Neuropsychological Review*, 19, 3, 365-384.
- Parks, J., Svendsen, D., Singer, P. & Foti, M. E. (Eds.). (2006). *Morbidity and Mortality in People with Serious Mental Illnesses*. Technical Report 13. Alexandria, VA: National Association of State Mental Health Program Directors Council.
- Patterson, T., Goldman, S., Mckibbin, C., Hughs, T. & Jeste, D. V. (2001). UCSD Performance-Based Skills Assessment: Development of a new measure of everyday functioning for severely mentally ill adults. *Schizophrenia Bulletin*, 27, 2, 235-245.
- Patton, M. Q. (2015). *Qualitative Research & Evaluation Methods: Integrating Theory and Practice*. Thousand Oaks, CA: Sage.
- Penn, D. L., Corrigan, P. W., Bentall, R. P., Racenstein, J. M., & Newman, L. (1997). Social cognition in schizophrenia. *Psychological Bulletin*, 121, 114–132.

- Peters, E., Day, J. S., & Garety P. (2004). Measuring delusional ideation: the 21-item Peters et al. Delusions Inventory (PDI). *Schizophrenia Bulletin*, 30, 4, 1005-1022.
- Peters, R. H., Wexler, H. K., & Lurigio, A. J. (2015). Co-occurring substance use and mental disorders in the criminal justice system: A new frontier of clinical practice and research. *Psychiatric Rehabilitation Journal*, 38, 1, 1-6.
- Petterson, H., Ruud, T., Ravndal, E., Havnes, I., & Landheim, A. (2014). Engagement in assertive community treatment as experienced by recovering clients with severe mental illness and concurrent substance use. *International Journal of Mental Health Systems*, 8, 40.
- Phelan, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., Strathdee, G., Loftus, L., McCrone, P., & Hayward P. (1995). The Camberwell Assessment of Need: the validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry*, 167, 5, 589-595.
- Pickett, K. E. & Wilkinson, R. G. (2015). Income inequality and health: A causal review. *Social Science & Medicine*, 128, 316-326.
- Pratt, S. I. & Mueser, K. T. (2011). Schizophrenia. In: M. M. Anthony & D. H. Barlow (Eds.). *Handbook of Assessment and Treatment Planning for Psychological Disorders*, 2nd ed. New York: The Guilford Press.
- Pratt, S. I., Sargent, J., Daniels, L., Santos, M. M. & Brunette, M. (2016). Appeal of electronic cigarettes in smokers with serious mental illness. *Addictive Behaviors*, 59, 30-34.
- Priest, H., Roberts, P., Dent, H., Blincoe, C., Lawton, D., & Armstrong, C. (2008). Interprofessional education and working in mental health: In search of the evidence base. *Journal of Nursing Management*, 16, 474-485.
- Priest, H., Roberts, P., Dent, H., Hunt, T., Weston, D., Chell, A., ... Armstrong, C. (2011). Preparing for collaborative working in mental health: an interprofessional education project with clinical psychology trainees and nursing students. *The Journal of Mental Health Training, Education and Practice*, 6, 1, 47-57.
- Priester, M. A., Browne, T., Lachini, A., Clone, S., DeHart, D., Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *Journal of Substance Abuse Treatment*, 61, 47-59.
- Ragland, J. D. (2007). Functional neuroimaging in schizophrenia. In Hillary & DeLuca (Eds) *Functional Neuroimaging in Clinical Populations*. New York, NY: Guilford Press.
- Ralph, R. O., Kidder, K., & Phillips, D. (2000). *Can We Measure Recovery? A Compendium of Recovery and Recovery-related Instruments*. Cambridge, MA: The Evaluation Center @ Human Services Research Institute.
- Ramos, C. M. (2007). Organizational change in a human service agency. *Consulting Psychology Journal: Practice and Research*, 59, 1, 41.
- Rathod, S., Kingdon, D., Pinninti, N., Turkington, D. & Phiri, P. (2017). *Cultural Adaptation of CBT for Serious Mental Illness: A Guide for Training and Practice*. Hoboken, NJ: Wiley-Blackwell.
- Reinhard, S. C., Gubman, G. D., Horwitz, A. V., & Minsky, S. (1994). Burden assessment scale for families of the seriously mentally ill. *Evaluation and Program Planning*, 17, 261-269.
- Reiser, R. P., Cliffe, T., & Milne, D. L. (2018). An improved competence rating scale for CBT Supervision: Short-SAGE. *the Cognitive Behaviour Therapist*, 11.

- Reisinger-Walker, E., McGee, R. E., & Druss, B. G. (2015). Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis. *JAMA Psychiatry*, 72, 4, 334-341.
- Resnick, S. G., & Leddy, M. A. (2015). Building Recovery-Oriented Service Systems Through Positive Psychology. In S. Joseph (Ed.), *Positive Psychology in Practice: Promoting Human Flourishing in Work, Health, Education, and Everyday Life*, 2nd ed., 695-710. New York, New York: Wiley.
- Ridgway, P. (2001). Re-storying psychiatric disability: Learning from first-person recovery narratives. *Psychiatric Rehabilitation Journal*, 24, 4, 335-343.
- Ritsher, J. B., Otilingam, P. G., & Grajales, M. (2003). Internalized stigma of mental illness: Psychometric properties of a new measure. *Psychiatry Research*, 121, 31-49.
- Rosenheck, R. A. (2001). Organizational process: A missing link between research and practice. *Psychiatric Services*, 52, 1607-1612.
- Rouse, J., Mutschler, C., McShane, K., & Habal-Brosek, C. (2017). Qualitative participatory evaluation of a psychosocial rehabilitation program for individuals with severe mental illness. *International Journal of Mental Health*, 46, 2, 139-156.
- Rowe, M., Benedict, P., Sells, D., Dinzeo, T., Garvin, C., Schwab, L., ... Bellamy, C. (2009). Citizenship, community, and recovery: A group-and peer-based intervention for persons with co-occurring disorders and criminal justice histories. *Journal of Groups in Addiction & Recovery*, 4, 4, 224-244.
- Rowe, M., & Pelletier, J.-F. (2012). Citizenship: A response to the marginalization of people with mental illnesses. *Journal of Forensic Psychology Practice*, 12, 4, 366-381.
- Roy, L., Crocker, A. G., Nicholls, T. L., Latimer, E. A. & Ayllon, A. R. (2014). Criminal behavior and victimization among homeless individuals with severe mental illness: A systematic review. *Psychiatric Services*, 65, 6, 739-750.
- Rudnick, A. (2011). Foundations and ethics of person-centered approaches to individuals with serious mental illness. In A. Rudnick & D. Roe (Eds.). *Serious Mental Illness: Person Centered Approaches*. Taylor & Francis.
- Rybarczyk, B. (2011). Social and Occupational Functioning Assessment Scale (SOFAS). (2011). *Encyclopedia of Clinical Neuropsychology*. New York, NY: Springer.
- Saillant, S., Hudelson, P., Dao, M. D., & Perron, N. J. (2016). The primary care physician/psychiatrist joint consultation: A paradigm shift in caring for patients with mental health problems? *Patient Education and Counseling*, 99, 2, 279-283.
- Schneider, L. C., Struening, E. L. (1983). SLOF: A behavioral rating scale for assessing the mentally ill. *Social Work Research Abstracts*, 19, 9-21.
- Schooler, N., Hogarty, G., & Weissman, M. (1979). Social Adjustment Scale II (SAS-II). In W. A. Hargreaves, C. C. Atkinson, & J. E. Sorenson (Eds.), *Resource Materials for Community Mental Health Program Evaluations* (pp. 290-303). Rockville, MD: NIMH.
- Schretlen, D. J., Cascella, N. G., Meyer, S. M., Kingery, L. R., Marc Testa, S., Munro, C. A., ... Pearlson, G. D. (2007). Neuropsychological functioning in bipolar disorder and schizophrenia. *Biological Psychiatry*, 62, 2, 179-186.

- Schroeder, S. A. & Morris, C. D. (2010). Confronting a neglected epidemic: Tobacco cessation for persons with mental illnesses and substance abuse problems. *Annual Review of Public Health*, 31, 297–314.
- Shankman, Stewart A., Funkhouser, Carter J., Klein, Daniel N., Davila, Joanne, Lerner, Debra & Hee, Danelle. (2017). Reliability and validity of severity dimensions of psychopathology assessed using the Structured Clinical Interview for DSM-5 (SCID). *International Journal of Methods in Psychiatric Research*, 27, 1, 1-12.
- Shihari, V., Guloksuz, S., Li, F., Tek, C., Woods, S., Pollard, J., ... Seidman, L. J. (2017). Mindmap: A population-based approach to early detection of psychosis in the United States. *Schizophrenia Bulletin*, Suppl 1, S95.
- Sin, J., & Spain, D. (2017). Psychological interventions for trauma in individuals who have psychosis: a systematic review and meta-analysis. *Psychosis*, 9, 1, 67-81.
- Siu, A. L. for the U.S. Preventive Services Task Force. (2015). Behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults, including pregnant women: U.S. Preventive Services Task Force recommendation statement. *Annals of Internal Medicine*, 163, 8, 622-634.
- Sklar, M., Groess, E., O'Connell, M. Davidson, L., & Aarons, G. (2013). Instruments for measuring mental health recovery: A systematic review. *Clinical Psychology Review*, 33, 8, 1082-1095.
- Slade, M. (2017). Implementing shared decision making in routine mental health care. *World Psychiatry*, 16, 146-153.
- Smith, T. E., Abraham, M., Bivona, M., Brakman, M. J., Brown, I. S., Enders, G., ... Swinford, J. W. (2017). "Just be a light": Experiences of peers working on acute inpatient psychiatric units. *Psychiatric Rehabilitation Journal*, 40, 4, 387-394.
- Stirman, S. W., Pontoski, K., Creed, T., Xhezo, R., Evans, A. C., Beck, A. T., & Crits-Christoph, P. (2017). A non-randomized comparison of strategies for consultation in a community-academic training program to implement an evidence-based psychotherapy. *Administration and Policy in Mental Health and Mental Health Services Research*, 44, 1, 55-66.
- Stobbe, J., Wierdsma, A., Kok, R. M., Kroon, H., Roosenschoon, B.-J., Depla, M. & Mulder, C. L. (2014). The effectiveness of assertive community treatment for elderly patients with severe mental illness: A randomized controlled trial. *BMC Psychiatry*, 14, 1.
- Stoltenberg, C. & McNeill, B. (2010). *IDM Supervision: An Integrative Developmental Model for Supervising Counselors and Therapists*. Rutledge, Taylor & Francis Group: New York, NY.
- Tessler, R., & Gamache, G. (1996). *Toolkit for Evaluating Family Experiences with Severe Mental Illness*. Amherst, MA: The Evaluation Center at HSRI.
- The Research Committee of the International Association of Psychosocial Rehabilitation Services. (1995). *The Psychosocial Rehabilitation Services Toolkit*. Columbia, MD: The Evaluation Center @ HSRI: Author.
- Thornicroft, G. (2011). Physical health disparities and mental illness: the scandal of premature mortality. *The British Journal of Psychiatry*, 199, 6, 441-442.
- Torrey, W. C., Drake, R. E., Dixon, L., Burns, B. J., Flynn, L., Rush, A. J., ... Klatzker, D. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services*, 52, 1, 45-50.

- U.S. Department of Health and Human Services. (2006). *The Road Ahead: Research Partnerships to Transform Services: A Report by the National Advisory Mental Health Council's Workgroup on Services and Clinical Epidemiology Research*. Bethesda, MD: National Institutes of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services (2008). *Assertive Community Treatment: Getting Started with EBPs*. DHHS Pub. No. SMA-08-4344. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services. (2009a). *Illness Management and Recovery: Getting Started with Evidence-Based Practices*. HHS Pub. No. SMA-09-4462. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services (2009b). *Supported Employment: Getting Started with Evidence-Based Practices*. DHHS Pub. No. SMA-08-4364. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services. (2009c). *Family Psychoeducation: Getting Started with Evidence-Based Practices*. HHS Pub. No. SMA-09-4422. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services. (2009d). *Integrated Treatment for Co-Occurring Disorders: Getting Started with Evidence-Based Practices*. DHHS Pub. No. SMA-08-4366. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services. (2010). *Permanent Supportive Housing: Getting Started with Evidence-Based Practices*. HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services. (2011a). *Supported Education: Getting Started with Evidence-Based and Promising Practices*. HHS Pub. No. SMA-11-4654. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services. (2011b). *Interventions for Disruptive Behavior Disorders: How to Use the Evidence-Based Practices KITS*. HHS Pub. No. SMA-11-4634. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services. (2015a). *Racial/Ethnic Differences in Mental Health Service Use among Adults*. HHS Publication No. SMA-15-4906. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved June 26, 2018, from <https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults>
- U.S. Department of Health and Human Services. (2015b). *Results from the 2014 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved June 24, 2018 <http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>.
- van Gestel-Timmermans, H., Brouwers, E. P., van Assen, M. A., & van Nieuwenhuizen, C. (2012). Effects of a peer-run course on recovery from serious mental illness: A randomized controlled trial. *Psychiatric Services*, 63, 54–60.

- Ventura J., Lukoff, D., Nuechterlein, K. H., Liberman, R. P., Green, M., Shaner, A. (1993). Appendix 1: Brief Psychiatric Rating Scale (BPRS) Expanded version (4.0) scales, anchor points and administration manual. *International Journal of Methods in Psychiatric Research*, 3, 227–244.
- Ventura, J., Reise, S. P., Keefe, R. S., Hurford, I., Wood, R., Bilder, R. (2013). The Cognitive Assessment Interview (CAI): Reliability and validity of a brief-based measure of cognition. *Schizophrenia Bulletin*, 39, 3, 583–591.
- Wallace, C. J., Lecomte, T., Wilde, J. & Liberman, R. P. (2001). Client Assessment of Strengths Interests and Goals (CASIG): A consumer-centered assessment for planning individualized treatment and evaluating program outcomes. *Schizophrenia Research*, 50, 105–119.
- Wallcraft, J., Schrank, B., & Amering, M. (2009). *Handbook of Service User Involvement in Mental Health Research* (Vol. 6). Hoboken, NJ: John Wiley & Sons.
- Ward, W., Zagalloff, A., Rieck, C., & Robiner, W. (published online 2/16/18). Interprofessional education: Opportunities and challenges for psychology. *Journal of Clinical Psychology in Medical Settings* <https://doi.org/10.1007/s10880-017-9538-3>.
- Weick, K. E., & Quinn, R. E. (1999). Organizational change and development. *Annual Review of Psychology*, 50, 1, 361-386.
- Weick, K. E. (1984). Small wins: Redefining the scale of social problems. *American Psychologist*, 39, 1, 40.
- Wetherell, J. L. & Jeste, D. V. (2004). Older adults with schizophrenia. *Elder Care*, 3. 2. 8-11.
- Whitaker, R. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York, NY: Basic Books.
- Whitley, R. (2016). Ethno-racial variation in recovery from severe mental illness: A qualitative comparison. *The Canadian Journal of Psychiatry*, 61, 6, 340-347.
- Wilk, C. M., Gold, J. M., Humber, K., Dickerson, F., Fenton, W. S. & Buchanan, R. W. (2004). Brief cognitive assessment in schizophrenia: normative data for the Repeatable Battery for the Assessment of Neuropsychological Status. *Schizophrenia Research*, 70, 2-3, 175-186.
- Wilkinson, G., Hesdon, B., Wild, D., Cookson, R., Farina, C., Sharma, V., Fitzpatrick, R., & Jenkinson, C. (2000). Self-report quality of life measure for people with schizophrenia: the SQLS. *British Journal of Psychiatry*, 177, 42-46.
- Winerip, M. (1994). *9 Highland Road: Sane Living for the Mentally Ill*. New York, NY: Vintage Books.
- Wong, S. C. P. & Gordon, A. (2006). The validity and reliability of the Violence Risk Scale: A treatment-friendly violence risk assessment tool. *Psychology, Public Policy, and Law*, 12, 3, 279-309.
- World Health Organization. (Undated). Information sheet: Premature death among people with severe mental illness. Geneva, Switzerland: Author.
- Wright, N. P., Turkington, D., Kelly, O. P., Davies, D., Jacobs, A. M., Hopton, J., & Beck, A. T. (2014). *Treating Psychosis: A Clinician's Guide to integrating Acceptance & Commitment Therapy, Compassion-Focused Therapy & Mindfulness Approaches within the Cognitive Behavioral Therapy Tradition*. Oakland, CA: New Harbinger Publications.

- Wright, J. H., Turkington, D., Kingdon, D. G. & Ramirez Basco, M. (2009). *Cognitive-Behavior Therapy for Severe Mental Illness: An Illustrated Guide*. Arlington, VA: American Psychiatric Publishing, Inc.
- Wu, C., Dagg, P. & Molgat, C. (2014). A pilot study to measure cognitive impairment in patients with severe schizophrenia with the Montreal Cognitive Assessment (MoCA). *Schizophrenia Research*, 158, 1-3, 151-155.
- Yale Program for Recovery and Community Health. Recovery Self-Assessment (RSA)
https://medicine.yale.edu/psychiatry/prch/tools/rec_selfassessment.aspx
- Yanos, P. T., Roe, D., & Lysaker, P. H. (2010). The impact of illness identity on recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation*, 13, 2, 73–93.
- Yin, R. K. (2017). *Case Study Research and Applications: Design and Methods*. Thousand Oaks, CA: Sage.
- Young, S. L., & Bullock, W. A. (2003). *The Mental Health Recovery Measure*. University of Toledo, Dept. of Psychology, Toledo OH: author.
- Yung, A. R., Woods, S. W., Ruhrmann, S., Addington, J., Schultze-Lutter, F., Cornblatt, B. A. ... McGlashan, T. H. (2012). Whither the attenuated psychosis syndrome? *Schizophrenia Bulletin*, 38, 6, 1130-1134.
- Yung, A. R., Yuen, H. P., McGorry, P. D., Phillips, L. J., Kelly, D., Dell'Olio, M., ... Buckby, J. (2005). Mapping the onset of psychosis: the Comprehensive Assessment of At-Risk Mental States. *Australian and New Zealand Journal of Psychiatry*, 39, 11-12, 964-971.
- Zandi, P. P., & Judy, J. T. (2010). The promise and reality of pharmacogenetics in psychiatry. *Clinics in laboratory medicine*, 30, 4, 931-974.
- Zarit, S., Reever, K., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. *The Gerontologist*, 20, 649-655.
- Ziedonis, D., Williams, J. M., & Smelson, D. (2003). Serious mental illness and tobacco addiction: a model program to address this common but neglected issue. *The American Journal of the Medical Sciences*, 326, 4, 223-230.
- Zisman-Ilani, Y., Barnett, E., Harik, J., Pavlo, A., & O'Connell, M. (2017). Expanding the concept of shared decision making for mental health: Systematic search and scoping review of interventions. *Mental Health Review Journal*, 22, 3, 191-213. doi.org/10.1108/MHRJ-01-2017-0002.

Appendix I

Appendix I: Training Guidelines for Post-Doctoral Psychology Residency Programs in Serious Mental Illness/Severe Emotional Disturbance (SMI/SED)

Criterion VI. Advanced Preparation in the Parameters of Practice

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

Commentary:

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

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

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

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

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

Please Note: Some of the information presented below is also presented Criterion II, Criterion III, Criterion IV, and Criterion V. The SMI Psychology Specialty has a dedicated, specialized Curriculum written as a practice guideline for psychologists who are working with persons with SMI/SED and published by APA. The information is repeated for ease of review. Some of the information presented in this Criterion is adapted from the APA Curriculum (American Psychological Association & Jansen, 2014).

Populations

Specialty training in SMI Psychology prepares SMI Psychologists to provide specialized care to individuals with SMI and SED. As noted previously, the Federal definition of serious mental illness is as follows:

SMI among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment, which substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, and bipolar disorder, and other

mental disorders that cause serious impairment. Downloaded from: http://nrepp.samhsa.gov/05f_glossary.aspx#S.

Similarly, individuals with SED are youth/adolescents who have early warning signs of psychosis, or early onset psychosis, or severe mood symptoms (e.g., manic episodes) related to the disorders above. For youth with early warning signs, this period is often referred to as the clinical high risk period but may be called by other names such as the prodromal syndrome. While it is clear that many children and youth experience mental health problems, those with SED have the most serious emotional disorders, and are those whose functioning is the most compromised if appropriate treatment and supports are not provided. Consistent with the Federal definition of SMI, the diagnostic categories that are our focus include schizophrenia, bipolar disorder, and severe major depression.

As outlined in criterion IV, the presentation of symptoms of SMI/SED is distinct from that of other individuals with psychological disorders not only by these symptoms' severity, but also by their unique nature (i.e., positive symptoms such as hallucinations and delusions, negative symptoms such as anhedonia and alogia), the resulting pervasive nature of the functional limitations that ensue from them, and the debilitating societal stigma and self-stigma that they often incite. SMI and SED are found in people in all ethnic, racial and socioeconomic groups, all genders, all religions, regions or countries of origin or in which people live.

As we have noted in previous criteria in this petition and will make clear in the remainder of this criteria (principally in the Procedures and Techniques section), it is the training received in SMI Psychology Specialty programs that enables SMI Psychologists to possess the necessary knowledge and skills to address these problems.

Prevalence

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

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

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

Specialty Training in Diversity-Related Issues

The percentage of individuals with SMI/SED constitutes a significant minority of the general population. They have unique needs that necessitate specialized training at the post-doctoral level for psychologists who are committed to working effectively with this population. In the Problems section below, we discuss some of the major challenges that individuals with SMI/SED face, such as co-occurring physical conditions, poverty, and entanglement with the criminal justice system. There are also diversity considerations that SMI Psychologists must take into account when providing treatment to this population, which are also discussed in the Problems section below and further discussed in Criterion III; these are important to note here.

The incidence and prevalence of SMI and SED are similar across virtually every demographic that one can think of – SMI and SED strike people in all ethnic and racial groups, socioeconomic groups, both genders and gender preferences, all religions, countries of origin in which people live, those with other conditions/disorders/disabilities, and virtually any other variable of interest. Specialty training in SMI Psychology emphasizes how age, gender, ethnicity, immigration status, and other demographic variables impact the development and course of SMI/SED and highlights the unique needs of this population across the lifespan.

Patterns of schizophrenia onset have been found to vary by sex, with earlier onset for males (peak incidence between ages 15 and 24), and more gradual increase over age 18 for females (peaking between 20-29, and then again between ages 45-54) (Tiffin & Welsch, 2013). Perhaps because of their earlier onset and their propensity for a greater preponderance of negative symptoms, males diagnosed with schizophrenia tend to have worse outcomes than females (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012). With regard to bipolar illness in adults, gender differences in prevalence of bipolar I are less apparent, though males may be more likely to present with an initial manic (rather than depressed) episode (Kawa et al., 2005); bipolar II is more prevalent in females (Nivoli et al., 2011).

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

Schizophrenia in late life is emerging as a major public health concern worldwide and impacts on persons affected, their families and caregivers, public health systems, and the public as costs escalate (Folsom, et al., 2006). Older adults with schizophrenia have been a largely neglected population, and only since 1990 has any systematic effort been made to study them. Older adults face a double stigma of having SMI and being older (Wetherell and Jeste, 2004). Clinical care for this ever-increasing segment of our population requires special consideration of the unique characteristics of older persons with schizophrenia. There are different symptoms and unique challenges associated with SMI in all age groups and for older adults, the central issue is that of age-related changes in the clinical features of schizophrenia, which include delusions, hallucinations, emotional changes, cognitive impairments, and adaptive life skills (Harvey, 2005). In 2005, it was estimated that over 9% of nursing home residents had SMI (Becker & Mehra, 2005) and estimates are that by 2030, the number of persons aged 65 who have a serious mental illness and over will double (Cohen, 2000) and be the same as the number of persons aged 30 – 44 with a similar disorder (Jeste & Liebowitz, 1997).

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

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

SMI Psychology Specialty training programs focus on diversity-related issues throughout the training experience through didactics, seminars, workshops, supervision, and clinical experience. Diversity training is not limited to diversity seminars—it is practical and applied and is interwoven throughout the training experience.

Training in a Major area of Study in an SMI Psychology Specialty program must integrate both knowledge and practice to be useful. Applications of cultural knowledge acquired in the classroom take place during practice training experiences. Thus, diversity training when working with the SMI/SED population is primarily practical and applied, with cultural competence defined as a foundational competency. Practical training for post-doctoral residents in this Specialty occurs in several main areas: primary and secondary placements, seminars, didactics, research, supervision, consultation, teaching, and administration. While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training experiences should exist across all programs. With regard to diversity experience, in addition to participation in the year-long diversity seminar, fellows should receive clinical training in at least one (and preferably more) clinical setting which 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.

By the end of the training year, trainees appreciate how personal characteristics can impact the development and maintenance of serious mental illness. By utilizing a strengths-based approach, and assessments that account for cultural and other aspects of diversity (see Criteria III and IV) trainees will also be able to identify the strengths that are inherent in these identities (e.g., cultural values) that can facilitate the recovery process along with the challenges faced by individuals with SMI/SED.

Specialty training in SMI Psychology emphasizes the heterogeneity of the population, including differences in community functioning. As noted in Criterion IV, a key challenge in working with the SMI/SED population is assessing and intervening with individuals with a wide range of community functioning. Many have significant functional impairments (e.g., social skills deficits, problems with successfully participating in activities of daily living, un or underemployment, diminished social networks), resulting from symptoms, neurocognitive problems, and developmental lags in adolescence and young adulthood (Tandon, Nasrallah, & Keshavan, 2009). On the other hand, with the advent of better-tolerated

psychopharmacology and innovative psychosocial treatments, there are a growing number of individuals with a diagnosis of schizophrenia or bipolar illness who lead full lives and achieve employment success (Cohen et al, 2016; Marwaha, Durrani, & Singh, 2013). Psychologists working with the SMI/SED population must be able to identify and address the severe symptoms and pervasive functional deficits that reduce the quality and quantity of life of some individuals diagnosed with SMI/SED, while also being capable of providing appropriate support for those individuals who are able to function more autonomously. The complexity of this endeavor, which is the purview of SMI Psychology, is typically not covered in a course of training in clinical or counseling psychology (Mueser, Silverstein, & Farkas, 2013), but as we described in Criterion V, Criterion VII and in our Training Guidelines, is fully addressed in the Major Area of Study SMI Psychology Specialty. Specialty training in SMI Psychology emphasizes the uniqueness of the population while attending to subgroups within the population (e.g., older individuals with SMI) and its heterogeneity of functioning levels and outcome. By the end of their training experience, trainees are able to provide individualized, person-centered treatment to a highly complex, underserved, stigmatized, and diverse population. Furthermore, they understand the complex intersection of personal characteristics (e.g., age, gender, ethnicity, and socioeconomic status) and the severe problems that are all too common in this population. The problems encountered by persons with SMI/SED are discussed below.

Problems

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

Psychological Problems

The psychological problems faced by those with SMI/SED can vary but most frequently include severe symptomatology such as hallucinations, delusions, extreme mood swings, disorganized thinking, and disordered or flattened affect, neuropsychological problems, trauma and severe anxiety, depression, and comorbid substance use.

Positive symptoms

Positive symptoms, or psychosis (e.g., hallucinations, delusions, disorganized thinking), constitute a loss of contact with reality and are common in individuals with SMI/SED. SMI Psychologists are not only familiar with but are comfortable diagnosing and working with patients who are experiencing psychosis. They understand the episodic nature of these symptoms and the difficulty of predicting outcome for patients who present with psychosis for the first time (Bentall, 1993). SMI Psychologists are also aware that approximately 20% of people will only experience one episode of psychosis (Rosen & Garety, 2005). It is imperative that SMI Psychologists are able to accurately diagnose patients with complex presentations and prioritize problems to address appropriately with their patients. Psychosis may be present in a variety of mental health diagnoses and may or may not be the primary concern of the patient.

Negative symptoms

There has been increasing recognition of the importance of addressing the negative symptoms of schizophrenia given its impact on functional outcomes (Remington et al., 2016); the presence of negative

symptoms early in psychotic illness is associated with a more adverse course, including more psychotic episodes and poorer functioning (Breier, Schreiber, Dyer, & Pickar, 1991; Fenton & McGlashan, 1991). Using data from the National Institute of Mental Health CATIE trial of chronic schizophrenia, Rabinowitz and colleagues (2012) found that baseline functioning and change in functioning were more strongly related to negative symptoms than any other symptoms, including positive symptoms and depression. They concluded that improvement in negative symptoms may have an independent effect on functional outcomes. In particular, avolition and apathy have been associated with poor functional outcomes (Strauss et al., 2013). Social amotivation and anhedonia are also prominent features of SMI and both may also be related to severe depression in this population (Harvey & Strassnig, 2012; Kollias, 2008). SMI Psychologists recognize the importance of addressing negative symptoms in order to improve the functioning of their patients.

Anosognosia (lack of insight)

Anosognosia or “lack of insight” is present in 57 to 98% of patients with schizophrenia (Buckley, et al., 2007). Insight is considered to be a multidimensional construct that includes recognition that one has a mental illness, identifying unusual experiences as symptoms of the illness, and recognizing the need for treatment (David, 1999). Anosognosia is predictive of treatment non-adherence, relapse frequency, violence towards self or others, involuntary hospitalizations, and poor psychosocial functioning (Buckley et al., 2007; Shad et al., 2007). It is an important problem to address in treatment in order to improve medication adherence and prevent relapse of symptoms (Lehrer & Lorenz, 2014). SMI Psychologists are experienced in treating individuals with SMI/SED, many of whom are involuntarily committed and lack insight into their mental illness.

Cognitive deficits and problems

SMI Psychologists are aware that impaired cognitive functioning is common for those with SMI/SED resulting in impaired cognition and memory and an inability to function well in social, educational, and work settings (Couture, Penn & Roberts, 2006; Hurford, Kalkstein, & Hurford, 2011; Nasrallah, Keefe, & Javitt, 2014), and their Specialty training prepares SMI Psychologists to treat persons with SMI/SED who have impaired cognitive functioning. Cognitive deficits and associated functional impairments are recognized as a relevant aspect of presentation for persons with SMI/SED such that the DSM-5 includes this in supplemental materials regarding psychosis. The Clinician-Rated Dimensions of Psychosis Symptom Severity provides options for dimensional assessment of a range of symptoms, including cognitive impairment (American Psychiatric Association, 2013). With respect to executive functioning, learning, memory, attention, concentration, and those executive functions that control and regulate adaptive abilities and behaviors, such as initiating, monitoring and changing behavior as needed are most often affected (David, Zammit, Lewis, Dalman, & Allebeck, 2008; Green, Kern, Braff, & Mintz, 2000). In addition to these executive function deficits, aspects of cognition that are critical for social functioning and interpersonal relationships are also typically affected. Examples of social cognition that are affected in SMI/SED include affect perception, perception of social (behavioral) cues, theory of mind, and attributional style or ability to correctly attribute the cause of events (Couture, Penn & Roberts, 2006; Galletly & Rigby, 2013). Deficits in both executive functioning and in social cognition present unique and serious obstacles to individuals who are struggling to recover from the effects of their illness and regain functional capability for education, work, and everyday social/community functioning because of their relationship to one’s ability to function well in these settings (Harvey & Strassnig, 2012; McGurk, et al., 2015). Unlike other forms of psychopathology, the cognitive deficits that accompany SMI/SED are often the leading cause of disability.

Psychological problems experienced as a result of trauma

SMI Psychologists are knowledgeable about the prevalence of trauma in the SMI/SED population and are trained to work toward ameliorating its effects. It has been estimated that as many as 90 percent of those with SMI have experienced trauma and many have had multiple exposures (Rosenberg, et al.,

2001). Trauma experiences are some of the most devastating life experiences encountered by people with SMI/SED because so much of this comes at the hands of people the individual knows and trusts. Trauma can be from many sources including physical, sexual, and emotional abuse, combat or war experiences, major illness, witnessing abuse or other traumatic events happening to others, catastrophic events, etc.

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

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

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

SMI Psychologists are trained to be sensitive to the impact of trauma in clinical presentations, and the potential of involuntary procedures (e.g., forced medication) to re-traumatize the people they work with.

There is accumulating evidence that children who experience severe adversity, physical abuse and especially those who are repeatedly abused are at increased likelihood for developing psychosis (Frounfelker, Vorhies Klodnick, Mueser & Todd, 2013; Rosenberg, Lu, Mueser, Jankowski & Cournos, 2007; Shevlin, Dorahy & Adamson, 2007; Varese, et al., 2012) and that sexual trauma may even be a contributing factor in the development of psychosis for some individuals (Thompson, et al., 2014). Additionally, the more trauma a child experiences the greater the likelihood of increased severity of psychotic symptomology (Lu, et al., 2013).

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

Co-occurring substance use

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

Biological Problems

SMI Psychologists are also trained to understand the biological problems faced by individuals with SMI/SED including the fact that heritability is thought to account for some proportion of causation of these illnesses; for example, investigators have found that schizophrenia may be linked to a physical process where connections between parts of the brain are “pruned” away causing brain changes that may lead to the disorder (Schizophrenia Working Group of the Psychiatric Genomics Consortium, 2014; Sekar, et al., 2016). In this section, we will focus on these physiologic problems commonly experienced by individuals with SMI/SED.

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

Specialty training for SMI Psychologists provides in-depth information about the principal reasons for these premature deaths: clinical risk factors, socioeconomic factors, and health system factors (Aron, Honberg, Duckworth, et al., 2009; Mitchell, Delaffon, & Lord, 2012), and provides SMI Psychologists with the necessary knowledge and skills to address these concerns both at the individual and the systems level. Clinical risk factors are usually discussed in terms of natural causes such as cancer, cardiovascular diseases, respiratory diseases, HIV/AIDS, diabetes, etc., and unnatural causes such as suicide, injuries from violence or other traumatic events, and accidents (De Hert, et al., 2011; Horvitz-Lennon, Kilbourne, & Pincus, 2006; Mazi-Kotwal & Upadhyay, 2011).

Premature death from natural causes

Respiratory diseases, cancers, diabetes and cardiovascular diseases – primarily attributable to smoking and obesity

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

self-stigma, physician bias, racial and cultural factors, are discussed in the section on Social Problems. SMI Psychologists seek to decrease the mortality gap between individuals with SMI/SED and the general population. Specialty training in SMI Psychology includes an emphasis on improving both the quality and quantity of life for their patients. The following biological problems are expected to be covered in SMI Psychology training programs in addition to clinical interventions that address these problems (see Procedures and Techniques).

Smoking

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

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

Obesity

Similarly to smoking, obesity is far more prevalent in people with SMI/SED than in the general population (Dickerson, et al., 2006; Parks, Svendsen, Singer & Foti, 2006). Poverty, homelessness, lack of cooking facilities, and cognitive difficulties, coupled with the iatrogenic effects of psychotropic medications which induce weight gain (Ellingrod, et al., 2012) all contribute to the prevalence of obesity. Obesity leads to musculoskeletal disorders, pain, and resultant inability to remain active, which in turn can lead to diabetes, insulin resistance, and cardiovascular disorders; these can ultimately lead to metabolic syndrome with its increased risk of type 2 diabetes, heart attack, and stroke (Allison, et al., 2009; Parks, et al., 2006).

Increased risk of obesity among individuals with SMI/SED may be due, in part, to side effects of pharmacological treatments for these disorders. The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study found that people using antipsychotic medications had much higher rates of metabolic syndrome than people in the general population (McEvoy, et al., 2005), putting them at significantly greater risk of the cardiovascular events that can result from the syndrome. Investigators have also suggested that second generation anti-psychotic medications may put people at risk of sudden cardiac arrest and death (Manu, 2011).

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

Their efforts to eat healthfully are undermined by the appetite stimulating effect of their medications. Besides, the atypical antipsychotic medications may also promote their responsiveness to external eating cues. For these patients quitting smoking is also harder than it is for individuals without schizophrenia. Nicotine provides greater stimulation and state-enhancement for them than it does for healthy individuals. They also have a poorer

appreciation of the risks associated with smoking. Recurrent episodes of acute psychosis are frequent in patients with schizophrenia and disrupt any efforts they might make towards a healthful lifestyle.... What is unique to patients with schizophrenia is their greater difficulty in breaking the pattern of unhealthy lifestyle and preventing its consequences due to factors related to their illness and its treatment (Hasnain, Victor & Vieweg, 2011, p. 409).

Premature death from unnatural causes

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

Suicide

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

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

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

Violence

Individuals with SMI/SED are exposed to high rates of interpersonal violence, including homicide (Carmen, Rieker & Mills, 1984; Goodman, et al., 2001; Greenfield, Strakowski, Tohen, Batson, & Kolbrener, 1994; Lipschitz, et al., 1996; Mueser, et al., 1998; Mueser, et al., 2004). Large scale reviews confirm that individuals diagnosed with SMI/SED are more likely to be victims of all forms of violence than the general population, with victimization prevalence in the order of 15–45% in the last year, and 40–90% over a lifetime (Choe, Teplin, & Abram, 2008; Maniglio, 2009). Individuals diagnosed with an SMI/SED are also more likely to be victims rather than perpetrators of violence (Choe, Teplin, & Abram, 2008; Desmarais, Van Dorn, Johnson, Grimm, Douglas, & Swartz, 2014).

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

Social Problems

SMI Psychologists are specially trained to assist persons with SMI/SED to overcome the many social problems they encounter. These problems are exacerbated by the psychological and physical health problems of individuals with SMI/SED. As we will show, the physical health problems that cause premature disability and death (discussed above) are exacerbated by social issues such as stigma, physician prejudice, poverty, and inability to access health care, to name just a few. The psychological, social, and health problems of people with SMI/SED who are involved with the criminal justice and forensic systems are even more difficult and are complicated by homelessness, substance abuse, physical health problems, and the double stigmas of mental illness and criminality. In the remainder of this section on social problems, we present some of the social problems faced by people with SMI/SED. Specialty training in SMI Psychology includes attention to these topics through didactics, workshops, discussion, supervision, and extensive experience working with individuals with SMI/SED who are struggling with these problems. SMI Psychologists are able to address these problems through targeted interventions (see the Procedures and Techniques section below) and advocacy on behalf of their patients.

Stigma

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

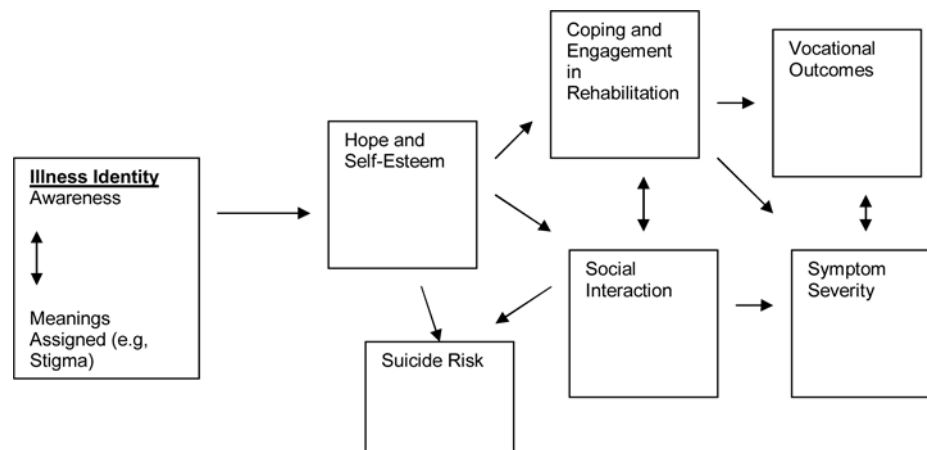
Most of us are influenced by the media and unfortunately, the media perpetuates the notion that people with SMI/SED are dangerous, violent, and responsible for most mass murders. In a random sample of news articles published in the US between 1995 and 2014, McGinty, Kennedy-Hendricks, Choksy, & Barry,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

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

Stigma and health care issues

Because of their extensive training in the adverse impact of stigma on individuals with SMI/SED, SMI Psychologists are in a unique position to address the internalized stigma that persons with SMI/SED face and to advocate for them in healthcare settings. Access to health care is impacted by stigma from health care systems and health outcomes are negatively affected (Anderson & Kurdyak, 2016). People who are stigmatized internalize that stigma and can be reluctant to seek treatment and adhere to treatment recommendations leading to increased illness severity. Self-stigma leads to decreased self-esteem, quality of life and social support (Livingston & Boyd, 2010) and can result in reluctance to pursue educational, vocational and social goals (Clement, et al., 2014; Corrigan, et al., 2014; Corrigan & Shapiro, 2010). Illness identity, or the internalization of being an ill person affects self-esteem and sense of hope, leading to depression, isolation, and suicidal ideation. Yanos, et al., (2010) characterized this by the figure below which describes these relationships.

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



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

As we have previously noted in this section and elsewhere in the petition, people with SMI/SED have poorer health status. The reasons for this range from cognitive impairment/deficits, to medication side effects, and also include such social factors as social disadvantage, racial bias, language or other cultural factors, physician stigma leading to somatic complaints not taken seriously, and self-stigma, leading to individuals’ embarrassment and reluctance to make and keep general medical appointments (De Hert, et al., 2011; Dickerson, et al, 2003; Howard, et al., 2010; Mechanic & Bilder, 2004; U.S. Department of Health and Human Services, 2001).

Stigma and ethnic minorities

African Americans and Hispanics are less likely to receive guideline-based treatment (Wang, Berglund, Kessler, 2001; Wang, Demler, & Kessler, 2002; Whitley & Lawson, 2010; Young, Klap,

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

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

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

The training that Specialty SMI Psychologists receive highlights these issues and enables SMI Psychologists to seek solutions to alleviate the harmful effects of stigmatization in healthcare settings.

Isolation

Stress associated with social exclusion can have pronounced psychological effects and impact negatively on physical health status. Most now acknowledge the power of social support; people lacking friends, a sense of community, and social support tend to have more physical health problems and adverse outcomes (Cacioppo & Hawkley, 2003; Cattell, 2001; Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Holt-Lunstad, Smith, & Layton, 2010; Szreter & Woolcock, 2004; Toussaint, Shields, Dorn, & Slavich, 2016). SMI Psychologists understand the importance of decreasing isolation and improving social support for individuals with SMI/SED.

Homelessness

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

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

Criminal justice and forensic system issues

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

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

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

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

SMI Psychologists who work in forensic and criminal justice settings require specialized knowledge often above and beyond their colleagues in other mental health settings. In particular, they need to be aware of the potential for re-traumatization in such settings and be able to advocate on behalf of their patients. They also need to be competent in the assessments and interventions developed and adapted for the needs of this population.

Characteristics of incarcerated individuals with SMI/SED

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

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

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

Trauma in the criminal justice/forensic systems

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

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

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

All too often, seriously ill prisoners receive little or no meaningful treatment. They are neglected, accused of malingering, or are treated as disciplinary problems. Without the necessary care mentally ill prisoners suffer painful symptoms and their conditions can deteriorate. They are afflicted with delusions and hallucinations, debilitating fears, and extreme and uncontrollable mood swings. They huddle silently in their cells and mumble incoherently or yell incessantly. They refuse to obey orders or lash out without provocation. They assault other prisoners or staff. They beat their heads against cell walls, smear themselves with feces, self-mutilate, and commit

suicide (p. 137). ... Security staff typically view mentally ill prisoners who break rules and act out as difficult and disruptive. Whether as punishment or simply an administrative housing decision, officials often place them in barren high-security solitary confinement units. The lack of human interaction and the limited mental stimulus of twenty-four-hour-a-day life in small, sometimes windowless segregation cells, coupled with the absence of adequate mental health services, dramatically aggravate the suffering of the mentally ill. Some deteriorate so severely that they must be removed to hospitals for acute psychiatric care. But after being stabilized they are returned to the same segregation conditions, and the cycle of decompensation begins again. The penal network is thus not only serving as a warehouse for the mentally ill, but, by relying on extremely restrictive housing for mentally ill prisoners, it is acting as an incubator for psychiatric breakdowns (p,140).

According to Disability Rights Washington (2013):

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

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

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

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

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

Research reveals that inmates placed in these harsh conditions often experience intense mental and physical distress; for inmates with mental illness, these conditions can have a catastrophic impact. Inmates in segregation routinely report extreme sensory deprivation, sleep deprivation, psychiatric decompensation, hallucinations, and behaviors relating to self-harm and even suicide (<http://solitarywatch.com/2014/08/04/what-solitary-confinement-does-to-the-human-brain/>). Because prison staff that work on these units often have little to no training related to working with inmates with mental illness, reports have found it is not unusual for prisons to employ chemical agents such as pepper spray or physical restraints to curtail or control the behaviors of inmates with mental illness in segregation (American Civil Liberties Union, 2014) (Disability Rights Washington, 2016, p.16).

Women in the criminal justice/forensic systems

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

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

Racial and cultural factors in the criminal justice/forensic systems

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

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

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

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

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

Immigrants and refugees in the criminal justice/forensic systems

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

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

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

SMI Psychologists who work in forensic and criminal justice settings require specialized knowledge often above and beyond their colleagues in other mental health settings. In particular, they need to be aware of the potential for re-traumatization in such settings and be able to advocate on behalf of their patients.

Procedures and Techniques

Didactic and Experiential Training Required for Practice in the SMI Psychology Specialty

Below, we present information on residency training, didactic seminars and workshops, supervision, etc., followed by information on the assessments and interventions that are specifically designed for this population to alleviate the problems they face. This is the advanced didactic and experiential preparation that provides the basis for services with respect to the essential parameters of practice in this Specialty.

Please Note: Detailed descriptions of each of the topics below are included in Criterion V and some information from Criterion V is presented here also. Additional information and resources for training, procedures, and techniques can be found in Criteria IV, V, and VII, and in the APA Curriculum we have cited throughout the petition (American Psychological Association & Jansen, 2014).

Specialty Practice Training by Setting (Residency, Secondary Placements, Lectures, Seminars, Workshops, Supervision, Consultation, Teaching, etc.)

Advanced scientific and theoretical knowledge specifically focused on the SMI/SED population is acquired via specialized didactic and experiential training at the post-doctoral level with a Major Area of Study where at least 80% of a resident's time is focused on the SMI/SED population, and that builds on and extends the broad and general preparation in health service psychology, and is based on the empirical literature.

The specialized training needed to develop competence to treat persons with SMI/SED differs markedly from that required to treat individuals with other mental health disorders and builds on, and expands doctoral level foundational and functional competencies, and includes:

- Specialized assessment methods that assess strengths and functional capability rather than solely symptomatology and deficits,
- Development of competence in diversity issues specific to persons with SMI/SED,
- Evidence-based and promising practices designed and tested specifically for this population,
- Interventions modified and found to be effective with people in this population within the forensic mental health system,
- Research methods adapted for populations such as this,
- Systems transformation methods specific to large mental health systems that serve this population, to name but a few.

While each post-doctoral residency program will determine the exact content of the post-doctoral program, the content of residency training should be focused on learning how to apply the scientific literature to develop the competencies necessary to conduct research, evaluation, consultation, teaching and supervision, and clinical assessments and interventions with, and on behalf of, those with SMI/SED and to assist them to recover and attain their full functional capability.

Across all placements, the post-doctoral resident should be the primary psychologist responsible for several individual clients. Residents should conduct a range of EBPs and promising practices, with fidelity to the models measured when fidelity criteria exist. Residents should also oversee at least one or more skills training group(s). Post-doctoral residents also conduct several assessments that include cultural, strengths-based, and functional assessments, and use those assessments to develop treatment plans or recommendations from those assessments. Residents should also work provide psychoeducation for several families or support systems of their clients. Given that much of the PSR work focuses on community integration, residents should have at least one ongoing experience outside the clinic (ACT, home-based interventions, etc.).

1. Required Primary Placement

Residents should expect to spend at least 80% time in the Major Area of Study with approximately 20 hours per week in a supervised, primary placement setting that is focused on the scientific understanding and treatment of the SMI/SED population. A secondary rotation, also focused on the SMI/SED population (see below), and grounded in the latest science, will be part of the post-doctoral leaning opportunity to broaden the experience of settings and patient types. As residents increase their competencies, confidence, and levels of responsibility, they should receive more complex cases, provide more independent clinical work, pursue their own training goals, and take on additional roles if desired. Residents also typically work with pre-doctoral interns and practicum students, and are involved with the hierarchical supervision of these interns and students along with their clinical responsibilities on their rotations. The intensity and level of these activities would be determined in a collaborative nature between trainee, supervisors, and the Directors of Training.

We note the need for targeted attention to diversity and cultural issues in all aspects of training. With regard to diversity experience, in addition to participation in the diversity seminar (described below), fellows should receive clinical training in at least one (and preferably more) clinical setting which 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.

The primary placement could take place in an outpatient program or on an in-patient unit. The

focus of the team should be on recovery-oriented PSR for those with SMI/SED. Residents would conduct screening, provide diagnostic clinical and strength based functional and resource assessments, work on initial goal-setting, provide psychoeducation to meet the person's expressed needs, help motivate individuals to engage in treatment, provide evidence-based and promising practices specific to persons with SMI/SED, and assist in data collection, program evaluation, and quality improvement. Residents will also participate in individual (and possibly group) supervision regarding specialized PSR and related clinical activities for the SMI/SED population in an appropriate and effective manner. Residents learn about recovery-driven systems and the kinds of services provided and are members of interprofessional teams. An SMI Psychology post-doctoral residency is fully focused on the SMI/SED population. Though doctorally prepared psychologists may have had some exposure and experience with individuals in this population, post-doctoral training in this Specialty is intense and concentrated; this concentration is required to develop the competencies needed to competently manage the complexities of the illnesses within the SMI/SED population.

Residents and other trainees also typically meet with peers, teams, and training faculty to review cases and process their experiences. They would also have the opportunity to lead rounds and facilitate discussions, offering supervision and team leading experiences.

The empirical literature (cited throughout this petition) drives all aspects of the SMI Psychology post-doctoral residency and is the foundation on which each component of the residency is built. This includes all clinical placements, didactic instruction, seminars, consultation, and supervision. It is this scientific literature that serves as the basis for all aspects of treatment of persons with SMI/SED, from engagement, through to assessment, goal setting/service planning, interventions, consultation, etc., and which supports research and development of new clinical measures and methods for this population.

Core components that PSR and recovery oriented units/teams would include:

- Individualized assessment/re-assessment focused on the cognitive deficits experienced by persons with SMI/SED and that lead to the functional deficits experienced by those treated by psychologists in this Specialty,
- Goal setting and treatment planning specific to persons with SMI/SED,
- Evidence-based and promising practices for this population (see topics from APA Curriculum, PORT study, NIMH RAISE trial, etc.),
- Individual or group psychotherapy targeted to the principal problems faced by persons with SMI/SED,
- Community integration skills needed for successful social integration of persons with SMI/SED.

2. Secondary Placements and Other Training Experiences

During the remaining 20 hours of the week, residents participate in additional rotations, didactic seminars, supervisory sessions, and other experiences, all of which are focused on SMI/SED and designed to round out their scientific understanding and knowledge of SMI/SED and fully develop their competence in service provision for this population.

SMI Psychology post-doctoral residents also participate as members of an interprofessional team on one or more units or teams that are different from the primary placement, but that also focus on recovery and provision of PSR services. These should be selected to broaden the resident's training experiences. Examples could include outpatient clinics or community programs where interventions such as family psychoeducation and social skills training are offered, or short stay units where treatment services for acute episodes of psychiatric illness are offered and where an individual is helped to

stabilize, his or her level of functioning is improved, and connections with outpatient treatments that promote community integration are established. A number of distinct clinical programs should be available to residents for secondary placements, and to the greatest extent possible, these should operate from a recovery and PSR orientation. Within each of these, residents would work closely with a wide range of healthcare providers (nurses, social workers, psychiatrists, occupational therapists, vocational specialists, recreational therapists, medical residents, dietitians, art therapists, peer support specialists, etc.), family members, and other partners.

3. Topics and Concepts that Should be Covered in one or more venues (residency, secondary placements, lectures, workshops, seminars, supervision)

We note that the empirical literature (cited throughout this petition) drives all aspects of the SMI/SED post-doctoral residency, secondary placements, and all didactic and supervisory experiences. This literature is cited throughout this petition; citations specific to the experiential and didactic training experiences in this Criterion can be found in Criterion V.

- **Principles of PSR**

Training designed to provide participants with a broad and thorough understanding of PSR interventions, principles, theories, and current research in clinical and community psychology as applied to persons with SMI/SED. Sessions focus on: current evidence-based and promising practices designed, developed, and empirically validated for persons with SMI/SED, stigma, diversity, ethics and boundaries (and how they may differ from those in traditional mental health and or other health service psychology specialties), and other relevant topics. The goal of PSR is an individual's recovery, measured not only as a reduction in symptoms but also as improved functioning and life satisfaction, and participation in environments of one's choice. The majority of services provided are PSR interventions, although residents in this specialty also provide traditional treatments such as symptom management and supportive therapy.

Residents must be able to:

- Competently explain the underlying principles and theories of a recovery approach to services for persons with SMI/SED;
- Demonstrate ability to put into practice the essential elements that differentiate PSR methods from more general psychological approaches;
- Demonstrate ability to describe the elements of evidence-based and promising PSR practices including their fidelity measures;
- Demonstrate acceptance of the importance of partnering with persons with SMI/SED, their families, support partners, and community systems.
- Demonstrate knowledge of the history of treatment of persons with SMI/SED, including deinstitutionalization and the history of coercion, and other significant developments that continue to feature prominently in treatment of persons with SMI/SED.

- **Goal Setting and Treatment Planning**

Goal setting and treatment planning for persons with SMI/SED involve components that require specialized skills. A critical part of the treatment planning process for persons with SMI/SED is to help them develop the functional skills and external resources they need to achieve their goals. A functional assessment is designed to gather information about a person's skills and capabilities in relation to the person's goals and to assist individuals with the development of realistic goals, development of tailored

clinical and recovery-oriented interventions that meet the client's identified goals, develop action steps for goal achievement, modify rehabilitation plans to reflect the needs and values of the client and determine satisfaction of services provided.

Beyond addressing symptoms, attention to helping individuals with these disorders develop life skills and work towards valued personal goals is often required in order to overcome the functional deficits that are so often present. The process of goal setting for persons with SMI/SED relies on the process of shaping as individuals work to recognize strengths, attain skills and resources needed.

Competencies psychologists need for goal setting and treatment planning with persons with SMI/SED include:

- Ability to assist clients assess their values as they develop individualized goals using shared decision making and person centered planning approaches
- Competence in developing tailored clinical and recovery-oriented interventions that meet the client's identified goals and develop action steps for goal achievement
- Ability to recognize when modifications to treatment plans are needed to reflect the needs and values of the client and determine satisfaction of services provided.
- **Research / Program Evaluation and Dissemination**

Each resident should be expected to design, develop, and implement a research, evaluation, or academic project that can be presented at a relevant national, regional or local conference and that is specifically targeted to an issue or problem in the Specialty. This is designed to assist in the formulation and execution of the project and would focus on topics such as overviews of research and evaluation of PSR assessment and intervention, research and evaluation methods, research dissemination, and critical reviews of research, including research methodology that is particularly germane to SMI/SED, which may include qualitative and mixed method designs, case studies, and participatory action research.

Residents gain experience in identifying, reviewing, and contributing to the scientific literature and knowledge base in SMI/SED. Learning outcomes include:

- Locate evidence in the literature from scientific studies relevant to the SMI/SED population, apply knowledge of research design and statistical methods to the evaluation of study findings, and select appropriate evidence on diagnostic and therapeutic effectiveness to improve patient care;
- Demonstrate familiarity with current scientific literature in PSR and related clinical activities for SMI/SED population; evaluate the relevance of scientific literature relevant to specific questions or patients;
- Demonstrate familiarity with methods of integrating scientific literature and clinical information regarding PSR and related clinical activities for SMI/SED population in the service of patient care and program development;
- Demonstrate knowledge of resources available to locate information on PSR and related clinical activities for SMI/SED population relevant to patient care and program development;
- Demonstrate understanding of how to use knowledge of research design and statistical methods to identify the level of evidence in published information when applying to PSR and related clinical activities for SMI/SED population;

- Develop and implement research questions in PSR and related clinical activities, and in health-care systems to improve the organization, delivery and effectiveness of SMI/SED-driven care;
- Demonstrate knowledge of ethical, legal, and regulatory standards for conducting research with human subjects with SMI/SED diagnoses;

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

- **Interprofessional Case Assessment Seminar**

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

Learning outcomes include:

- Demonstrate knowledge of the etiology of SMI/SED
- Demonstrate knowledge of pharmacological issues and treatments for persons with SMI/SED
- Recognizing and demonstrating ability to appreciate the value of assessments from other disciplines/professionals;
- Ability to work collaboratively with professionals from other disciplines involved with each case.

- **Systems Change Seminar**

This is a didactic seminar using seminal research literature to guide discussions about leadership, management styles and organizational development, this seminar draws heavily from the research literature on change management, organizational development, and systems design. Similarly to other disciplines, dissemination and implementation of new methods for working with persons with SMI/SED is challenging. The PSR literature is extensive and several special issues have been devoted to the issue. Residents meet with a range of leaders and managers, who lead discussions on topics ranging from mentoring, decision-making, workforce development, negotiation styles, politics in organizations, leadership in education and community organizations, all with an eye toward effecting systems change to reflect relevant mental health policies for recovery and rehabilitation for persons with SMI/SED.

Residents should demonstrate an ability to:

- Understand the challenges in developing and maintaining an interprofessional workforce;

- Demonstrate leadership through mentoring and supervision;
- Recognize and negotiate the politics of organizations and the issues specific to systems that treat persons with SMI/SED.
- **Diversity Seminar**

Diversity training for work with this population is critical and while targeted diversity training is required, diversity training for those working with persons with SMI/SED must also be primarily practical and applied with cultural competence defined as a foundational competency. Issues related to the full range of human diversity should be incorporated into all aspects of training including primary and secondary placements, seminars, lectures, and supervision sessions. Applications of cultural knowledge acquired in the didactics take place during practical training experiences. The seminar itself will include journal club readings and discussion of contemporary research literature on diversity and cultural competency issues in SMI/SED, such as the following topics: clinician reasoning in the use of cultural formulation to resolve uncertainty in the diagnosis of psychosis, cultural adaptation and treatment.

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

Learning outcomes include:

- Fully understanding psychiatric disability as part of diversity;
- Recognition of ethical issues both generally and as these may be different for persons with SMI/SED, especially as these relate to, and intersect with diversity issues. Development of skill in resolving ethical problems and dilemmas, development of understanding and respectful attitudes, current knowledge and skills in relation to all aspects of human diversity;
- Residents are expected to make a substantial effort to recognize, understand, appreciate and discuss topics such as age, sex, gender, ability/disability/illness, culture, ethnicity, race, language/culture of origin, sexual orientation, socioeconomic status, and religious/spiritual beliefs and attitudes, among others, as well as the intersection of these and how they are considered and integrated in provision of services and design of evaluation and research, with regard to persons with SMI/SED.

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

- Poor attention to physical health complaints by health care providers, misattributions of legitimate health concerns to psychotic symptoms, discriminatory practices including failure to follow treatment guidelines when people of color and diverse cultural backgrounds are seen, and need for attention to language barriers, traditional beliefs about mental illness, and religious/cultural issues;
- The exploration of power differentials, dynamics, and privilege should be at the core of understanding issues of diversity and impact on social structures and institutionalized forms of discrimination that may influence the person's perception of her/his potential for improved quality of life.

- **Laws and Ethics Seminar:**

Mental health recovery for those with SMI/SED raises important ethical issues regarding competence and safety while balancing with self-determination and autonomy. Although the APA Code of Ethics is relevant for all clinical practice, attention must be paid to issues of competency, capacity, and legal requirements, use of restraints and seclusion, culture and diversity, and even family involvement in working with persons with SMI/SED. Training in ethical decision making and application of this knowledge for persons with SMI/SED is critical.

Learning outcomes include:

- Ability to balance the need for competent decision making with self-autonomy in light of risks to self and others;
- Knowledge of the emergent literature on the dangers of seclusion and restraint and ability to if, when, and under what circumstances such procedures can be used;
- Understanding of the biases surrounding culture, race, gender and other diversity issues and the impact of those biases on decisions made by professionals in the mental health system. Ability to recognize those biases within oneself and refrain from making decisions based by those biases.

- **Consultation Seminar:**

Using contemporary research and clinical literature, this seminar is designed to provide didactic training and opportunities to discuss issues pertaining to consultation at the individual, team, and system levels. In all cases, the discussion is focused on how to apply what was learned to the SMI/SED PSR setting. Within the bounds of confidentiality and privacy, residents must be able to listen, understand, communicate, and display excellent rapport and proficiency with relevant stakeholders including: persons with SMI/SED, family members, relevant community members, interprofessional staff and other healthcare providers within and outside of the system, and community agencies and partners.

Learning outcomes include:

- Residents must demonstrate an ability to effectively present information and develop treatment recommendations that are understandable to the person with SMI/SED, his or her support team, and in accord with the individual's goals;
- Residents are able to competently work with an interprofessional team and present information about persons with SMI/SED so that team members can understand and learn from the presentation;
- Residents regularly provide consultation to interprofessional teams within the medical and or academic setting on how to implement EBPs for SMI/SED, best practices in PSR and community integration, and recovery-oriented mental health care for persons with SMI/SED;
- Consultation services include the provision of educational trainings on SMI/SED topics, the principles and strategies of PSR and recovery-oriented services for staff, partner agencies, organizations, and trainees from psychology and other disciplines;
- Residents provide consultation to community providers working with individuals with SMI/SED (examples may include providing training, technical assistance, case consultation, etc.).

4. Teaching and Supervision

Residents receive training in providing competency-based clinical supervision and training in supervision for specific clinical modalities following evidence-based practices. Residents should perform clinical supervision of pre-doctoral practicum students and doctoral interns (where the residency setting also has interns and pre-doctoral students), be supervised themselves by experienced clinical trainers, and take part in workshops or other training opportunities to develop their own supervisory skills, with reference to the population of persons with SMI/SED. They should also have the opportunity to present talks and seminars.

Residents should be able to:

- Demonstrate knowledge of methods of teaching specific to PSR and related clinical activities for SMI/SED population, e.g., in case conferences, seminars, didactics, and journal clubs. Effectively translate knowledge of specialized PSR and related clinical activities for SMI/SED population to interprofessional audiences;
- Demonstrate knowledge of methods of providing supervision to other psychology trainees that emphasizes skill building in providing patient care, consulting with other professionals, identifying relevant scientific data and conducting research, practice management and related clinical activities specific to PSR for the SMI/SED population.
- Demonstrate knowledge of, and ability to supervise implementation of EBPs and fidelity scales where these exist. Topics include: models of supervision, clinical competency, goals of supervision, reducing anxiety in supervision, silence, countertransference, supervision and ethics, risk management, self-care for the therapist and supervisor, and diversity awareness.

5. Supervision Meetings

- **Group Supervision Meetings.** These meetings incorporate the scientific literature cited throughout this petition to provide residents opportunities to learn more about how to work with those who have SMI/SED and can include processing past group or individual sessions, reviewing skills, role playing exercises, and learning more about various theories as well as practice tools and techniques. Residents learn to critically examine the empirical literature and to apply the evidence from the literature to their professional activities.

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

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

6. Professional Development Seminar

This seminar is typically a monthly meeting for all psychology post-doctoral residents at the site that focuses on professional development. Topics could include: applying for a career development award, general licensure requirements, both broadly and specific to the jurisdiction of the residency, studying for the EPPP, obtaining employment, managing a research and clinical career, and other timely topics of interest to professional psychologists.

Interventions and Assessment Instruments Specific to SMI/SED

Interventions

Specialized interventions designed, developed and empirically validated or adapted specifically for this population to help individuals as they work to ameliorate the very different challenges they face. The 2009 Schizophrenia Patient Outcomes Research Team (PORT) (Kreyenbuhl, Buchanan, Dickerson & Dixon, 2010) study remains the most rigorous and undisputed summary of efficacious interventions to date. Although some of these interventions are utilized in the care of individuals with concerns other than SMI/SED (e.g., cognitive remediation may be provided to individuals with eating disorders), this combination of treatments is unique to the care of individuals with SMI/SED and define a unique skill set that separates psychologists caring for individual with SMI/SED from psychologists practicing in other areas of care. The PORT study identified 8 evidence based practices (EBPs) and 4 promising practices. These are:

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

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

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

Psychologists preparing to work with individuals with SMI and SED must become proficient in the evidence-based and promising practices designed and tested specifically for this population. While research continues to identify the best interventions to help individuals reach their full potential and achieve a satisfying life, results of the 2009 Schizophrenia Patient Outcomes Research Team (PORT) study remain the most rigorous and undisputed summary of efficacious interventions to date. The PORT study identified 8 evidence-based practices (EBPs) and 4 promising practices. The 8 EBPs are: assertive

community treatment, supported employment, cognitive behavioral therapy, family-based services, token economy, skills training, PSR interventions for alcohol and substance use disorders, and PSR interventions for weight management. The 4 promising practices are: medication/illness management, cognitive remediation, PSR treatments for recent onset schizophrenia, and peer support and peer-delivered services (Kreyenbuhl, et al., 2010). Although some of these interventions are utilized in the care of individuals with concerns other than SMI/SED (e.g., cognitive remediation may be provided to individuals with eating disorders), this combination of treatments is unique to the care of individuals with SMI/SED and define a unique skill set that separates psychologists caring for individual with SMI/SED from psychologists practicing in other areas of care.

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

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

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

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

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

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

Evidence-based Practices

Assertive community treatment

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

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

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

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

Supported employment

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

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

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

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

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

The essential principles of supported employment are:

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

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

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

Cognitive behavioral therapy (CBT) and Cognitive behavioral therapy for psychosis (CBTp)

CBT

Cognitive behavioral therapy (CBT) uses education and behavioral shaping techniques to help individuals learn to think in a more accurate, balanced, and adaptive manner and to engage in adaptive behaviors that help to correct distorted thinking and promote recovery. CBT is not aimed specifically at eliminating symptomatology, i.e., changing either positive or negative symptoms, although the severity of these may be reduced. CBT may sometimes be helpful for persons with SMI/SED as it is sometimes used for other aspects of illness outside of psychosis, as for example it has been helpful for individuals with SMI/SED who have sleep disturbances or who are worried.

CBTp

CBT for psychosis (CBTp) is a highly specialized form of CBT that has been developed and tested, with positive results for those with SMI/SED. Data from numerous studies have demonstrated the efficacy of CBTp (Lecomte, et al., 2008; Morrison & Barrett, 2010; Rector & Beck, 2001; Wykes, et al., 2008; Zimmerman, Favrod, Trieu & Pomini, 2005). Research has also demonstrated the benefits of CBTp in preventing the experience of a first episode of psychosis among individuals at clinical high risk for psychosis (Stafford et al., 2013) and research continues in this new area.

CBTp treatment requires adapting CBT for persons with psychosis and its use requires considerable training and skill. Cognitive behavioral therapy for psychosis (CBTp) is aimed at psychotic symptoms but treatment also targets anxiety, low mood, self-esteem, etc. CBTp helps individuals to expand their understanding of the thoughts and behaviors that may underlie and/or exacerbate their symptomatic and functional concerns. Specific strategies are presented to help individuals learn how to better recognize and cope with the experience of symptomatic concerns so as to reduce distress and interference with functioning. Additionally, there is strong emphasis on development of the therapeutic alliance focused on understanding the client's experience of psychosis in order to normalize this experience and facilitate willingness to discuss symptoms, experiences, and impact of the experience on functioning. Treatment can be provided individually or in a group setting (Mueser, Deavers, Penn & Cassisi, 2013). Client engagement, recognition of possible cognitive deficits, acceptance of suspiciousness that might arise and willingness to be flexible are key (Morrison & Barrett, 2010; Mueser, et al., 2013).

Although CBTp falls under the larger umbrella of cognitive-behavioral interventions, CBTp is recognized as an intervention distinctive from traditional CBT requiring specialized skills and techniques not included as part of other cognitive behavioral interventions (e.g., CBT for depression). First, this intervention requires that the therapist have a clear understanding of the current evidence-based models that highlight how cognitive and behavioral factors may contribute to the experience of psychotic symptoms and may facilitate the occurrence of intense distress following the experience of these symptoms. An example of such a model is Tarrier's EBAC model (2007), which conceptualizes experience and exacerbation of positive symptoms of psychosis as comprised of a self-perpetuating process progressing from a sensory experience (e.g., hearing a voice), to a belief about that sensory experience (e.g., believing that the devil is talking to me), to behavioral response (i.e., action) to this experience (e.g., isolating in one's room), to a search for confirmatory evidence in support of the

effectiveness of the behavioral response (e.g., seeing that nothing bad happened after isolating which leads one to conclude that this is an effective coping strategy). Second, therapists must be aware of and able to effectively address the unique barriers to developing an effectively therapeutic alliance among individuals with SMI/SED. For example, deficits in facial emotion recognition common among individuals with schizophrenia (Kohler et al., 2003) may require the CBTp therapist to be more alert to possible misinterpretations of their emotional response by the client. Finally, effective delivery of CBTp requires that the therapist be aware of the types of cognitive distortions that are common among individuals with SMI/SED that are not typically addressed in CBT interventions for other mental disorders. Examples of such cognitive distortions include jumping to conclusions, biases, vague recollections, and biases against confirmatory evidence (Breitborde & Moe, 2016).

Research using the Delphi (consensus) model identified elements considered to be important or essential to CBTp by experts in the field (Morrison & Barratt, 2010). Further, various measures have been developed to assess adherence/fidelity when providing psychotherapy within the CBTp model. These include the *Cognitive Therapy Scale for Psychosis* (CTS-Psy; Haddock, et al., 2001) and the *Revised Cognitive Therapy for Psychosis Adherence Scale* (R-CTPAS; Rollinson, et al, 2008). A recent meta-analysis reinforced the previously found positive outcomes for CBTp, finding that CBTp was more effective for reducing positive symptoms, while social skills training was more effective for reducing negative symptoms (Turner, van der Gaag, Karyotaki & Cuijpers, 2014). There are also promising results for Recovery-Oriented CBT, a recent adaptation of classic CBTp that targets negative symptoms and functioning (Grant et al., 2011; 2017). And, very recently, a small preliminary study found long term improvements in perceived distress and affective disturbance, without changes to psychotic symptomatology, following CBTp (Mason, Peters, Williams, & Kumari, 2017). Despite these findings, CBTp is not widely recognized or taught in psychology training programs in the US (Kimhy, et al., 2013), although it has been in wide use in other countries for several years.

Family based services (also known as family psychoeducation)

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

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

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

Reviews of consumer psychoeducation found that experimental groups had reduced nonadherence (primarily with medication regimens), fewer relapses, and reduced hospitalization rates compared with control groups. Some studies found significant improvements in social and

global functioning, consumer satisfaction, and quality of life. Multifamily psychoeducation groups (the focus of numerous studies) were associated with significantly improved problem-solving ability and a reduced burden on families, compared with control groups, among other strong outcome effects. ... Psychoeducation should be included in covered services. Group and family interventions are especially powerful (Lyman, et al., 2014, p. 416).

And from the same publication:

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

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

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

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

Essential elements of family psychoeducation programs include:

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

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

Token economy interventions

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

economy interventions are long term interventions and commitment to long term, high intensity staff training and to providing the intervention over a long period of time are required.

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

Token economies are based on the seminal work of Paul and Lentz (1977) whose work provided the cornerstone of empirical support for social learning programs. Token economies, or social learning programs are the only interventions among the eight designated EBPs specifically recommended for long-term inpatient or residential care to improve personal hygiene, social interactions, and other adaptive behaviors.

Token economies have been used successfully in institutional settings for several decades and there are many studies that support the efficacy of this highly effective intervention (Ayllon & Azrin, 1965; Beck, Menditto, Baldwin, Angelone & Maddox, 1991; Dickerson, Tenhula & Green-Paden, 2005; Glynn, 1990; Hall, Baker & Hutchinson, 1977; Silverstein, Hatashita-Wong, Wilkniss, et al., 2006).

Skills training

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

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

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

Increasingly there is recognition of the need for long term follow-up of tailored skills training. One

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

PSR interventions for alcohol and substance use disorders (also known as concurrent disorders treatment or integrated dual diagnosis treatment)

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

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

- Assertive outreach
- Integrated case management
- An individualized treatment plan that addresses both the substance use disorder and the person's mental illness
- Integrated services provided by the same clinician or clinical team
- Availability of multiple therapeutic approaches
- Comprehensive approach
- Knowledge about the effects of alcohol and drugs and their interactions with mental illness and the medications that are used to treat mental illnesses
- Reduction of negative consequences
- Cognitive behavioral therapy
- Stage-wise treatment provided as individuals progress over time through different stages of recovery
- Relapse prevention
- Motivational interviewing to help the individual develop awareness, hopefulness, and motivation
- Long term approach to ensure time unlimited treatment (Drake, Mercer-McFadden, McHugo & Bond, 1998; Haddock, et al., 2003; Mueser, Noordsy, Drake & Fox, 2003).

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

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

PSR interventions for weight management

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

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

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

Promising Practices

Medication/illness management

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

Harrow, Jobe & Faull, 2012; McGorry, Alvarez-Jimenez & Killackey, 2013; Wunderlink, Nieboer, Wiersma, Sytema & Nienhuis, 2013).

A widely used approach consists of teaching illness management skills and usually involves a series of sessions where mental health providers help individuals with SMI/SED learn a broad range of coping strategies for living with their illness. Illness Management and Recovery (IMR) (Gingerich & Mueser, 2011) consists of combining a set of specific EBPs for teaching people how to manage their disorder in collaboration with professional staff and family members in order to achieve their own recovery goals. Enhanced IMR is an adapted version of the IMR intervention for those who also experience substance use disorders (Gingerich, et al 2018). The coping strategies taught in most illness management programs are a subset of those utilized in other EBPs and are designed to help individuals build healthy, wellness oriented lifestyles. Programs usually run for three to six months and consist of educational and skills building sessions. Programs are designed so that family members can also attend, with permission of the individual.

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

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

These components include:

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

Topics covered in an illness management program include:

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

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

Cognitive enhancement: cognitive remediation and social cognition training

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

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

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

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

Lastly, a recent meta-analysis of interventions using aerobic exercise supervised by physical activity professionals combined with psychotropic medication was conducted and results indicate substantial improvement in cognitive functioning (social cognition, working memory, and attention) for individuals with SMI; these effects were even larger with greater intensity levels of aerobic exercise (Firth,

et al., 2016). Given the importance of reducing obesity and its consequences, aerobic exercise may have multiple benefits for this population. As with other PSR interventions for this population, it may be that combining multiple interventions such as aerobic exercise with targeted cognitive improvement interventions such as cognitive remediation, social cognition training, and supported employment will prove to be the best approach for enhancing overall cognitive functioning and improving the outlook for cardiovascular health, and attainment of educational, vocational, and social goals.

PSR treatments for recent onset schizophrenia

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

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

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

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

Although there are many factors that influence functional outcomes, there is growing evidence that early intervention with pharmacologic and PSR interventions during the first episode of psychosis may lead to improved outcomes (Baksheev, Allott, Jackson, McGorry & Killackey, 2012; Bertelsen, et al., 2008; Bird, et al., 2010; Ehmann, Yager & Hanson, 2008; Kane, et al., 2016; Marshall & Rathbone, 2011; Tandon, Keshavan & Nasrallah, 2008) and may prevent or delay relapse (Álvarez-Jiménez, Parker, Hetrick, McGorry, & Gleeson, 2011). These results are strengthened when there is sufficient funding to support the interventions fully and with fidelity to the researched model (Csillag, et al., 2016). First episode intervention programs (such as the RAISE initiative) generally include the provision of

multimodal PSR interventions (CBTp, family based psychoeducation, illness management, educational and vocational interventions), pharmacotherapy, and some form of case management with lower case-loads and an assertive approach to treatment, all within the context of intervening as early as possible.

Despite the promising results of early intervention research, the evidence also suggests that the effects may not be sustained beyond the intervention period and continued intervention may be needed (Bertelsen, et al., 2008; Bird, et al., 2010; Bosanac, Patton & Castle, 2010; Gleeson, et al., 2013; McGorry, Nelson, Goldstone & Yung, 2010; Norman, et al., 2011; Pretia & Cella, 2010), especially during what is considered the five year critical period from onset of psychotic symptoms (Addington, Leriger & Addington, 2003; Birchwood, 2000; Birchwood, Todd & Jackson, 1998; Harrison, et al., 2001; McGlashan, 2006; McGorry, 2002; Perkins, Gu, Boteva, & Lieberman, 2005; Wyatt & Hunter, 2001). The NIMH RAISE initiative is continuing research designed to determine the sustainability of early intervention results (Kane et al., 2016).

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

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

Somewhat distinct from the issue of long term medication use is a related but slightly different aspect of medication use, i.e., duration of untreated psychosis (DUP). Evidence suggests that the longer an individual remains without treatment after evidencing psychosis, the poorer the ultimate outcome (Marshall, et al., 2005). There is also evidence that reducing DUP leads to better long term outcomes (Kane, et al., 2016; McGlashan, et al., 2011). This is also an important and emerging area of intense research interest that needs to be followed carefully. Similar results have been found with regard to delayed access to evidence-based psychosocial care, where greater delays in access are associated with a worse course of negative symptoms and longer average duration of subsequent rehospitalizations (de Haan et al., 2003).

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

Peer support and peer delivered services

Participation of consumers in the design and delivery of mental health services is one of the

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

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

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

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

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

Stigma and self-stigma

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

Interventions to change attitudes and decrease discriminatory behaviors among health providers and the public at large have also been developed. Corrigan, Mueser, Bond, Drake and Solomon, (2008) identified the most promising of these as education and contact, with contact being the stronger of the

two (Corrigan, Morris, Michaels, Rafacz, & Rüsck, 2012). Peer delivered services can serve as a stepping stone as peers are individuals with a serious mental health disorder who have recovered sufficiently to be of assistance to individuals not yet recovered and many peers work in mental health service settings; contact with peer specialists can change provider attitudes (Nemec, Swarbrick, & Legere, 2015). To date, despite the plethora of psychological research identifying the effects of stigma, no single intervention or combination of interventions has been proven definitively to change attitudes and behavior.

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

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

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

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

Trauma interventions

We have stressed that many if not most of those with SMI/SED have experienced severe and often repeated abuse leading to serious trauma reactions. Treatment must be specifically geared toward helping people with SMI/SED work through the devastating effects of the traumatic experiences they

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

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

Finally, in addition to trauma specific psychotherapy, pharmacotherapy is an important component of treatment to reduce the anxiety, depression, and insomnia that often accompany trauma reactions and PTSD, making it possible for individuals to participate in psychotherapy treatment. Due to the high prevalence of male perpetrated violence against women, the treatment needs of women may be very different from those of men (Bently, 2005). Women that have been abused by men will likely be unable to work through those issues in a mixed group – a mixed trauma group can actually exacerbate their trauma. Services offered in women only groups may be essential for women who have been abused both to help them recover and to avoid exacerbating their trauma (Salina, Lesondak, Razzano, & Weilbaecher, 2007; Saxena, et al., 2014; Wright, et al., 2012).

Suicide prevention interventions

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

For people with SMI/SED, greater awareness of their condition and feelings of hopelessness are associated with higher risk of suicide; thus individuals need to be carefully assessed for suicidal ideation especially if they are markedly depressed, and/or there is considerable improvement in their awareness of their condition (Pompili, et al., 2007). Treatment for affective symptoms, especially depression, improving adherence to treatment and very close follow up may be effective in preventing suicide

(Hawton, et al., 2005). Outreach and close follow up are among the few non-pharmacologic preventive measures that have been definitively identified as effective in preventing suicide with this population, although high levels of support have been shown to reduce risk (Sinclair, et al., 2004).

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

Violence prevention interventions

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

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

Interventions to decrease homelessness

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

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

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

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

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

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

Smoking cessation

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

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

As we mentioned in the section on Social Problems, the terms forensic system and criminal justice system are frequently used interchangeably, making a separate discussion of these systems difficult. As in the previous section, we do not make a distinction between these systems in our discussion of interventions for the population of people with SMI/SED in these settings.

While these deplorable conditions of jails and prisons may make forensic psychiatric hospitals appear to be stellar institutions, and despite the fact that some forensic psychiatric institutions are at the forefront of providing the latest services and opportunities for this population, for the majority of U.S. jails, prisons, and forensic psychiatric hospitals, there are not adequate or appropriate services for people with serious mental illnesses in any setting. In many ways, forensic/criminal justice settings are antithetical to the concept of recovery for people with SMI/SED. Individuals who are incarcerated or are in these settings have little free choice and often have serious threats to their own safety. Thus, in most of these settings, there is little ability to provide services consistent with the recovery paradigm and to offer services designed to help people learn the skills they need to achieve their life goals.

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

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

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

However, research on clinical interventions for people with SMI/SED in criminal justice/forensic settings has been limited, with much of that research aimed principally at reducing re-arrest, although some attention has been given to symptom improvement. In the forensic/criminal justice arena, there are several reasons for the limited research and the emphasis on reducing re-arrest, chief among them is the

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

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

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

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

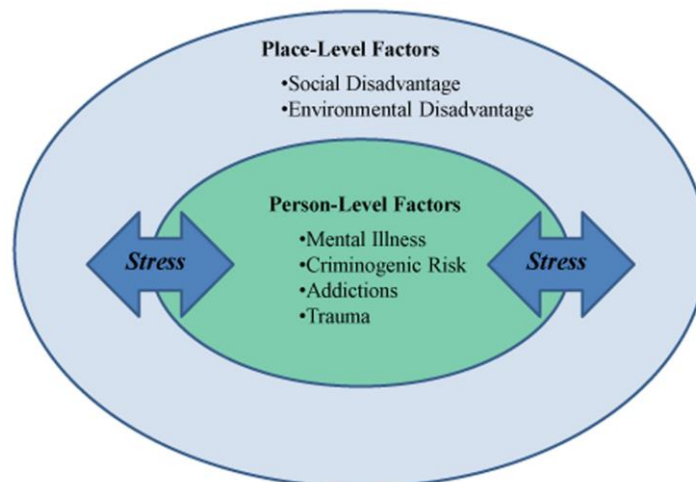
Notwithstanding the above, two overarching findings that have emerged consistently across settings and populations are the following:

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

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

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

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



Within this model, a comprehensive array of interventions to address each risk factor is proposed. While most agree that such an approach is needed, continued funding cuts combined with the stigma associated with SMI/SED and criminality make implementation of comprehensive services difficult, albeit extremely important.

Although intervention research related to forensic/criminal justice settings is limited, three clinical EBPs (assertive community treatment, cognitive behavioral therapy, concurrent disorders treatment (also known as integrated dual diagnosis treatment) and some promising practices (trauma informed care, trauma specific services and supported housing) have been studied in forensic/criminal justice settings. Related interventions, most often based on cognitive behavioral approaches, are often offered in various justice related settings and some of these have begun to show positive results (Haddock, et al., 2009; Tew, Dixon, Harkins & Benett, 2012). Systematic reviews of published studies have also begun to provide evidence that interventions to help people with SMI/SED in forensic systems can be beneficial (Duncan, Nicol, Ager & Dalgleish, 2006; Mancini, Linhorst, Menditto & Coleman, 2013; Martin, Dorken, Wamboldt & Wootten, 2012).

For the most part, research on these efforts is in early stages. Consequently, the following discussion is limited to what is currently known about using the existing evidence-based and promising practices. We do not present information on concurrent disorders treatment, despite the high prevalence of SMI/SED in this population as the research has not been specific to the SMI/SED population. We also limit our presentation of CBT to what is known about its use with the population of interest; notably, little research exists on CBTp for this population although recent evidence suggests the importance of CBTp for this population (Quinn & Kolla, 2017). We do include information on trauma interventions because of the role that trauma plays in the development and exacerbation of SMI/SED, and the extremely high prevalence of women with SMI/SED and trauma history in the forensic and criminal justice systems. We also include some information about mental health courts and transition planning due to the research supporting the efficacy of these interventions for persons with SMI/SED.

Forensic assertive community treatment (FACT)

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

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

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

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

Cognitive behavioral therapy (CBT) and Cognitive behavioral therapy for psychosis (CBTp) for persons with SMI/SED in the criminal justice/forensic systems

Some investigators have shown that CBT holds promise for helping individuals with schizophrenia achieve better interpersonal functioning (Williams, Ferrito & Tapp, 2014), and for helping individuals reduce the impact of substance misuse (Morris & Moore, 2009). Additionally, medication and psychoeducation combined with CBT have been found to be beneficial (Tapp, et al., 2013). Recently, some have begun incorporating CBTp into studies of persons with SMI/SED who are involved in the forensic and justice systems and positive results are emerging (Quinn & Kolla, 2017). More research targeted to the intersection of SMI/SED and criminality is needed to determine the potential benefits of specialized interventions such as CBTp for those in criminal justice and forensic settings.

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

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

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

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

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

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

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

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

Several studies have reported the extremely high rates of abuse for women in the forensic/criminal justice system; most who study this issue consider this to be the norm for women in the justice system (Osher & Steadman, 2007; Parsons & Sandwick, 2012). The traumatic experiences of women put them at heightened risk for PTSD and other anxiety disorders with 34 percent meeting criteria for PTSD (Alvorado, 2002; Trauffer & Spatz Widom, 2017). The extraordinarily high rate of trauma evidenced by women in the justice system has also put them at risk for substance abuse and dependence (DeHart, Lynch, Belknap, Dass-Brailsford & Green, 2014; Salisbury & Van Voorhis, 2009) and three-quarters of the women who had a mental health problem also met criteria for substance abuse or dependence (Abram, et al., 2003; James & Glaze, 2006). The U.S. Bureau of Justice Statistics found that 73% of the women in state prisons and 75% of women in local jails have symptoms of mental disorders, compared to 12% of women in the general population.

Additionally, incarcerated women have greater chronic medical and mental health disorders and drug dependence than men; this is true even for those conditions more prevalent in men (Binswanger, et al., 2010), indicating increased need for treatment of these conditions for women (de Vogel, Stam, Bouman, Ter Horst & Lancel, 2016). Women with mental health problems who do not receive appropriate mental health treatment while in the forensic/criminal justice system are highly vulnerable and at high risk for homelessness, violence, further abuse and trauma, and repeated involvement in the criminal justice system when they are released (Lynch & Heath, 2017; Smith, Simonian & Yarussi, 2006). Incorporation of a continuing care model which includes trauma informed treatment is essential to assist women with SMI/SED in forensic settings (Saxena, Grella & Messina, 2016).

Supported housing for those released from the criminal justice/forensic systems

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

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

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

Mental health courts

Mental health courts have been introduced in several jurisdictions throughout the US and Canada. Mental health courts are specialized court dockets that deal exclusively with people with mental

health disorders in the criminal justice system. These courts combine community treatment services for people with SMI/SED with criminal justice supervision and have the following goals:

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

Mental health courts are used for individuals who can be adjudicated to community supervision. The combination of criminal justice supervision with community treatment holds promise of helping individuals with serious mental illnesses avoid incarceration, increase community tenure and achieve stability. Almquist & Dodd, 2009, offered the following related to mental health courts:

Research has found that participants in some mental health courts have lower rates of recidivism than individuals with mental illnesses processed through the traditional criminal court system. Some research findings indicate that this trend continues after individuals are no longer under court supervision. Mental health courts have also been found to connect participants with mental health treatment services more effectively than do the traditional court system and jails. In addition, mental health courts have the potential to save money through reduced recidivism and associated savings in jail and court costs. Also, treatment costs are reduced by avoiding expensive inpatient care (p. vi).

Although chiefly a criminal justice intervention for individuals who are not incarcerated, the principle of coordinated care that mental health courts embody is one that the mental health service delivery system has been advocating for years. Some studies have concluded that mental health courts improve access to mental health treatment and reduce recidivism (Kennedy-Hendricks, Huskamp, & Barry, 2016). Combined with a range of interventions provided at the intensity needed by this population, and when implemented with competent and knowledgeable court outreach personnel who assist individuals to access needed health mental health, and legal services, it may be that mental health courts hold promise of helping individuals remain out of the forensic/criminal justice system and achieve a stable and satisfying life in the community (Sylvestre, Aubry, Smith & Bridger, 2010).

We note however, that factors such as community isolation, social disadvantage, poverty and stigmatization will impede the success of interventions aimed at helping individuals achieve successful re-integration into the community. A wide range of interventions aimed at ensuring proper housing, successful employment if the person is able to work, help with medical and mental health follow up, and community integration that diminishes stigmatization are all necessary to help individuals in this population succeed (Barrenger & Draine, 2013; Epperson, et al., 2014).

Transition planning and follow-up in the criminal justice/forensic systems

For people who are being discharged from forensic and criminal justice settings, providing adequate and appropriate transition planning and follow up are crucial (Cuddeback, et al., 2013). Failure to provide the needed planning and follow up is a major reason for the revolving door of release, illness, substance use, homelessness, trauma, and re-incarceration that afflicts this population.

Almost all jail inmates with co-occurring mental illness and substance use disorders will leave correctional settings and return to the community. Inadequate transition planning puts people with co-occurring disorders who enter jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness, and re-arrest (Osher, Steadman & Barr, 2002, p. 1)...Inadequate transition planning puts people with co-occurring disorders who entered the jail in a state of crisis back on the streets in the middle of the same crisis (p. 3).

A comprehensive model to address the problem and provide guidance for how to ensure that coordinated and integrated planning and follow up services are delivered has been developed and is called the APIC model (Osher, Steadman & Barr, 2002).

The model consists of the following components:

- Assessment of the person's clinical and social needs, and public safety risks
- Planning for the treatment and services required to address the person's needs
- Identifying required community and correctional programs responsible for post-release services
- Coordinating the transition plan to ensure implementation and avoid gaps in care with community-based services.

The authors stress that planning must take the following into account:

- The period immediately after release is critical – the first hour, day or week can determine success or failure and high intensity interventions that support the person during this time are essential;
- The person him or herself must be engaged and asked what helped or hindered success following previous incarcerations – this is considered the most important part of the assessment and planning process;
- Seeking input from family members;
- Addressing housing and the other multiple needs of the person;
- Naming specific community referrals that are appropriate for the person's medical, mental health, social and economic needs and forwarding a copy of the person's discharge summary to the community provider;
- Connecting the person with appropriate medical resources and making needed appointments;
- Initiating applications for needed benefits (Medicaid, SSDI/SSI, veterans benefits, food stamps, Temporary Assistance for Needy Families (TANF), etc.
- Ensuring that the person has:
 - An adequate supply of appropriate medication that will last until the first follow up appointment
 - Adequate clothing
 - Resources to obtain adequate nutrition
 - Transportation from jail to place of residence and from residence to appointments
 - A plan for childcare if needed that will allow him or her to keep appointments (Osher, et al., 2002, p. 8–9).

To ensure the person has as much support as needed to follow through with services, it is crucial to explicitly inform the person him or herself, the family, those in the releasing facility and the treatment providers in the community of the names and contact information for the person(s) responsible for following up between the time of release and the first follow-up appointment. On-going support is essential, as is a mechanism to stay in touch with the individual and reach those who miss the first follow-up appointment to re-schedule and get the person back on track with the transition (Osher, et al., 2002). Connecting people with their communities and ensuring that follow-up and help with all needed aspects (housing, employment, medical and mental health services, normalized leisure and socialization to diminish stigma, etc.) is essential (Barrenger & Draine, 2013).

Transition planning must attend to the cultural, racial, gender and age related factors that are important to ensure the person is linked to services that are accepting and compatible (Hicks, 2004; Osher, et al., 2002; Rotter, et al., 2005).

Interventions for bipolar disorder

Psychotropic medications for individuals with bipolar disorder have been available since the 1970s but pharmacologic interventions are not sufficient to help individuals learn the skills needed to overcome the difficult challenges associated with this disorder (Geddes & Miklowitz, 2013; Salcedo, et al, 2016; Swartz, Levenson, & Frank, 2012; U.K. National Collaborating Centre for Mental Health, 2006).

As with most disorders under the SMI heading, bipolar disorder is extremely challenging and it is only recently that research has identified PSR interventions for this population; thus far several have been tested and found to be helpful. Interventions originally intended for other populations have been adapted for this population, as it is recognized that the standard application of the intervention is not sufficient or that the psychotherapy can be applied to a population not originally expected. Since virtually every publication on this topic recommends a similar combination of psychological interventions (with pharmacotherapy) for the treatment of this disorder (Geddes & Miklowitz, 2013; Salcedo, et al, 2016; Swartz, et al., 2012; U.K. National Collaborating Centre for Mental Health, 2006) and since we discussed all but one of these above, the previously discussed recommended interventions are simply listed below. (We provide information about the additional intervention (IPSRT) following the list). They are:

- Psychoeducation for the person and family about the illness
- Family focused therapy
- Promoting medication adherence
- Social support
- Reducing drug and alcohol misuse
- Interpersonal and social rhythm therapy (IPSRT)

Interpersonal and social rhythm therapy (IPSRT) is a multi-component approach that focuses on working collaboratively to identify key triggers for interpersonal conflicts and stressors such as role transitions, grief arising from substantial loss, and other problem that may predispose to relapse and helping the individual learn skills to cope with or resolve these interpersonal problem areas, and at the same time, learn to improve the regularity of everyday routines (particularly sleep and waking) in order to minimize relapse.

In addition to the interventions listed above, two others have been suggested as important; there may be considerable overlap between these and the interventions listed above. These additional interventions are:

- Dialectical behavior therapy (DBT) (Salcedo, et al., 2016; Van Dijk, Jeffrey, & Katz, 2013)
- Mindfulness-based cognitive therapy (Salcedo, et al., 2016).

Like IPSRT, we have not mentioned dialectical behavior therapy (DBT) in this petition so a very short synopsis of it is presented here. Dialectical behavior therapy (DBT) is a form of cognitive behavioral therapy that was originally developed to treat highly suicidal individuals with borderline personality disorder (Linehan, 1993) and has been adapted for this population (Goldstein, et al., 2015). DBT is designed to help people change patterns of behavior that are not helpful, such as self-harm, suicidal ideation, and substance abuse. Like IPSRT, DBT helps individuals increase their emotional and cognitive regulation by learning about the triggers that lead them to react in undesirable ways and to develop

coping skills to avoid undesired reactions. DBT combines mindfulness with therapy designed to help individuals learn to tolerate distress, regulate their emotional reactions, and become more capable of handling interpersonal situations (Psych Central, 2016).

Given the recency of research and the challenges faced by those with bipolar disorder, it may be that a differential combination of interventions will be needed by some individuals.

Experiential Training: Additional Topics

Motivational interviewing has been shown, in several clinical trials, to be a highly effective intervention that assists people to make changes in their lives (Miller & Rose, 2009). The strategy is particularly important when individuals are confronting behaviors that are difficult to change, such as addictive behaviors, but has been shown to be useful for a wide variety of situations and populations, and may be helpful for those with chronic mental health disorders (Arkowitz, Westra, Miller & Rollnick, 2008; Hettema, Steele & Miller, 2005; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Rollnick, Butler, Kinnersley, Gregory, & Mash, 2010; Rubak, Sandbaek, Lauritzen & Christensen, 2005). Motivational interviewing is considered an EBP for substance abuse. The goal of motivational interviewing is to help individuals explore their ambivalence about their behavior and may be useful in helping people with SMI/SED persist in treatment seeking and adherence despite the stigma they face and the many obstacles they encounter. There have been some adaptations for use with people with SMI/SED (Carey, Leontieva, Dimmock, Maisto, & Batki, 2007; Drymalski, & Campbell, 2009) but research indicating the efficacy of the approach for this population is not conclusive (Barrowclough, et al., 2010; Chien, Mui, Cheung, & Gray, 2015) and further study is needed. We include it here because it may be useful in helping those with SMI and SED modify behaviors that are particularly harmful such as smoking, overeating, non-adherence to medication regimens, criminal behavior, etc.

Several other interventions are considered an important component of any mental health service that assists persons with SMI/SED. These include supported education (increasingly included with programs where supported employment is offered), leisure services to lessen isolation and teach social skills, and activities of daily living which are typically not learned by individuals whose illness begins in adolescence and whose illness is severe. Psychologists who are program managers, administrators, and those in policy/funding positions should know about these and recognize their importance within an overall mental health service system for people with SMI/SED.

In conclusion, research evidence has been accumulating that an integrated approach that combines multiple interventions within a recovery oriented context may be the most effective approach (Lyman, et al., 2014; Spaulding & Deogun, 2011) and scholars are increasingly calling for such an integrated, recovery oriented system (Davidson & Chan, 2014). Such an approach must be targeted to the unique needs of each individual including those in forensic and criminal justice systems (Epperson, et al., 2011; Strauss, 2014). In addition, it has become apparent that cognitive impairment is likely at the heart of the functional skill deficits so commonly experienced by people with SMI/SED (Harvey & Penn, 2010) leading to the conclusion that integrated approaches should include cognitive enhancement approaches as a fundamental component (Pfammatter, et al., 2011; Roder, Mueller & Schmidt, 2011) and underscores the importance of social cognition for improving community functioning. Indeed, some have stated that including cognitive remediation “may result in a magnitude of change that exceeds that which can be achieved by targeted treatments alone” (Pinkham & Harvey, 2013, p. 499).

However, to date, no definitive combination of approaches has been determined to be most effective, although some combination of cognitive therapies (cognitive remediation, social cognition training, cognitive behavioral therapy for psychosis), supported employment, psychoeducation (client/family approaches, illness management approaches), seems to be most promising. As discussed above, early intervention in first episode psychosis is increasingly recognized as critically important and the RAISE initiative results (Kane, et al., 2016) reinforce the efficacy of this approach which is also most likely applicable to those who have had additional episodes of psychosis. Continued research and

identification of which interventions work best for whom, under which conditions, at which stage of illness, and potentially at which age of each individual, may lead to the development of personalized approaches tailored for each individual.

Assessment Instruments

Please Note: For an excellent overview, see the chapter by Glynn and Mueser (2018) which presents a comprehensive review of the many instruments available for use in assessing persons with SMI/SED and presents information about their psychometric properties. We list here some selected assessments that post-doctoral residents should be familiar with (also listed in Criterion V and in the Training Guidelines). The assessment instruments below are examples of the most widely known and used assessment instruments in a wide array of categories. There is a broad array of assessments that have been developed that are specific to this population, and it would not be possible to master all of them during a post-doctoral training year. At the minimum, however, post-doctoral residents should be familiar with these assessments and able to administer at least one and preferably two from each of the major categories. Following the listing, detailed information about culturally informed, strengths based and functional assessments, also an integral part of the didactic and experiential training, is provided. For the sake of brevity, we list only titles of the well-known instruments. We present detailed information about those that are aimed at helping to identify strengths and cultural identify as these are less well-known.

Comprehensive assessment is essential to any recovery service plan. Residents should be able to appropriately assess, evaluate and then develop practical interventions for individuals with severe and persistent mental illnesses, including those with complicated mental, substance abuse, and medical comorbidities, often with histories of trauma. In addition to being able to use strengths based and culturally informed assessments, residents should achieve competence in conducting a cultural formulation interview; the DSM-5 Cultural Formulation Interview (American Psychiatric Association, 2013) is recommended for use in training programs in this Specialty.

- **Culturally informed assessment**

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).

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).
Self-Stigma of Mental Illness Scale (SSMI) (Corrigan, Watson, & Barr, 2006).
Internalized Stigma of Mental Illness Scale (ISMI) (Ritsher et al., 2003).
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, 2006).

- **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 (see the following section for additional information)**

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, 2011).

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 – Note: the predictive accuracy of instruments in this category “remains a source of considerable uncertainty” (Fazel, Singh, Doll, & Grann, 2012).**

Hare Psychopathy Checklist-Revised (PCL-R) (Hare, 1991).

Historical, Clinical, Risk Management-20 V3 (HCR-20) (Douglas, Hart, Webster, & Belfrage, 2013).

- **Recovery based assessments 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).

The importance of strengths-based and culturally relevant assessment

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

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

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

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

A strengths-based assessment approach recognizes that every individual has capabilities, accomplishments and potential, and considers positive factors in the person's surrounding environment

such as his or her natural support network including family strengths, community supports, and social service system network. These characteristics mean that each person has the potential for future accomplishments that will facilitate continuing to attain the life he or she wishes to achieve (Davidson, et al., 2008; Farkas, et al., 2000).

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

Determining an individual's strengths and capabilities is important for children and young people as well. The Outcomes Roundtable for Children and Families (a consortium of researchers, youth, family members, providers, and policymakers) identified important outcomes that all families want for their children, and noted that families seeking services for children with mental health concerns want services that promote the development of competencies, and functional lifetime outcomes. This focus transcends symptom reduction, and goes beyond reduction of deficits (Bellonci, Jordan, Massey, Lieberman, Zubritsky & Edwall, 2012).

For psychologists, learning to conduct comprehensive ecological, functional, strengths-based assessments requires a paradigm shift that is fundamental to the concept of recovery, i.e., the notion that people with SMI/SED have considerable resilience and strengths that can be used to build successive accomplishments and that psychologists and other mental health practitioners are partners in helping to enhance the skills and resources already inherent in each person.

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

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

From an ecological perspective, to fully know and understand a person it is important to look at the individual's personal characteristics, information about his or her environment, and the pattern of interactions the person has within his or her environment (Wilson, 2004).

Information for this broader assessment should be gathered about several life domains including living situation, educational and vocational accomplishments and aspirations, socialization and leisure, health status, financial and legal situation, and everyday circumstances in such realms as independent

living, transportation, money management, etc. Similar to other components of the recovery oriented treatment process, the assessment should be one of two equal partners gathering information for future work together rather than one person (the psychologist) delving into the life of another person (the person with an illness) (Elder, Evans & Nizette, 2009).

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

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

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

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., Laro, 2014; Luhrmann, 2007; Versola-Russo, 2006). Further, the DSM-5 highlights culture-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.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is not a recovery oriented manual but the *DSM 5’s Cultural Formulation Interview* (American Psychiatric Association, 2013) offer some questions that can be used as a guide for helping to understand the person and his or her contextual life and experiences. The questions should not necessarily be asked verbatim but can be used as a guide to topics that may be relevant and the questions should be phrased to reflect sensitivity to the person’s background and culture. Not all of the questions will be relevant to every person or in every situation. The examples below may be the impetus for additional discussion about the person’s background and cultural experiences and can spark additional discussion as opportunities arise:

I. Cultural identity of the individual:

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

II. Cultural explanations of the individual's illness:

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

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

- What kind of stressors have you been experiencing?
- What kinds of social support are available?
- What religious or other support systems are available?
- How do the symptoms impact your functioning? (American Psychiatric Association, 1994; American Psychiatric Association, 2013).

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

- What do you call your problem? What caused it? Note: the answer has everything to do with the cultural filters of the person and can provide you with rich information and possible avenues for discussion of support networks.
- Whom do you include as family? Whom do you trust? Note: these are the people who may form the person's support network.
- Have you ever been a member of a faith community? Note: this is important because many people believe that God has turned a blind eye when they become ill or develop chemical dependency problems and they cease involvement with church, synagogue, mosque or other religious communities.
- Are you a member of a faith community now? If so, would you like the Rabbi, Priest, Pastor, Imam, etc. to be part of and involved in your support network? If not, why not? Note: it is a rare clergy member who will not participate as best he/she can when called.
- Are you now going, or have you ever gone, to an Indigenous Healer for help with your problem?

Would you like that person involved as part of your recovery support network? Note: this question is especially relevant for Native people, Latinos and people of African origin.

- With whom do you have intimate relations and relationships? Note: this way of asking about sexual orientation is a bit more sensitive than asking a person's sexual orientation outright.
- Have you ever experienced racism, police brutality, discrimination and/or other forms of oppression? Note: expect a wealth of clinical information from this question, if not initially, information will be likely to be forthcoming as a trusting relationship develops.
- How do you identify culturally/racially/ethnically? Note: mental health practitioners tend to make assumptions about people based on their outward appearances and often, those assumptions are incorrect.
- What do you know about your culture? What holidays do you observe? Are they related to your culture?
- Has your family always lived in this area? Note: this question can elicit histories of emigration and immigration, as well as issues such as sharecropping in families of African origin, migrant workers, etc.
- What were the messages about your culture that you received while growing up? What were the messages you received about the cultures of others? Note: issues such as self-hate, ethnic privilege and discrimination, reverse and internalized racism, etc. surface with this question (Ali, 2011).

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

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

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

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

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

different and unique from others? What makes you smile?

- Interests and activities: e.g., If you could plan the “perfect day,” what would it look like? What do you care about? What matters to you? Name three things that you occasionally look forward to? What dissatisfies you about your life? What do you wish you could change?
- Living environment: e.g., What are the most important things to you when deciding where to live?
- Employment: e.g., What would be your ideal job and why? What skills do you have, for example, artistic or athletic talents, technological expertise, leadership, capacity for work? Think back to before you first began to struggle with the illness, what did you dream of being when you grew up – tell me about it?
- Learning: e.g., What kinds of things have you liked learning about in the past?
- Trauma: e.g., In relationships with other previous or current therapist(s), doctor(s), friends, family, other consumers, teachers, or anyone else, have you ever been treated inappropriately or in ways that were harmful to you (e.g., poor boundaries, sexual inappropriateness, physical abuse, taunting, bullying, etc.)?
- Safety and legal issues: e.g., Do you have any legal issues that are causing you problems?
- Financial: e.g., Would you like to be more independent with managing your finances? If so, how do you think you could do that?
- Lifestyle and health: e.g., Do you have any concerns about your overall health? What are those concerns? Tell me a bit about your mental health: What does a good day look like? A bad day?
- Choice-Making: e.g., What are the some of the choices that you currently make in your life? Are there choices in your life that are made for you?
- Transportation: e.g., How do you currently get around from place to place? What would help?
- Faith and spirituality: e.g., What type of spiritual or faith activities do you participate in? How do you find meaning in your life? Where and when do you feel most at peace?
- Relationships and important people: e.g., Who is the person in your life that believes in you? In what ways does this person convey this belief in you? To what degree is your family, spouse, or significant other available to provide support for you?
- Hopes and dreams: e.g., Tell me a bit about your hopes or dreams for the future? What you are seeking? What are your goals for yourself?
- Resilience: e.g., What would you say are indicators of your resilience; for example, the attributes of intelligence, sense of humor, optimism, creativity? What helps you get through the day? What are your greatest strengths? What has helped you in the past?
- Mental health treatment: e.g., What can the staff do to help? What can you do to help? Who else can help? What services do you want? What, if any, do you want to avoid? What do you hope to accomplish from mental health treatment?

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

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

Published assessment instruments to assess strengths and functional capacity

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

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

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

1. *The Social Performance Schedule* (Wykes & Sturt, 1986)
2. *The Social Functioning Scale* (Birchwood, Smith, Cochrane, Wetton, & Copestake, 1990)
3. *The Social-Adaptive Functioning Evaluation (SAFE)* (Harvey, Davidson, Mueser, Parrella, White, & Powchik, 1997)
4. *The Independent Living Skills Inventory (ILSI)* (Menditto, et al., 1999)

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

5. *The DSM-IV Social and Occupational Functioning Assessment Scale (SOFAS)* (Morosini, Magliano, Brambilla, Uglioni, & Pioli, 2000) - See above for examples of questions from this instrument
6. *The Self-reported Quality of Life Measure for People with Schizophrenia* (Wilkinson, et al., 2000)
7. *The Client's Assessment of Strength, Interests, and Goals (CASIG)* (Wallace, Lecomte, Wilde & Liberman, 2001)

The CASIG is a structured interview that the authors describe as follows: the "CASIG makes consumers active directors/collaborators in planning their own treatment, and the inclusion of their perspectives and those of the informants via parallel versions of the test increases communication among stakeholders" (Wallace, et al., 2001). The CASIG asks the individual about his or her goals in five areas of community living: housing, money/work, interpersonal relationships, health, and spiritual activities. The person is also asked to identify the services he or she thinks would be needed to achieve those goals. Other questions ask about current and past community functioning, medication compliance

and side effects, quality of life, quality of treatment, symptoms, and performance of intolerable community behaviors. A review of assessment instruments by Silverstein (2000) indicated that the CASIG includes: “(a) numerous areas essential to community living, (b) its results are directly relevant for treatment planning, (c) it can be repeatedly administered to assess progress, and (d) it focuses on goals and skills as well as symptoms and behavioral or cognitive difficulties.”

There are now two additional versions of the CASIG, a self-report version, the CASIG-SR and an informant version, the CASIG-I (Lecomte, Wallace, Caron, Perreault, & Lecomte, 2004).

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

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

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

According to Bellack (2007):

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

10. *The Multidimensional Scale of Independent Functioning* (Jaeger, Czobor, & Berns, 2003)

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

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

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

12. *Psychiatric Rehabilitation Training Technology: Functional Assessment* (Cohen, Farkas & Cohen, 2007)

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

Functional assessment is developing an understanding of a person’s functioning in the critical skills needed to be successful and satisfied in a particular environment. The functional assessment evaluates individuals’ spontaneous use, prompted use, and performance of critical skills in relation to their needed use. This technology teaches practitioners how to help define and

evaluate the skills needed for consumers to be successful and satisfied in particular residential, educational, vocational, or social environments. Practitioners learn how to list critical skills, describe skill use, evaluate skill functioning, and coach individuals through the assessment process. An evaluation of the individual's present ability to use these skills is then completed (Cohen, et al., 2007).

References

- Abram, K. & Teplin, L. (1991). Co-occurring disorders among mentally ill jail detainees: implications for public policy. *American Psychologist*, 46, 1036–1045.
- Abram, K., Teplin, L., & McClelland, G. (2003). Co-morbidity of severe psychiatric disorders and substance use disorders among women in jail. *American Journal of Psychiatry*, 150, 1007–1010.
- Adair, C. E., Streiner, D. L., Barnhart, R., Kopp, B., Veldhuizen, S., Patterson, M. ... Goering, P. (2016). Outcome trajectories among homeless individuals with mental disorders in a multisite randomised controlled trial of housing first. *The Canadian Journal of Psychiatry*, 61, 1, 30-39.
- Addington, J., Leriger, E. & Addington, D. (2003). Symptom outcome 1 year after admission to an early psychosis program. *Canadian Journal of Psychiatry*, 48, 3, 204-207.
- Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. (2006). *Women, Mental Health and Mental Illness and Addiction in Canada: An Overview*. Canadian Women's Health Network and the Centres of Excellence for Women's Health. Winnipeg, MB: Author.
- Agency for Healthcare Research and Quality. (2009). *Mental Health Research Findings*. Rockville, MD: AHRQ Pub. No. 09-P011.
- Ahn, W., Proctor, C. & Flanagan, E. H. (2009). Mental health clinicians' beliefs about the biological, psychological and environmental bases of mental disorders. *Cognitive Science*, 33, 147-182.
- Alexandre, P. K., Martins, S. S. & Richard, P. (2009). Disparities in adequate mental health care for past-year major depressive episodes among Caucasian and Hispanic youths. *Psychiatric Services*, 60, 10, 1365–1371.
- Ali, S. (2011). Personal communication and presentation. New York Association of Psychiatric Rehabilitation Services, Inc., Recovery to Practice Webinar on Person Centered Planning, April, 2011.
- Allison, D. B., Newcomer, J. W., Dunn, A. L., Blumenthal, J. A., Fabricatore, A. N., Daumit, G. L., ... Alpert, J. E. (2009). Obesity among those with mental disorders: A National Institute of Mental Health meeting report. *American Journal of Preventive Medicine*, 36, 4, 341-350.
- Almquist, L. & Dodd, E. (2009). *Mental Health Courts: A Guide to Research Informed Policy and Practice*. New York, NY: Council of State Governments Justice Center.
- Alphs, L., Anand, R., Islam, M. Z., Meltzer, H. Y., Kane, J. M., Krishnan, R., ... Kerwin, R. (2004). The international suicide prevention trial (interSePT): Rationale and design of a trial comparing the

relative ability of clozapine and olanzapine to reduce suicidal behavior in schizophrenia and schizoaffective patients. *Schizophrenia Bulletin*, 30, 577-586.

- Álvarez-Jiménez, M., Hetrick, S. E., Gonzalez-Branch, C., Gleeson, J. F., & McGorry, P. D. (2008). Non-pharmacological management of antipsychotic-induced weight gain: Systematic review and meta-analysis of randomised controlled trials. *British Journal of Psychiatry*, 193, 2, 101–107.
- Álvarez-Jiménez, M., Martínez-García, O., Pérez-Iglesias, R., Ramírez, M. L., Vázquez-Barquero, J. L., Crespo-Facorro, B. (2010). Prevention of antipsychotic-induced weight gain with early behavioural intervention in first-episode psychosis: 2-year results of a randomized controlled trial. *Schizophrenia Research*, 116, 1, 16–19.
- Álvarez-Jiménez, M., Parker, A. G., Hetrick, S. E., McGorry, P. D., & Gleeson, J. F. (2011). Preventing the second episode: A systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis. *Schizophrenia Bulletin*, 37, 3, 619–630.
- Alvorado, R. (2002). Strengthening America's Families: Programs that Work for Justice-Involved Women with Co-occurring Disorders. In Davidson, S. & Hills, H. (Eds.) *Series on Women with Mental Illness and Co-Occurring Disorders*. Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.
- American Psychiatric Association. (1994). *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. Arlington, VA: Author.
- American Psychiatric Association. (2000). *Task Force Report: Psychiatric Services in Jails and Prisons 2nd ed.* Washington, DC: American Psychiatric Association Press.
- American Psychiatric Association. (2013). Cultural formulation. In: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, pps 749-759. Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013). *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. Arlington, VA: Author.
- American Psychological Association. (2002). *Ethical Principles of Psychologists and Code of Conduct*. Washington, DC: Author.
- American Psychological Association. (2015). *Guidelines on Trauma Competencies for Education and Training*. Washington, DC: Author. Retrieved from: <http://www.apa.org/ed/resources/trauma-competencies-training.pdf>
- American Psychological Association & Jansen, M. A. (2014). *Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders*. Washington, DC: American Psychological Association.
- Amminger, G. P., Schafer, M. R., Papageorgiou, K., Klier, C. M., Cotton, S. M., Harrigan, S. M., & Berger, G. E. (2010). Long-chain {omega}-3 fatty acids for indicated prevention of psychotic disorders A randomized, placebo-controlled trial. *Archives of General Psychiatry*, 76, 2, 146–154.

- Amminger, G. P., Schafer, M. R., Schlogelhofer, M., Klier, C. M., & McGorry, P. D. (2015). Longer-term outcome in the prevention of psychotic disorders by the Vienna omega-3 study. *Nature Communications*, 6, 8934, 1-7, doi: 10.1038/ncomms8934.
- Anaya, C., Martinez, Aran A., Ayuso-Mateos, J. L., Wykes, T., Vieta, E. & Scott, J. (2012). A systematic review of cognitive remediation for schizo-affective and affective disorders. *Journal of Affective Disorders*, 142, 1-3, 13-21.
- Anderson, K. K. & Kurdyak, P. (2016). Factors associated with timely physician follow-up after a first diagnosis of psychotic disorder. *The Canadian Journal of Psychiatry*, doi: 10.1177/0706743716673322.
- Andreason, N. C. (1986). Scale for the assessment of thought, language and communication disorders. *Schizophrenia Bulletin*, 12, 3, 473-482.
- Andreasen, N. C., Flaum, M., Swayze, V. W., et al. (1990). Positive and negative symptoms in schizophrenia: A critical reappraisal. *Archives of General Psychiatry*, 47, 7, 615-621.
- Andrews, D. A., Bonta, J. & Wormith, J. S. (2011). The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention? *Criminal Justice and Behavior*, 38, 7, 735-755.
- Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P. & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, 28, 369-404.
- Appleby, L., Dennehy, J. A., Thomas, C. S., Faragher, E. B., & Lewis, G. (1999). Aftercare and clinical characteristics of people with mental illness who commit suicide: A case-control study. *The Lancet*, 353, 1397-1400.
- Arkowitz, H., Westra, H. A., Miller, W. R. & Rollnick, S. (Eds.). (2008). *Motivational Interviewing in Treating Psychological Problems*. New York: Guilford Press.
- Armstrong, N. P. & Steffen, J. J. (2009). The recovery promotion fidelity scale: Assessing the organizational promotion of recovery. *Community Mental Health Journal*, 45, 3, 163-170.
- Arns, P., Rogers, E. S., Cook J., & Mowbray, C. (2001). The IAPSRS toolkit: Development, utility, and relation to other performance systems. *Psychiatric Rehabilitation Journal*, 25, 43-52.
- Aron, L., Honberg, R., Duckworth, K., et al. (2009). *Grading the States 2009: A report on America's health care system for adults with serious mental illness*. Arlington, VA: National Alliance on Mental Illness.
- Atdjian, S. & Vega, W. A. (2005). Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services*, 56, 12, 1600-1602.
- Aubry, T., Nelson, G., & Tsemberis, S. (2015). Housing first for people with severe mental illness who are homeless: A review of the research and findings from the At Home-Chez Soi demonstration project. *Canadian Journal of Psychiatry*, 60, 11, 467-474.

- Aubry, T., Goering, P., Veldhuizen, S., Adair, C. E., Bourque, J., Distasio, J. ... Tsemberis, S. (2016). A multiple-city RCT of housing first with assertive community treatment for homeless Canadians with serious mental illness. *Psychiatric Services*, 67, 275–281.
- Auther, A. M., Smith, C. W., & Cornblatt, B. A. (2006). *Global Functioning: Social Scale (GF: Social)*. Glen Oaks, NY: Zucker Hillside Hospital.
- Ayllon, T. & Azrin, N. H. (1965). The measurement and reinforcement of behavior of psychotics. *Journal of the Experimental Analysis of Behavior*, 8, 357–383.
- Baksheev, G. N., Allott, K., Jackson, H. J., McGorry, P. D. & Killackey, E. (2012). Predictors of vocational recovery among young people with first episode psychosis: Findings from a randomized controlled trial. *Psychiatric Rehabilitation Journal*, 35, 6, 421–427.
- Bakst, S., Rabinowitz, J. & Bromet, E. J. (2010). Antecedents and patterns of suicide behavior in first-admission psychosis. *Schizophrenia Bulletin*, 36, 4, 880–889.
- Barnao, M. (2013). The Good Lives Model tool kit for mentally disordered offenders. *Journal of Forensic Practice*, 15, 3, 157-170.
- Barrenger, S. L. & Draine, J. (2013). “You Don't Get No Help”: The role of community context in effectiveness of evidence-based treatments for people with mental illness leaving prison for high risk environments. *American Journal of Psychiatric Rehabilitation*, 16, 2, 154–178.
- Barrowclough, C., Haddock, G., Wykes, T., Beardmore, R., Conrod, P., Craig, T., ... Tarrier, N. (2010). Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: Randomised controlled trial. *BMJ*, 341:c6325.
- Bartels, S. J., Pratt, S. I., Mueser, K. T., Forester, B. P., Wolfe, R., Cather, C., ... Feldman, J. (2014). Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness. *American Journal of Geriatric Psychiatry*, 22, 11, 1251–1261. <http://dx.doi.org/10.1016/j.jagp.2013.04.013>
- Beck, A., Karberg, J. & Harrison, P. (2002). *Prison and Jail Inmates at Midyear 2001*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Beck, A. T., Baruch, E., Balter, J. M., Steer, R. A., & Warman, D. M. (2004). A new instrument for measuring insight: the Beck Cognitive Insight Scale. *Schizophrenia Research*, 68, 2-3, 319-29.
- Beck, N. C., Menditto, A. A., Baldwin, L., Angelone, E. & Maddox, M. (1991). Reduced frequency of aggressive behavior in forensic patients in a social learning program. *Psychiatric Services*, 42, 7, 750–752.
- Becker, D., Whitley, R., Bailey, E. & Drake, R. (2007). Long-term employment trajectories among participants with severe mental illness in supported employment. *Psychiatric Services*, 58, 922–928.
- Becker, M. & Mehra, S. (2005). *Serious Mental Illness in Florida nursing homes: A study of resident, facility, cost, and quality of care characteristics (Report to Agency for Health Care Administration)*, Tampa, FL: University of South Florida.

- Bell, M. D., Choi, K-H, Dyer, C. & Wexler, B. E. (2014). Benefits of cognitive remediation and supported employment for schizophrenia patients with poor community functioning. *Psychiatric Services, 65*, 4, 469–475.
- Bellack, A. S. (2004). Skills training for people with severe mental illness. *Psychiatric Rehabilitation Journal, 27*, 375–391.
- Bellack, A. S., Brown, C. H., & Thomas-Lohrman, S. (2006). Psychometric characteristics of role play assessments of social skill in schizophrenia. *Behavior Therapy, 37*, 4, 339-352.
- Bellack, A. S., Green, M. F., Cook, J. A., Fenton, W., Harvey, P. D., Heaton, R. K. ... Wykes, T. (2007). Assessment of community functioning in people with schizophrenia and other severe mental illnesses: A white paper based on an NIMH-sponsored workshop. *Schizophrenia Bulletin, 33*, 3, 805–822.
- Bellonci, C., Jordan, P. E., Massey, O. T., Zubritsky, C. & Edwall, G. (2012). Reframing Mental Health Practice for Children, Youth, and Families: In Search of Developmental Competencies to Improve Functioning across Life Domains (Issue Brief). Outcomes Roundtable for Children and Families.
- Bentall, R. P. (1993). Deconstructing the concept of 'schizophrenia'. *Journal of Mental Health, 2*, 223–38.
- Bergland, A., Meaas, I., Debesay, J., Brovold, T., Jacobsen, E. L., Antypas, K., & Bye, A. (2016). Associations of social networks with quality of life, health and physical functioning. *European Journal of Physiotherapy, 18*, 2, 78-88.
- Bertelsen, M., Jeppesen, P., Petersen, L., Thorup, A., Øhlenschlaeger, J., le Quach, P., ... Nordentoft, M. (2008). Five-year follow-up of a randomized multicenter trial of intensive early intervention vs standard treatment for patients with a first episode of psychotic illness: The OPUS Trial. *Archives of General Psychiatry, 65*, 7, 762-771.
- Best, K. A., Boothroyd, R. A., Giard, J. A., Stiles, P. G., Suleski, J., Ort, R., & White, R. (2006). Poor and depressed, the tip of the iceberg: The unmet needs of enrollees in an indigent health care plan. *Administration and Policy in Mental Health and Mental Health Services Research, 33*, 2, 172-181.
- Binswanger, I. A., Merrill, J. O., Krueger, P. M., White, M. C., Booth, R. E. & Elmore, J. G. (2010). Gender differences in chronic medical, psychiatric, and substance-dependence disorders among jail inmates. *American Journal of Public Health, 100*, 3, 476–482.
- Birchwood, M. (2000). The critical period of early intervention. In D. F. M. Birchwood & C. Jackson (Eds.). *Early Intervention in Psychosis: A Guide to Concepts, Evidence and Interventions*. Chickchester, UK: Wiley.
- Birchwood, M., Iqbal, Z., & Upthegrove, R. (2005). Psychological pathways to depression in schizophrenia: Studies in acute psychosis, post-psychotic depression and auditory hallucinations. *European Archives of Psychiatry and Clinical Neuroscience, 255*, 202–212.

- Birchwood, M., Smith, J., Cochrane, R., Wetton, S., & Copestake, S. (1990). The Social Functioning Scale: The development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenia patients. *British Journal of Psychiatry*, 157, 853–859.
- Birchwood, M., Todd, P. & Jackson, C. (1998). Early-intervention in psychosis: The critical period hypothesis. *British Journal of Psychiatry Supplement*, 172, 33, 53-59.
- Bird, V., Premkumar, P., Kendall, C., Whittington, J., Mitchell, J., & Kuipers, E. (2010). Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: Systematic review. *The British Journal of Psychiatry*, 197, 350–356.
- Birman, D., Ho, J., Pulley, E., Batia, K., Everson, M. L., Ellis, H., ... Gonzalez, A. (2005). *Mental Health Interventions for Refugee Children in Resettlement*. [White Paper II]. Chicago, IL: National Child Traumatic Stress Network, Refugee Trauma Task Force.
- Blackburn, R. (2004). "What works" with mentally disordered offenders. *Psychology, Crime & Law*, 10, 3, 297–308.
- Blazer, D. G., Hybels, C. F., Simonsick, E. M. & Hanlon, J. T. (2000). Marked differences in antidepressant use by race in an elderly community sample: 1986–1996. *American Journal of Psychiatry*, 157, 1089–1094.
- Blitz, C. L., Wolff, N., Pan, K. Y. & Pogorzelski, W. (2005). Gender-specific behavioral health and community release patterns among New Jersey prison inmates: Implications for treatment and community reentry. *American Journal of Public Health*, 95, 10, 1741–1746.
- Blitz, C. L., Wolff, N. & Shi, J. (2008). Physical victimization in prison: The role of mental illness. *International Journal of Law and Psychiatry*, 31, 5, 385–393.
- Bolton, C., Gooding, P., Kapur, N., Barrowclough, C., & Tarrier, N. (2007). Developing psychological perspectives of suicidal behaviour and risk in people with a diagnosis of schizophrenia: We know they kill themselves but do we understand why? *Clinical Psychology Review*, 27, 511–536.
- Bond, G. R., Becker, D. R., Drake, R. E., Rapp, C. A., Meisler, N., Lehman, A. F., ... Blyler, C. R. (2001). Implementing supported employment as an evidence-based practice. *Psychiatric Services*, 52, 3, 313–322.
- Bond, G. R., Drake, R. E., Mueser, K. T., & Becker, D. R. (1997). An update on supported employment for people with severe mental illness. *Psychiatric Services*, 48, 3, 335-346.
- Bond, G., Drake, R., Mueser, K. & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. *Disease Management & Health Outcomes*, 9, 3, 141-159.
- Bosanac, P., Patton, G. C. & Castle, D. J. (2010). Early intervention in psychotic disorders: Faith before facts? *Psychological Medicine*, 40, 353–358.
- Bossarte, R. M., Simon, T. R. & Barker, L. (2006). Characteristics of homicide followed by suicide incidents in multiple states, 2003–04. *Injury Prevention*, 12, (supplement 2), ii33–ii38.

- Brar, J. S., Ganguli, R., Pandina, G., Turkoz, I., Berry, S., Mahmoud, R. (2005). Effects of behavioral therapy on weight loss in overweight and obese patients with schizophrenia or schizoaffective disorder. *Journal of Clinical Psychiatry*, 66, 2, 205–212.
- Breier, A., Schreiber, J. L., Dyer, J., & Pickar, D. (1991). National Institute of Mental Health longitudinal study of chronic schizophrenia: Prognosis and predictors of outcome. *Archives of General Psychiatry*, 48, 239-246.
- Breitborde, N. J. K., & Moe, A. M. (2016). Cognitive behavioral therapy for people with first-episode psychosis: A service delivery protocol. Phoenix, AZ: Institute for Mental Health Research.
- Bromley, E., Gabrielian, S., Brekke, B., Pahwa, R., Daly, K., Brekke, J. S., & Braslow, J. T. (2013). Experiencing community: Experiences of individuals diagnosed as having serious mental illness. *Psychiatric Services*, 64, 7, 672–679.
- Brown, S., Kim, M., Mitchell, C. & Inskip, H. (2010). Twenty-five year mortality of a community cohort with schizophrenia. *The British Journal of Psychiatry*, 196, 116–121.
- Buchanan, R. W., Kreyenbuhl, J., Kelly, D. L., Noel, J. M., Boggs, D. L., Fischer, B. A., ... Schizophrenia Patient Outcomes Research Team (PORT). (2010). The 2009 schizophrenia PORT psychopharmacological treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36, 1, 71-93.
- Buckley, P. F., Wirshing, D. A., Bhushan, P., et al. (2007). Lack of insight in schizophrenia: Impact on treatment adherence. *CNS Drugs*, 21, 2, 129–141.
- Burgess, D., van Ryn, M., Dovidio, J. & Saha, S. (2007). Reducing racial bias among health care providers: Lessons from social-cognitive psychology. *Journal of General Internal Medicine*, 22, 882–887.
- Burns, T., Catty, J., Becker, T., Drake, R., Fioritti, A., Knapp, M., ... EQOLISE Group. (2007). The effectiveness of supported employment for people with severe mental illness: A randomised controlled trial. *The Lancet*, 370, 1146–1152.
- Burns, T., Catty, J., White, S., Becker, T., Koletsi, M., Fioritti, A., ... EQOLISE Group. (2009). The impact of supported employment and working on clinical and social functioning: Results of an international study of individual placement and support. *Schizophrenia Bulletin*, 35, 5, 949–958.
- Burns, T., Fioritti, A., Holloway, F., Malm, U. & Rossler, W. (2001). Case management and assertive community treatment in Europe. *Psychiatric Services*, 52, 631-636.
- Burns, B. J. & Santos, A. B. (1995). Assertive community treatment: An update of randomized trials. *Psychiatric Services*, 46, 7, 669-675.
- Bustillo, J., Lauriello, J., Horan, W. & Keith, S. (2001). The psychosocial treatment of schizophrenia: An update. *American Journal of Psychiatry*, 158, 2, 163-175.
- Cacioppo, J. T. & Hawkey, L. C. (2003). Social isolation and health, with an emphasis on underlying mechanisms. *Perspectives in Biology and Medicine*, 46, 3, S39-S52.

- Campbell, A. S. (2004). How was it for you? Families' experiences of receiving behavioural family therapy. *Journal of Psychiatric and Mental Health Nursing*, 11, 261-267.
- Carey, K. B., Leontieva, L., Dimmock, J., Maisto, S. A., & Batki, S. L. (2007). Adapting motivational interventions for comorbid schizophrenia and alcohol use disorders. *Clinical Psychology: A Publication of the Division of Clinical Psychology of the American Psychological Association*, 14, 1, 39–57.
- Carmen, E., Rieker, P. P. & Mills, T. (1984). Victims of violence and psychiatric illness. *American Journal of Psychiatry*, 141, 378-383.
- Cattell, V. (2001). Poor people, poor places, and poor health: The mediating role of social networks and social capital. *Social Science & Medicine*, 52, 10, 1501-1516.
- Catty, J., Lissouba, P., White, S., Becker, T., Drake, R. E., Fioritti, A., ... Burns, T. (2008). Predictors of employment for people with severe mental illness: Results of an international six-centre randomised controlled trial. *British Journal of Psychiatry*, 192, 224-231.
- Center for Behavioral Health Statistics and Quality. (2016). Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health (HHS Publication No. SMA 16-4984, NSDUH Series H-51).
- Centers for Disease Control and Prevention. (2005). Adverse Childhood Experiences Study. [www.cdc.gov.NCCDPHP/ACE/findings.htm](http://www.cdc.gov/NCCDPHP/ACE/findings.htm).
- Chan, J. Y., Hirai, H. W., & Tsoi, K. K. (2015). Can computer-assisted cognitive remediation improve employment and productivity outcomes of patients with severe mental illness? A meta-analysis of prospective controlled trials. *Journal of Psychiatric Research*, 68, 293-300.
- Chang, Z., Lichtenstein, P., Langstrom, N., Larsson, H., & Fazel, S. (2016). Association between prescription of major psychotropic medications and violent reoffending after prison release. *JAMA*, 316, 17, 1798-1807.
- Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World Psychiatry*, 13, 2, 153–160.
- Chien, W. T., Mui, J. H. C., Cheung, E. R. C., & Gray, R. (2015). Effects of motivational interviewing-based adherence therapy for schizophrenia spectrum disorders: a randomized controlled trial. *Bio Med Central*, 16, 270, 1-14.
- Chilvers, R., Macdonald, G. M. & Hayes, A. A. (2010). Supported housing of people with severe mental disorders. *Cochrane Database of Systematic Reviews*, 12, 1–12.
- Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014) Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services*, 65, 429–441.
- Choe, J. Y., Teplin, L. A., & Abram, K. M. (2008). Perpetration of violence, violent victimization, and severe mental illness: Balancing public health concerns. *Psychiatric Services*, 59, 2, 153-164.

- Chu, J. P., Emmons, L., Wong, J., Goldblum, P., Reiser, R., Barrera, A. Z., & Byrd-Olmstead, J. (2012). The public psychology doctoral training model: Training clinical psychologists in community mental health competencies and leadership. *Training and Education in Professional Psychology*, 6, 2, 76–83.
- Chung, H., Mahler, J. C. & Kakuma, T. (1995). Racial differences in treatment of psychiatric inpatients. *Psychiatric Services*, 46, 581–591.
- Clarke, J., Febrara, A., Hatzipantelis, M. & Nelson, G. (2005). Poetry and prose: Telling stories of formerly homeless mentally ill people. *Qualitative Inquiry*, 11, 913–932.
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., ... Thornicroft, G. (2014). What is the impact of mental health-related stigma on helpseeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, 45, 1, 1-17.
- Cocozza, J. J., Jackson, E. W., & Hennigan, K. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment*, 28, 109-119.
- Cohen, C. I. (2000). Directions for Research and Policy on Schizophrenia and Older Adults: Summary of the GAP Committee Report. *Psychiatric Services*, 51, 3, 299-302.
- Cohen, M., Farkas, M. & Cohen, B. (2007). *Psychiatric Rehabilitation Training Technology: Functional Assessment*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.
- Coid, J. (1983). The epidemiology of abnormal homicide and murder followed by suicide. *Psychological Medicine*, 13, 855–860.
- Coldwell, C. & Bender, W. (2007). The effectiveness of Assertive Community Treatment for homeless populations with severe mental illness: A meta-analysis. *American Journal of Psychiatry*, 164, 393-399.
- Compton, M. T., Ramsay, C. E., Shim, R. S., Goulding, S. M., Gordon, T. L., Weiss, P. S., & Druss, B. G. (2009). Health services determinants of the duration of untreated psychosis among African-American first-episode patients. *Psychiatric Services*, 60, 11, 1489–1494.
- Conner, K. O., McKinnon, S. A., Ward, C. J., Reynolds, C. F., III, & Brown, C. (2015). Peer education as a strategy for reducing internalized stigma among depressed older adults. *Psychiatric Rehabilitation Journal*, 38, 186–193.
- Conus, P., Cotton, S., Schimmelmann, B. G., McGorry, P. D., & Lambert, M. (2010). Pretreatment and outcome correlates of sexual and physical trauma in an epidemiological cohort of first-episode psychosis patients. *Schizophrenia Bulletin*, 36, 6, 1105–1114.
- Cook, J. A., Burke-Miller, J. K., & Roessel, E. (2016). Long-term effects of evidence-based supported employment on earnings and on SSI and SSDI participation among individuals with psychiatric disabilities. *The American Journal of Psychiatry*, 173, 10, 1007-1014.
- Cook, J. A., Copeland, M. E., Jonikas, J. A., Hamilton, M. M., Razzano, L. A., Grey, D. D., ... Boyd, S. (2012). Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning. *Schizophrenia Bulletin*, 38, 4, 881-891.

- Cook, J. A., Jonikas, J. A., Hamilton, M. M., Goldrick, V., Steigman, P. J., Grey, D. D., ... Burke, L. (2013). Impact of wellness recovery action planning on service utilization and need in a randomized controlled trial. *Psychiatric Rehabilitation Journal*, 36, 4, 250–257.
- Cook, J. A., Leff, H. S., Blyler, C. R., Gold, P. B., Goldberg, R. W., Mueser, K. T., ... Burke-Milleer, J. (2005a). Results of a multisite randomized trial of supported employment interventions for individuals with severe mental illness. *Archives of General Psychiatry*, 62, 5, 505-512.
- Cook, J. A., Lehman, A. F., Drake, R., McFarlane, W. R., Gold, P. B., Leff, H. S., ... grey, D. D. (2005b). Integration of psychiatric and vocational services: A multisite randomized, controlled trial of supported employment. *American Journal of Psychiatry*, 162, 10, 1948-1956.
- Cook, J. M. & Newman, E. (2014). A consensus statement on trauma mental health: The New Haven competency conference process and major findings. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6, 4, 300–307.
- Copeland, M. E. (2002). Overview of WRAP: Wellness Recovery Action Plan. *Mental Health Recovery Newsletter*, 3, 1–9.
- Corbiere, M., Lanctot, N., Lecomte, T., Latimer, E., Goering, P., Kirsh, B., ... Kamagiannis, T. (2010). A pan-Canadian evaluation of supported employment programs dedicated to people with severe mental disorders. *Community Mental Health Journal*, 46, 1, 44–55.
- Corcoran, R., Mercer, G., Frith, C. D. (1995). Schizophrenia, symptomatology and social inference: Investigating “Theory of mind” in people with schizophrenia. *Schizophrenia Research* 17, 5–13.
- Correll, C. U., Olvet, D. M., Auther, A. M., Hauaser, M., Kishimoto, T., Carrión, R. E., Snyder, S. & Cornblatt, B. A. (2014). The Bipolar Prodrome Symptom Interview and Scale–Prospective (BPSS-P): description and validation in a psychiatric sample and healthy controls. *Bipolar Disorders*, 16, 5, 505–522.
- Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, 2014, 15, 2, 37–70.
- Corrigan, P. W., Mittal, D., Reaves, C. M., Haynes, T. F., Han, X., Morris, S., & Sullivan, G. (2015). Mental health stigma and primary health care decisions. *Psychiatry Research*, 218, 35-38.
- Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsçh, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services*, 63, 963–973.
- Corrigan, P. W., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation, An Empirical Approach*. New York, NY: Guilford Press.
- Corrigan, P. W. & Rao, D. (2012). On the Self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, 57, 8, 464–469.

- Corrigan, P. W., & Shapiro, J. R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review*, 30, 8, 907–922.
- Corrigan, P. W., Steiner, L., McCracken, S. G., Blaser, B., & Barr, M. (2001). Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. *Psychiatric Services*, 52, 12, 1598-1606.
- Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*, 25, 875-884.
- Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry*, 60, 837-44.
- Council of State Governments. (2005). Criminal Justice/Mental Health Consensus Project. New York, NY: Council of State Governments/Eastern Regional Conference.
- Couture, S. M. & Penn, D. L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health*, 12, 291-305.
- Couture, S. M., Penn, D. L., & Roberts, D. L. (2006). The functional significance of social cognition in schizophrenia: A review. *Schizophrenia Bulletin*, 32, S1, S44–S63.
- Cross, S. P. M., Hermens, D. F., Scott, E. M., Ottavio, A., McGorry, P. D. & Hickie, I. B. (2014). A clinical staging model for early intervention youth mental health services. *Psychiatric Services*, 65, 7, 939-943.
- Crowther, R., Marshall, M., Bond, G. & Huxley, P. (2001). Vocational Rehabilitation for People with Severe Mental Illness (Cochrane Review). *The Cochrane Library*, 3.
- Csillag, C., Nordentoft, M., Mizuno, M., Jones, P. B., Killackey, E., Taylor, M. C., ... McDaid, D. (2016) Early intervention services in psychosis: From evidence to wide implementation. *Early Intervention in Psychiatry*, 10, 6, 540-546.
- Cuddeback, G. S., Wright, D. & Bisig, N. G. (2013). Characteristics of participants in jail diversion and prison reentry programs: Implications for forensic ACT. *Psychiatric Services*, 64, 10, 1043–1046.
- Cuijpers, P., & Smit, F. (2002). Excess mortality in depression: A meta-analysis of community studies. *Journal of Affective Disorders*, 72, 227-236.
- Culhane, D. P., Metraux, S. & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, 13, 1, 107–163.
- Cusack, K. J., Frueh, B. C. & Brady, K. T. (2004). Trauma history screening in a Community Mental Health Center. *Psychiatric Services*, 55, 157-162.
- Cusack, K., Frueh, B., Hiers, T., Suffoletta-Maierle, S. & Bennett, S. (2003). Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in Mental Health*, 30, 453-460.

- Cusack, K. J., Morrissey, J. P., Cuddeback, G. S., Prins, A. & Williams, D. M. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal*, 46, 4, 356–363.
- Darves-Bornoz, J. M., Lemperiere, T., Degiovanni, A. & Gaillard, P. (1995). Sexual victimization in women with schizophrenia and bipolar disease. *Social Psychiatry and Psychiatric Epidemiology*, 30, 78–84.
- Dass-Brailsford, P. & Myrick, A. C. (2010). Psychological trauma and substance abuse: The need for an integrated approach. *Trauma, Violence, & Abuse*, 11, 4, 202-213.
- David, A. S. (1990). Insight and psychosis. *British Journal of Psychiatry*, 156, 798–808.
- David, A. S., Zammit, S., Lewis, G., Dalman, C., & Allebeck, P (2008). Impairments in cognition across the spectrum of psychiatric disorders: Evidence from a Swedish conscript. *Schizophrenia Bulletin*, 34, 6, 1035-1041.
- Davidson, L. (2010). PORT through a recovery lens. *Schizophrenia Bulletin*, 36, 1, 107–108.
- Davidson, L. & Chan, K. K. S. (2014). Common factors: Evidence-based practice and recovery. *Psychiatric Services*, 65, 5, 675-677.
- Davidson, L., Rowe, M., Tondora, J., O'Connell, M. J., & Lawless, M. S. (2008). *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*. New York: Oxford University Press.
- Davies-Netzley, S., Hurlburt, M. S., & Hough, R. (1996). Childhood abuse as a precursor to homelessness for homeless women with severe mental illness. *Violence and Victims*, 11, 129–142.
- de Haan, L., Linszen, D. H., Lenior, M. E., de Win, E. D., & Gorsira, R. (2003). Duration of untreated psychosis and outcome of schizophrenia: Delay in intensive psychosocial treatment versus delay in treatment with antipsychotic medication. *Schizophrenia Bulletin*, 29, 2, 341-348.
- De Hart, D., Lynch, S., Belknap, J., Dass-Brailsford, P., & Green, B. (2014). Life history models of female offending: The roles of Serious Mental Illness and Trauma in Women's Pathways to jail. *Psychology of Women Quarterly*, 38, 1, 138-151
- De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Pakmas, M., Cohen, D., Asai, I. ... Leucht, S . (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, 10, 1, 52–77.
- de Leon, J., & Diaz, F. J. (2005). A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. *Schizophrenia research*, 76, 2, 135-157.
- Desmarais, S. L., van Dorn, R. A., Johnson, K. L., Grimm, K. J., Douglas, K. S., & Swartz, M. S. (2014). Community violence perpetration and victimization among adults with mental illnesses. *American Journal of Public Health*, 104, 12, 2342-2349.

- De Vogel, V., Stam, J., Bouman, Y. H. A., Ter Horst, P. & Lancel, M. (2016). Violent women: A multicentre study into gender differences in forensic psychiatric patients. *The Journal of Forensic Psychiatry & Psychology*, 27, 2, 145-168.
- Dickerson, F. B., Brown, C. H., Kreyenbuhl, J. A., Fang, L., Goldberg, W., Wohlheiter, K., & Dixon, L. B. (2006). Obesity among individuals with serious mental illness. *Acta Psychiatrica Scandinavica*, 113, 4, 306–313.
- Dickerson, F. B., McNary, S. W., Brown, C. H., Kreyenbuhl, J., Goldberg, R. W., & Dixon, L. B. (2003). Somatic healthcare utilization among adults with serious mental illness who are receiving community psychiatric services. *Medical care*, 41, 4, 560-570.
- Dickerson, F. B., Tenhula, W. N. & Green-Paden, L. D. (2005). The token economy for schizophrenia: Review of the literature and recommendations for future research. *Schizophrenia Research*, 75, 405–416.
- Dickinson, D., Tenhula, W., Morris, S., Brown, C., Peer, J., Spencer, K. ... Bellack, A. S. (2010). A randomized, controlled trial of computer-assisted cognitive remediation for schizophrenia. *American Journal of Psychiatry*, 167, 170–180.
- Dickey, B., Norman, S. T., Weiss, R. D., Drake, R. E., & Azeni, H. (2002). Medical morbidity, mental illness, and substance use disorders. *Psychiatric Services*, 53, 7, 861-867.
- Disability Rights Washington. (2013). *Lost and Forgotten: Conditions of Confinement While Waiting for Competency Evaluation and Restoration*. Seattle, WA: Author.
- Disability Rights Washington. (2016). *Locked up and locked down - Segregation of inmates with mental illness*. Seattle, WA: Amplifying Voices of Inmates with Disabilities Prison Project.
- Ditton, P. M. (1999). *Mental Health and Treatment of Inmates and Probationers*, Special Report NCJ-174463. Washington, DC: US Dept of Justice, Bureau of Justice Statistics.
- Dixon, L. (2000). Assertive community treatment: Twenty-five years of gold. *Psychiatric Services*, 51, 6, 759–765.
- Dixon, L., Adams, C. & Lucksted, A. (2001). Update on family psychoeducation for schizophrenia. *Schizophrenia Bulletin*, 26, 1, 5–20.
- Dixon, L. B., Glynn, S. M., Cohen, A. N., Drapalski, A. L., Medoff, D., Fang, L. J., ... Gioia, D. (2014). Outcomes of a brief program, REORDER, to promote consumer recovery and family involvement in care. *Psychiatric Services*, 65, 1, 116–120.
- Dixon, L. B., Lucksted, A., Medoff, D. R., Burland, J., Stewart, B., Lehman, A. F. ... Murray-Swank, A. (2011). Outcomes of a randomized study of a peer-taught Family-to-Family education program for mental illness. *Psychiatric Services*, 62, 6, 591–597.
- Dixon, L., McFarlane, W., Lefley, H., Lucksted, A., Cohen, M., Falloon, I., ... Sondheim, D. (2001). Evidence-based practices for services to family members of people with psychiatric disabilities. *Psychiatric Services*, 52, 7, 903-910.

- Docherty, N. M., DeRosa, M., & Andreason, N. C. (1996). Communication disturbances in schizophrenia and mania. *Archives of General Psychiatry*, 53, 358-364.
- Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). HCR-20V3: Assessing risk of violence – User guide. Burnaby, BC, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.
- Draine, J., Salzer, M. S., Culhane, D. P., & Hadley, T. R. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*, 53, 5, 565-673.
- Drake, R. E., Mercer-McFadden, C., McHugo, G. J. & Bond, G. R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin*, 24, 589-608.
- Druss, B. G., Bradford, D. W., Rosenheck, R. A., Radford, M. J., & Krumholz, H. M. (2000). Mental disorders and use of cardiovascular procedures after myocardial infarction. *Journal of the American Medical Association*, 283, 506–511.
- Druss, B. G., Marcus, S. C., Rosenheck, R. A., Olfson, M., Tanielian, T., & Pincus, H. A. (2000). Understanding disability in mental and general medical conditions. *American Journal of Psychiatry* 157, 9, 1485–1491.
- Drymalski, W. M., & Campbell, T. C. (2009). A review of motivational interviewing to enhance adherence to antipsychotic medication in patients with schizophrenia: Evidence and recommendations. *Journal of Mental Health*, 18, 6–15.
- Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association*, 286, 24, 3089-3097.
- Dumont, J. & Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. *Outlook*, Spring, 4-6.
- Duncan, E. A. S., Nicol, M. M., Ager, A. & Dalgleish, L. (2006). A systematic review of structured group interventions with mentally disordered offenders. *Criminal Behaviour and Mental Health*, 16, 217–241.
- Durose, M. (2003). *Felony Sentences in State Courts, 2000*. Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Ehmann, T., Yager, J. & Hanson, L. (2008). *Early Psychosis: A Review of the Treatment Literature*. Vancouver, BC: University of British Columbia.
- Eisen, S. V., Normand, S-L., Belanger, A. J., Spiro, A., & Esch D. (2004). The Revised Behavior and Symptom Scale (BASIS-R): Reliability and validity. *Medical Care*, 42, 1230–1241.
- Elder, R., Evans, K. & Nizette, D. (2009). *Psychiatric and Mental Health Nursing*, 2nd ed. Chatsworth NSW, Australia: Elsevier.

- Elklit, A. & Shevlin, M. (2011). Female sexual victimization predicts psychosis: A case-control study based on the Danish registry system. *Schizophrenia Bulletin*, 37, 6, 1305–1310.
- Ellingrod, V. L., Taylor, S. F., Dalack, G., Grove, T. B., Bly, M. J., Brook, R. D., ... & Pop-Busui, R. (2012). Risk factors associated with metabolic syndrome in bipolar and schizophrenia subjects treated with antipsychotics: The role of folate pharmacogenetics. *Journal of Clinical Psychopharmacology*, 32, 2, 261.
- Ellis, B. H., Lincoln, A., Charney, M., Ford-Paz, R., Benson, M., & Strunin, L. (2010). Mental health service utilization of Somali adolescents: Religion, community, and school as gateways to healing. *Journal of Transcultural Psychiatry*, 47, 5, 789–811.
- Ellis, B. H., Miller, A. B., Baldwin, H. & Abdi, S. (2011). New directions in refugee youth mental health services: Overcoming barriers to engagement. *Journal of Child & Adolescent Trauma*, 4, 69–85.
- Epperson, M., Wolff, N., Morgan, R., Fisher, W., Frueh, B. C. & Huening, J. (2011). *The Next Generation of Behavioral Health and Criminal Justice Interventions: Improving Outcomes by Improving Interventions*. New Brunswick, NJ: Rutgers University, Center for Behavioral Health Services & Criminal Justice Research.
- Epperson, M. W., Wolff, N., Morgan, R. D., Fisher, W. H., Frueh, B. C., & Huening, J. (2014). Envisioning the Next Generation of Behavioral Health and Criminal Justice Interventions. *International Journal of Law and Psychiatry*, 37, 5, 427–438.
- Evans, S., Newton, R. & Higgins, S. (2005). Nutritional intervention to prevent weight gain in patients commenced on Olanzapine: A randomized controlled trial. *Australian and New Zealand Journal of Psychiatry*, 39, 479–486.
- Fakhoury, W. K., Murray, A., Shepherd, G. & Priebe, S. (2002). Research in supported housing. *Social Psychiatry and Psychiatric Epidemiology*, 37, 7, 301–315.
- Farkas, M. & Anthony, W. A. (2010). Psychiatric rehabilitation interventions: A review. *International Review of Psychiatry*, 22, 2, 114–129.
- Farkas, M., Sullivan Soydan, A. & Gagne, C. (2000). *Introduction to Readiness*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.
- Fazel, S. & Grann, M. (2004). Psychiatric morbidity among homicide offenders: A Swedish population study. *American Journal of Psychiatry*, 161, 2129–2131.
- Fazel, S., Wolf, A., Palm, C. & Lichtenstein, P. (2014). Violent crime, suicide, and premature mortality in patients with schizophrenia and related disorders: a 38-year total population study in Sweden. *The Lancet Psychiatry*, 1, 1, 44-54.
- Felitti, V. J. (2002). The relationship of adverse childhood experiences to adult health: Turning gold into lead. English translations of: Felitti V. J. (2002). Belastungen in der Kindheit und Gesundheit im Erwachsenenalter: die Verwandlung von Gold in Blei. *Z Psychosom Med Psychother*, 48, 4, 350-369.

- Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 14, 4, 245-258.
- Fellner, J. (2006). A Conundrum for corrections, a tragedy for prisoners: Prisons as facilities for the mentally ill. *Washington University Journal of Law & Policy*, 22, 1, 1-11.
- Fenton, W. S., & McGlashan, T. H. (1991). Natural history of schizophrenia subtypes: II. Positive and negative symptoms and long-term course. *Archives of General Psychiatry*, 48, 978-986.
- Fialko, L., Freeman, D., Bebbington, P. E., Kuipers, E., Garety, P. A., Dunn, G., & Fowler, D. (2006). Understanding suicidal ideation in psychosis: Findings from the Psychological Prevention of Relapse in Psychosis (PRP) trial. *Acta Psychiatrica Scandinavica*, 114, 177–186.
- Finkelstein, N., VandeMark, N., Fallot, R., Brown, E., Cadiz, S., & Heckman J. (2004). *Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment*. Sarasota, FL: National Trauma Consortium.
- Firth, J., Stubbs, B., Rosenbaum, S., Vancampfort, D., Marchow, B., Schuch, F., ... Yung, A. R. (2016). Aerobic exercise improves cognitive functioning in people with schizophrenia: A systematic review and meta-analysis. *Schizophrenia Bulletin*, doi:10.1093/schbul/sbw115.
- Fisher, M., Holland, C., Subramaniam, K. & Vinogradov, S. (2009). Neuroplasticity-based cognitive training in schizophrenia: An interim report on the effects 6 months later. *Schizophrenia Bulletin*, 36, 4, 869–879.
- Folsom, S. P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan, S., ... Jeste, D. V. (2005). Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *American Journal of Psychiatry*, 162, 2 370-376.
- Forchuk C, Ward-Griffin C, Csiernik R. & Turner K. (2006). Surviving the tornado of mental illness: Psychiatric survivors' experiences of getting, losing, and keeping housing. *Psychiatric Services*, 57, 558–562.
- Folsom, D. P., Lebowitz, B. D., Lindamer, L. A., Palmer, B. W., Patterson, T. L., & Jeste, D. V. (2006). Schizophrenia in late life: emerging issues . *Dialogues in Clinical Neuroscience*, 8, 1, 45–52.
- Foulks, E. F. (2004). Commentary: Racial bias in diagnosis and medication of mentally ill minorities in prisons and communities. *The Journal of the American Academy of Psychiatry and the Law*, 32, 34–35.
- Frank, R. G. & McGuire, T. G. (2011). Mental health treatment and criminal justice outcomes. In: Cook, P. J., Ludwig, J., & McCrary, J. (Eds.). *Controlling crime: Strategies and tradeoffs*. Chicago, IL: University of Chicago Press.
- Fristad, M. A., Goldberg-Arnold, J. S. & Gavazzi, S. M. (2002). Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder. *Bipolar Disorders*, 4, 254-262.

- Frounfelker, R., Vorhies Klodnick, V., Mueser, K. T. & Todd, S. (2013). Trauma and posttraumatic stress disorder among transition age youth with serious mental health conditions. *Journal of Traumatic Stress*, 26, 409-412.
- Frueh, B., Cousins, V., Hiers, T., Cavanaugh, S., Cusack, K. I. & Santos, A. (2002). The need for trauma assessment and related clinical services in a state public mental health system. *Community Mental Health Journal*, 38, 351-356.
- Frueh, B., Dalton, M., Johnson, M., Hiers, T., Gold, P., Magruder, K. M. & Santos, A. B. (2000). Trauma within the psychiatric setting: Conceptual framework, research directions, and policy implications. *Administration and Policy in Mental Health*, 28, 2, 147-154.
- Frueh, B. C., Grubaugh, A. L., Cusack, K. J., Kimble, M. O., Elhai, J. D. & Knapp, R. G. (2009). Exposure-based cognitive-behavioral treatment of PTSD in adults with schizophrenia or schizoaffective disorder: A pilot study. *Journal of Anxiety Disorders*, 23, 665–75.
- Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., ... Hiers, T. G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services*, 56, 9, 1123-1133.
- Fusar-Poli, P., Bonoldi, I., Yung, A. R., Borgwardt, S., Kempton, M. J., Valmaggia, L., ... McGuire, E. P. (2012). Predicting psychosis: Meta-analysis of transition outcomes in individuals at high clinical risk. *Archives of General Psychiatry*, 69, 3, 220–229.
- Galletly, C. & Rigby, A. (2013). An overview of cognitive remediation therapy for people with severe mental illness. *International Scholarly Research Notices*, Volume 2013, ID 984932.
- Gannon, T. A. & Ward, T. (2014). Where has all the psychology gone? A critical review of evidence-based psychological practice in correctional settings. *Aggression and Violent Behavior*, 19, 4, 435-446.
- Gearon, J. S., Bellack, A. S., & Tenhula, W. N. (2004). Preliminary reliability and validity of the Clinician-Administered PTSD Scale for schizophrenia. *Journal of Consulting and Clinical Psychology*, 72, 1, 121-125.
- Geddes, J. R. & Juszczak, E. (1995). Period trends in rate of suicide in first 28 days after discharge from psychiatric hospital in Scotland, 1968-92. *British Medical Journal*, 311, 357–360.
- Geddes, J. R. & Miklowitz, D. J. (2013). Treatment of bipolar disorder. *The Lancet*, 381(9878), 1672-1682.
- German, D. & Latkin, C. A. (2012). Social stability and HIV risk behavior: Evaluating the role of accumulated vulnerability. *AIDS and Behavior*, 16, 1, 168–178.
- Giffort, D., Schmook, A., Woody, C., Vollendorf, C., & Gervain, M. (1995). Construction of a Scale to Measure Consumer Recovery. Springfield, IL: Illinois Office of Mental Health.
- Giller, E. (1999). *What is Psychological Trauma?* Brooklandville, MD: Sidran Institute.

- Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2012). Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. *Cochrane Database Systematic Review*, CD006726. doi: 10.1002/14651858.CD006726.pub2.
- Gillis, L., Dickerson, G. & Hanson, J. (2010). Recovery and homeless services: New directions for the field. *The Open Health Services and Policy Journal*, 3, 71-79.
- Gilmer, T. P., Stefancic, A., Ettner, S. L., Manning, W. G., & Tsemberis, S. (2010). Effect of full-service partnerships on homelessness, use and costs of mental health services, and quality of life among adults with serious mental illness. *Archives of General Psychiatry*, 67, 6, 645–652.
- Gingerich, S. & Mueser, K. T. (2010). *Illness Management and Recovery Implementation Resource Kit* (revised ed.) Rockville MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Gingerich, S. & Mueser, K. T. (2011). *Illness Management and Recovery: Personalized Skills and Strategies for Those with Mental Illness*. Center City, MN: Hazelden.
- Gingerich, S., Mueser, K. T., Meyer-Kalos, P. S., Fox-Smith, M., Freedland, T. (2018) *Enhanced Illness Management and Recovery (E-IMR)* unpublished manuscript. Minnesota Center for Chemical and Mental Health, School of Social Work, College of Education and Human Development, University of Minnesota, St. Paul, MN.
- Gleeson, J. F. M., Cotton, S. M., Alvarez-Jimenez, M., Wade, D., Gee, D., Crisp, K., ... McGorry, P. D. (2013). A randomized controlled trial of relapse prevention therapy for first-episode psychosis patients: Outcome at 30-month follow-up. *Schizophrenia Bulletin*, 39, 2, 436–448.
- Glynn, S. M. (1990). Token economy approaches for psychiatric patients: Progress and pitfalls for over 25 years. *Behavior Modification*, 14, 383–407.
- Glynn, S. M., Cohen, A. N., Dixon, L. B. & Niv, N. (2006). The potential impact of the recovery movement on family interventions for schizophrenia: opportunities and obstacles. *Schizophrenia Bulletin*, 32, 3, 451-463.
- Glynn, S. M., Marder, S. R., Liberman, R. P., Blair, K., Wirshing, W. C., Wirshing, D. A., ... Mintz, J. (2002). Supplementing clinic-based skills training with manual-based community support sessions: Effects on social adjustment of patients with schizophrenia. *American Journal of Psychiatry*, 159, 5, 829-837.
- Glynn, S. M. & Mueser, K. T. (2018). Schizophrenia. In Hunsley, J. & Mash, E. J. (Eds.). *A Guide to Assessments that Work (Second Edition)* pps. 391-412. New York, NY: Oxford University Press.
- Goldacre, M., Seagroatt, V. & Hawton, K. (1993). Suicide after discharge from psychiatric inpatient care. *The Lancet*, 342, 283–286.
- Goldstein, T. R., Fersch-Podrat, R. K., Rivera, M., Axelson, D. A., Merranko, J., Yu, H., ... Birmaher, B. (2015). DBT for adolescents with bipolar disorder: Results from pilot randomized trial. *Journal of Child and Adolescent Psychopharmacology*, 25, 2, 140-149.

- Goodman, L. A., Dutton, M. A., & Harris, M. (1995). Episodically homeless women with serious mental illness: Prevalence of physical and sexual assault. *American Journal of Orthopsychiatry*, 65, 4, 468–478.
- Goodman, L. A., Dutton, M. A., & Harris, M. (1997). The relationship between violence dimensions and symptom severity among homeless, mentally ill women. *Journal of Traumatic Stress*, 10, 1 51-70.
- Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S. D., Swartz, M., Essock, S. M., ... 5 Site Health and Risk Study Research Committee. (2001). Recent victimization in women and men with severe mental illness: Prevalence and correlates. *Journal of Traumatic Stress*, 14, 615-632.
- Grant, B. F., Hasin, D. S., Chou, S. P., Stinson, F. S., & Dawson, D. A. (2004). Nicotine dependence and psychiatric disorders in the united states: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry*, 61 11, 1107-1115.
- Grant, P. M., Bredemeier, K., & Beck, A. T. (2017). Six-month follow-up of recovery-oriented cognitive therapy for low-functioning individuals with schizophrenia. *Psychiatric Services*, 68, 10, 997-1002.
- Grant, P. M., Huh, G. A., Perivoliotis, D., Stolar, N. M., & Beck, A. T. (2012). Randomized trial to evaluate the efficacy of cognitive therapy for low-functioning patients with schizophrenia. *Archives of General Psychiatry*, 69, 2, 121-127.
- Gray, S. W. (2011). *Competency-Based Assessments in Mental Health Practice*. Hoboken, NJ: John Wiley & Sons.
- Green, M. F., Kern, R. S., Braff, D. L., & Mintz, J. (2000). Neurocognitive deficits and functional outcome in schizophrenia: Are we measuring the “right stuff”? *Schizophrenia Bulletin*, 26, 119-136.
- Green, C. A., Wisdon, J. P., Wolfe, L. & Firemark, A. (2012). Engaging youths with serious mental illnesses in treatment: STARS study consumer recommendations. *Psychiatric Rehabilitation Journal*, 35, 5, 360-368.
- Greenberg, G. A. & Rosenheck, R. A. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services*, 59, 170–177.
- Greenfield, S. F., Strakowski, S. M., Tohen, M., Batson, S. C., & Kolbrener, M. L. (1994). Childhood abuse in first episode psychosis. *British Journal of Psychiatry*, 164, 831-834.
- Grisso, T., Appelbaum, P. S. & Hill-Fotouhi C. (1997). The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions. *Psychiatric Services*, 48, 11, 1415-1419.
- Grubaugh, A. L., Frueh, B. C., Zinzow, H. M., Cusack, K. J. & Wells, C. (2007). Patients' perceptions of care and safety within psychiatric settings. *Psychological Services*, 4, 3, 193-201.
- Grubaugh, A. L., Zinzow, H. M., Paul, L., Egede, L. E., & Frueh, B. C. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review*, 31, 6, 883–899.

- Grunebaum, M. F., Hanga, C. G., Choo, T. H., Keilp, J. G., Moitra, V. K., Parris, M. S., ... Mann, J. J. (2017). Ketamine for rapid reduction of suicidal thoughts in major depression: A midazolam-controlled randomized clinical trial. *American Journal of Psychiatry*, published online ahead of print, doi.org/10.1176/appi.ajp.2017.17060647.
- Grynszpan, O., Perbal, S., Pelissolo, A., Fossati, P., Jouvent, R., Dubal, S., & Perez-Diaz, F. (2011). Efficacy and specificity of computer-assisted cognitive remediation in schizophrenia: A meta-analytical study. *Psychological Medicine*, 41, 1, 163–173.
- Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. N. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes. *Journal of Community & Applied Social Psychology*, 13, 171–186.
- Gunter, T. D., Arndt, S., Wenman, G., Allen, J., Loveless, P., Sieleni, B. & Black, D. W. (2008). Frequency of mental and addictive disorders among 320 men and women entering the Iowa prison system: Use of the MINI-Plus. *Journal of the American Academy of Psychiatry and the Law*, 36, 1, 27–34.
- Haddock, G., Barrowclough, C., Shaw, J. J., Dunn, G., Novaco, R. W. & Tarrier, N. (2009). Cognitive-behavioural therapy v. social activity therapy for people with psychosis and a history of violence: Randomised controlled trial. *The British Journal of Psychiatry*, 194, 152–157.
- Haddock, G., Barrowclough, C., Tarrier, N., Moring, J., O'Brien, R., Schofield, N., ... Lewis, S. (2003). Cognitive-behavioural therapy and motivational intervention for schizophrenia and substance misuse: 18-month outcomes of a randomised controlled trial. *British Journal of Psychiatry*, 183, 418-426.
- Haddock, G., Devane, S., Bradshaw, T., McGovern, J., Tarrier, N., Kinderman, P., ... Harris, N. (2001). An investigation into the psychometric properties of the Cognitive Therapy Scale for Psychosis (CTS-Psy). *Behavioural and Cognitive Psychotherapy*, 29, 2, 221-233.
- Haddock, G., McCarron, J., Tarrier, N., & Faragher, E. B. (1999). Scales to measure dimensions of hallucinations and delusions: The psychotic rating scales (PSYRATS). *Psychological Medicine*, 29, 879-889.
- Hall, J. N., Baker, R. D. & Hutchinson, K. (1977). A controlled evaluation of token economy procedures with chronic schizophrenic patients. *Behavior Research and Therapy*, 15, 261–283.
- Hammersley, P., Burston, D., & Read, J. (2004). Learning to listen: Childhood trauma and adult psychosis. *Mental Health Practice*, 7, 6, 18-21.
- Haney, C. (2003). Mental health issues in long term solitary and “Supermax” confinement. *Crime and Delinquency*, 49, 1, 124–156.
- Hare, R. D. (1991). *The Psychopathy Checklist—Revised manual* - Toronto, Ontario, Canada: Multi-Health Systems 1991

- Harris, M. & Bachrach, L. (1990). Perspectives on homeless mentally ill women. *Hospital and Community Psychiatry*, 41, 253-254.
- Harris, E. C. & Barraclough, B. (1997). Suicide as an outcome for mental disorders. A meta-analysis. *British Journal of Psychiatry*, 170, 205–228.
- Harris, E. C. & Barraclough, B. (1998). Excess mortality of mental disorder. *British Journal of Psychiatry*, 173, 11-53.
- Harris, M., & Fallot, R. D. (2001). Designing trauma-informed addictions services. *New directions for Mental Health Services*, 89, 57-73.
- Harris, J. I., Farchmin, L., Stull, L., Boyd, J., Schumacher, M., & Drapalski, A. L. (2015). Prediction of changes in self-stigma among veterans participating in partial psychiatric hospitalization: The role of disability status and military cohort. *Psychiatric Rehabilitation Journal*, 38, 179–185.
- Harrison, P. M. & Beck, A. J. (2002). *Prisoners in 2001*. Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Harrison, P. M. & Karberg, J. C. (2003). *Prison and Jail Inmates at Midyear 2002*. Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J., ... Wiersma, D. (2001). Recovery from psychotic illness: A 15 and 25 year international follow up study. *British Journal of Psychiatry*, 178, 506–517.
- Harrow, M. & Jobe, T. H. (2007). Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications: A 15-year follow-up study. *Journal of Nervous and Mental Disease*, 195, 406–414.
- Harrow, M. & Jobe, T. H. (2013). Does long-term treatment of schizophrenia with antipsychotic medications facilitate recovery? *Schizophrenia Bulletin*, 39, 5, 962–965.
- Harrow, M., Jobe, T. H. & Faull, R. N. (2012). Do all schizophrenia patients need antipsychotic treatment continuously throughout their life time? A 20-year longitudinal study. *Psychological Medicine*, 42, 10, 2145–2155.
- Harry, M., van Busschbach, J. T., Stant, A. D., van Vugt, M. D., Weeghel, J. & Kroon, H. (2014). Effectiveness of individual placement and support for people with severe mental illness in the Netherlands: A 30-month randomized controlled trial. *Psychiatric Rehabilitation Journal*, 37, 2, 129-136.
- Harvey, P. D. (2005). *Schizophrenia in late life; Aging effects on symptoms and course of illness*. Washington DC: American Psychological Association.
- Harvey, P. D., Davidson, J., Mueser, K. T., Parrella, J., While, L., & Powchik, P. (1997). Social-Adaptive Functioning Evaluation (SAFE): A rating scale for geriatric psychiatric patients. *Schizophrenia Bulletin*, 23, 131–145.

- Harvey, P. D. & Strassnig, M. (2012). Predicting the severity of everyday functional disability in people with schizophrenia: cognitive deficits, functional capacity, symptoms, and health status. *World Psychiatry*, 11, 73-79.
- Harvey, P. D. & Penn, D. (2010). Social cognition: The key factor predicting social outcome in people with schizophrenia? *Psychiatry*, 2010, 7, 41–44.
- Harvey, P. D. & Strassnig, M. (2012). Predicting the severity of everyday functional disability in people with schizophrenia: Cognitive deficits, functional capacity, symptoms, and health status. *World Psychiatry*, 11, 2, 73-79.
- Hasnain, M., Victor, W. & Vieweg, R. (2011). Do we truly appreciate how difficult it is for patients with schizophrenia to adapt a healthy lifestyle? *Acta Psychiatrica Scandinavica*, 123, 6, 409–410.
- Hawton, K., Sutton, L., Haw, C., Sinclair, J. & Deeks, J. J. (2005). Schizophrenia and suicide: Systematic review of risk factors. *British Journal of Psychiatry*, 187, 9-20.
- Hayden, E. P. & Mash, E. J. (2014). Child psychopathology: A developmental-systems perspective. In E. J. Mash & R. Barkley (Eds.). *Child Psychopathology*. Third Edition. (pp. 3-72). New York: Guilford.
- Health Canada. (2002). Best Practices: Concurrent Mental Health and Substance Use Disorders. Ottawa, ON: Health Canada. Available at: http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/bp_disorder-mp_concomitants/index-eng.php
- Heffernan, J. & Pilkington, P. (2011). Supported employment for persons with mental illness: Systematic review of the effectiveness of individual placement and support in the UK. *Journal of Mental Health*, 20, 4, 368–380.
- Heila, H., Isometsa, E. T., Henriksson, M. M, Heikkinen, M. E., Marttunen M. J., & Lonnqvist, J. K. (1997). Suicide and schizophrenia: A nationwide psychological autopsy study on age- and sex specific clinical characteristics of 92 suicide victims with schizophrenia. *American Journal of Psychiatry*, 154, 1235–1242.
- Hennen, J. & Baldessarine, R. J. (2004). Suicidal risk during treatment with clozapine: A meta-analysis. *Schizophrenia Research*, 73, 139-145.
- Herman, J. (1992). *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*. New York: Basic Books.
- Hettema, J., Steele, J. & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology*, 1, 91–111.
- Hickie, I. B, Scott, E. M., Hermens, D. F., Naismith, S. L., Guastella, A. J., Kaur, M. ... McGorry, P. D. (2013). Applying clinical staging to young people who present for mental health care. *Early Intervention in Psychiatry*, 7, 1, 31-43.
- Hicks, J. W. (2004). Ethnicity, race, and forensic psychiatry: Are we color-blind? *Journal of the American Academy of Psychiatry and Law*, 32, 21–33.

- Hiroeh, U., Appleby, L., Mortensen, P. B. & Dunn, G. (2001). Death by homicide, suicide, and other unnatural causes in people with mental illness: A population-based study. *The Lancet*, 358, 9299, 2110–2112.
- Hiroeh, U., Kapur, N., Webb, R., Dunn, G., Mortensen, P. B., & Appleby, L. (2007). Deaths from natural causes in people with mental illness: A cohort study. *Journal of Psychosomatic Research*, 64, 275-283.
- Hodas, G. (2006). *Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care*. Available at www.nasmhpd.org
- Hoffmann, H., Jäckel, D., Glauser, S. & Kupper, Z. (2012). A randomised controlled trial of the efficacy of supported employment. *Acta Psychiatrica Scandinavica*, 125, 2, 157–167.
- Hoffmann, H., Jäckel, D., Glauser, S., Mueser, K. T., & Kupper, Z. (2014). Long-term effectiveness of supported employment: 5-year follow-up of a randomized controlled trial. *American Journal of Psychiatry*, 171, 11, 1183-1190.
- Hogan, M. F., & Grumet, J. G. (2016). Suicide prevention: An emerging priority for health care. *Health Affairs*, 35, 6, 1084-1090.
- Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality a meta-analytic review. *Perspectives on Psychological Science*, 10, 2, 227-237.
- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Med*, 7, 7, e1000316.
- Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, 3, 80-100.
- Horan, W. P., Kern, R. S., Tripp, C., Helleman, G., Wynn, J. K., Bell, M., ... Green, M. F. (2011). Efficacy and specificity of Social Cognitive Skills Training for outpatients with psychotic disorders. *Journal of Psychiatric Research*, 45, 1113–1122.
- Horvitz-Lennon, M., Kilbourne, A. M., & Pincus, H. A. (2006). From silos to bridges: Meeting the general health care needs of adults with severe mental illnesses. *Health Affairs*, 25, 3, 659-669.
- Howard, L. M., Barley, E. A., Davies, E., Rigg, A., Lempp, H., Rose, D., ... Thornicroft, G. (2010). Cancer diagnosis in people with severe mental illness: Practical and ethical issues. *The Lancet Oncology*, 11, 8, 797–804.
- Hurford, I. M., Kalkstein, S. & Hurford, M. O. (2011) Cognitive rehabilitation in schizophrenia. *Psychiatric Times*, March 15.
- Ikebuchi, E., Sato, S., Yamaguchi, S., Shimodaira, M., Taneda, A., Hatsuse, N., ... & Ito, J. I. (2017). Does improvement of cognitive functioning by cognitive remediation therapy effect work outcomes in severe mental illness? A secondary analysis of a randomized controlled trial. *Psychiatry and Clinical Neurosciences*, 71. DOI: 10.1111/pcn.12486.

- Ising, H. K., Kraan, T. C., Rietdijk, J., Dragt, S., Klaassen, R. M. C., Boonstra, N. & ... van der Gaag, M. (2016). Four-year follow up of cognitive behavioral therapy in persons at ultra high risk for developing psychosis: The Dutch Early Detection Intervention Evaluation (EDIE-NL) Trial. *Schizophrenia Bulletin*, 42, 5, 1243-1252.
- Jaeger, J., Berns, S. M., & Czobor, P. (2003). The multidimensional scale of independent functioning: A new instrument for measuring functional disability in psychiatric populations. *Schizophrenia Bulletin*, 29, 1, 153-168.
- Jaeger, J. J., Czobor, P., & Berns, S. (2003). Multidimensional scale of independent functioning: A new instrument for measuring functional disability in psychiatric populations. *Schizophrenia Bulletin*, 29, 153–168.
- James, D. J. & Glaze, L. E. (2006). *Mental Health Problems of Prison and Jail Inmates*. Washington DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Jansen, H. S. F., Watts, C., Ellsberg, M., Heise, L. & Garcia-Moreno, C. (2002). Forced sex and physical violence in Brazil, Peru, and Thailand: WHO multi-country results.
- Jarskog, L. F., Hamer, R. M., Catellier, D. J., Stewart, D., D., LaVange, L., Ray, N., ... and for the METS Investigators. (2013). Metformin for weight loss and metabolic control in overweight outpatients with schizophrenia and schizoaffective disorder. *American Journal of Psychiatry*, 170, 9, 1032-1040.
- Jean-Baptiste, M., Tek, C., Liskov, E., Chakunta, U. R., Nicholls, S., Hassan, A. Q., ... Wexler, B. E. (2007). A pilot study of a weight management program with food provision in schizophrenia. *Schizophrenia Research*, 96, 198–205.
- Jennings, A. (1994). On being invisible in the mental health system. *Journal of Mental Health Administration*, 21, 4, 374-387.
- Jennings, A. (2008). *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services – 2008 Update*. Alexandria, VA: National Center for Trauma Informed Care.
- Jeste, D. V., Lebowitz, B. D. (1997). Coming of age. *The Leifer Report*, Special Edition, 39–40.
- Johnson, R., Beckenbach, H., & Kilbourne, S. (2013). Forensic psychological public safety risk assessment integrated with culturally responsive treatment for juvenile fire setters: DSM-5 implications. *Journal of Criminal Psychology*, 3 1, 49-64.
- Joint Centre for Bioethics. (undated). *Aid To Capacity Evaluation (ACE)*.
http://www.jcb.utoronto.ca/tools/ace_download.shtml
- Joukamaa, M., Heliövaara, M., Knekt, P., Aromaa, A., Raitasalo, R., & Lehtinen, V. (2001). Mental disorders and cause-specific mortality. *British Journal of Psychiatry*, 179, 498-502.
- Joy, M., Clement, T., & Sisti, D. (2016). The ethics of behavioral health information technology: Frequent flyer icons and implicit bias. *JAMA*, published online September 08, 2016. doi:10.1001/jama.2016.12534.

- Kan, C. K., Ho, T. P., Dong, J. Y. & Dunn, E. L. (2007). Risk factors for suicide in the immediate post-discharge period. *Social Psychiatry and Psychiatric Epidemiology*, 42, 208–214.
- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... Heinssen, R. K. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173, 4, 362-372.
- Kataoka, S. L., Zhang, L. & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159, 1548–1555.
- Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., Williamson, D. & Ryan, N. (1997). Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL): Initial reliability and validity data. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 7, 980-988.
- Kay, S. R., Fiszbein, A., & Opler, L. A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, 13, 2, 261-76.
- Keefe, R. S.E., Goldberg, T. E., Harvey, P. D., Gold, J. M., Poe, M. P., & Coughenour, L. (2004). The Brief Assessment of Cognition in Schizophrenia: reliability, sensitivity, and comparison with a standard neurocognitive battery. *Schizophrenia Research*, 68, 2-3, 283-297.
- Kennedy-Hendricks, A., Huskamp, H. A., & Barry, C. L. (2016). Improving access to care and reducing involvement in the criminal justice system for people with mental illness. *Health Affairs*, 35, 6, 1076-1083.
- Kessler, R. C., Avenevoli, S., Costello, J., Green, J. G., Gruber, M. J., McLaughlin, K. A. ... Merikangas, K. R. (2012). Severity of 12-month DSM-IV disorders in the national Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, 69, 381-389.
- Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., ... Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health services research*, 36, 6 Pt 1, 987–1007.
- Khalsa, H. M. K., Salvatore, P., Hennen, J., Baethge, Tohen, M., & Baldessarini, R. J. (2008). Suicidal events and accidents in 216 first-episode bipolar I disorder patients: Predictive factors. *Journal of Affective Disorders*, 106, 1, 179–184.
- Khare, C., Mueser, K. T., & McGurk, S. R. (2016). Vocational rehabilitation for individuals with schizophrenia. *Current Treatment Options in Psychiatry*, 3, 2, 99-110.
- Kilbourne, A. M., Switzer, G., Hyman, K., Crowley-Matoka, M., & Fine, M. J. (2006). Advancing health disparities research within the health care system: A conceptual framework. *American Journal of Public Health*, 96, 12, 2113–2121.
- Kirkpatrick, B., Strauss, G. P., Nguyen, L., Fischer, B. A., Daniel, D. G., Cienfuegos, A., & Marder, S. R. (2011). The Brief Negative Symptom Scale: Psychometric properties. *Schizophrenia Bulletin*, 37, 2, 300–305.

- Kimhy, D., Tarrier, N., Essock, S., Malaspina, D., Cabannis, D., & Beck, A. T. (2013). Cognitive behavioral therapy for psychosis – training practices and dissemination in the United States. *Psychosis*, 5, 3, 296-305.
- King, E. A., Baldwin, D. S., Sinclair, J. M., Baker, N. G., Campbell, M. J., & Thompson, C. (2001). The Wessex Recent In-Patient Suicide Study, 1. Case-control study of 234 recently discharged psychiatric patient suicides. *British Journal of Psychiatry*, 178, 531–536.
- King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Passetti, F., ... & Serfaty, M. (2007). The Stigma Scale: Development of a standardised measure of the stigma of mental illness. *The British Journal of Psychiatry*, 190, 248-254.
- Kisely, S., Smith, M., Lawrence, D., Cox, M., Campbell, L. A., & Maaten, S. (2007). Inequitable access for mentally ill patients to some medically necessary procedures. *Canadian Medical Association Journal*, 176, 779-784.
- Knitzer, J. (1982). *Unclaimed Children*. Washington, DC: Children's Defense Fund.
- Koh, H. K. & O'Connell, J. J. (November, 2016). Improving Health Care for Homeless People. *The JAMA Forum*, JAMA.
- Kohler, C. G., Turner, T. H., Bilker, W. B., Brensinger, C. M., Siegel, S. J., Kanesh, S. J., ... Gur, R. C. (2003). Facial emotion recognition in schizophrenia: Intensity effects and error pattern. *American Journal of Psychiatry*, 160, 10, 1768-1774.
- Kollias, C. T., Kontaxakis, V. P., Havaki-Kontaxaki, B. J., Stamouli, S., Margariti, M., & Petridou, E. (2008). Association of physical and social anhedonia with depression in the acute phase of schizophrenia. *Psychopathology*, 41, 6, 365-370.
- Konrad, N. (2002). Prisons as new asylums. *Current Opinion in Psychiatry*, 15, 583–587.
- Kooyman, I., Dean, K., Harvey, S. & Walsh, E. (2007). Outcomes of public concern in schizophrenia. *The British Journal of Psychiatry*, 191, s29–s36.
- Kopelowicz, A., Liberman, R. P. & Zarate, R. (2007). Psychosocial treatments for schizophrenia. In P. Nathan & J. Gorman (Eds.). *Treatments that Work*, 2nd ed. New York: Oxford University Press.
- Koroukian, S. M., Bakaki, P. M., Golchin, N., Tyler, C., & Loue, S. (2012). Mental illness and use of screening mammography among Medicaid beneficiaries. *American Journal of Preventive Medicine*, 42, 606–609.
- Kreisman, D. E., Simmens, S. J., & Joy, V. D. (1979). Rejecting the patient: preliminary validation of a self-report scale. *Schizophrenia Bulletin*, 5, 220-222.
- Kreyenbuhl, J., Buchanan, R.W., Dickerson, F. B. & Dixon, L. B. (2010). The Schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2009. *Schizophrenia Bulletin*, 36, 1, 94-103.

- Kreyenbuhl, J., Nossel, I. R., & Dixon, L. B. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *Schizophrenia Bulletin*, 35, 4, 696-703.
- Kring, A. M., Gur, R. E., Blanchard, J. J., Horan, W. P., & Reise, S. P. (2013). The Clinical Assessment Interview for Negative Symptoms (CAINS): Final development and validation. *American Journal of Psychiatry*, 170, 165-172.
- Kuno, E. & Rothbard, A. B. (1997). Racial disparities in antipsychotic prescription patterns for patients with schizophrenia. *American Journal of Psychiatry*, 159, 567–572.
- Kurtz, M. M. & Mueser, K. T. (2008). A meta-analysis of controlled research on social skills training for schizophrenia. *Journal of Consulting and Clinical Psychology*, 76, 491–504.
- Kurtz, M. M. & Richardson, C. L. (2012). Social cognitive training for schizophrenia: A meta-analytic investigation of controlled research. *Schizophrenia Bulletin*, 38, 5 1092–1104.
- Kwon, J. S., Choi, J. S., Bahk, W. M., Yoon, K. C., Hyung, K. C., Chul, S. Y., & Geun, O. C. (2006). Weight management program for treatment emergent weight gain in Olanzapine-treated patients with schizophrenia or schizoaffective disorder: A 12 week randomized controlled trial. *Journal of Clinical Psychiatry*, 67, 4, 547–553.
- Lamberti, J. S., Deem, A., Weisman, R. L. & LaDuke, C. (2011). The role of probation in Forensic Assertive Community Treatment. *Psychiatric Services*, 62, 4, 418–421.
- Large, M., Kaneson, M., Myles, N., Myles, H., Gunaratne, P., & Ryan, C. (2016). Meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients: Heterogeneity in results and lack of improvement over time. *PLoS ONE*, 11, 6, doi:10.1371/journal.pone.0156322.
- Lasser, K., Boyd, J. W., Woolhandler, S., Himmelstein, D. U., McCormick, D., & Bor, D. H. (2000). Smoking and mental illness: A population-based prevalence study. *Journal of the American Medical Association*, 284, 20, 2606-2610.
- Lawrence, D., Hancock, K. J., & Kisely, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: Retrospective analysis of population based registers. *The BMJ*, 346, 2539.
- Lawrence, D., Holman, C. D. J., & Jablensky, A. V. (2001). *Duty to care: Preventable physical illness in people with mental illness*. Perth, Australia: University of Western Australia.
- Lawrence, D. & Kisely, S. (2010). Inequalities in healthcare provision for people with severe mental illness. *Journal of Psychopharmacology*, 24, 4 (supplement), 61–68.
- Lawrence, D., Mitrou, F., & Zubrick, S. R. (2009). Smoking and mental illness: Results from population surveys in Australia and the United States. *BMC Public Health*, 2009 9, 285, 1-14.
- Lawson, W. B. (1999). The art and science of ethnopsychopharmacotherapy. In J. Herrera, W. B. Lawson & J. J. Sramek, J. (Eds.). *Cross Cultural Psychiatry*. New York, NY: John Wiley & Sons Inc.

- Lecomte, T., Leclerc, C., Corbiere, M., Wykes, T., Wallace, C. J. & Spidel, A. (2008). Group cognitive behavior therapy or social skills training for individuals with a recent onset of psychosis? Results of a randomized controlled trial. *Journal of Nervous and Mental Disease*, 196, 12, 866–875.
- Lecomte, T., Wallace, C. J., Caron, J., Perreault, M., & Lecomte, J. (2004). Further validation of the Client Assessment of Strengths Interests and Goals. *Schizophrenia Research*, 66, 59–70.
- Lee, H. & Lin, H. (2009). Are psychiatrist characteristics associated with post discharge suicide of schizophrenia patients? *Schizophrenia Bulletin*, 35, 4, 760–765.
- Leff, H. S., Chow, C. M., Pepin, R., Conley, J., Allen, I. E., & Seaman, C. A. (2009). Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness. *Psychiatric Services*, 60, 4, 473-482.
- Leff, J. P. & Vaughn, C. (1985). *Expressed emotion in families*. New York: Guildford Press.
- Lehrer, D. S., & Lorenz, J. (2014). Anosognosia in schizophrenia: Hidden in plain sight. *Innovations in Clinical Neuroscience*, 11, 5-6, 10-17.
- Lenon, S. (2000). Living on the edge. *Canadian Woman Studies*, 20, 3, 123-126.
- Lewis, C. (2006). Treating incarcerated women: Gender matters. *Psychiatric Clinics of North America*, 29, 3, 773–789.
- Lieberman, R. P., Glynn, S., Blair, K. E., Ross, D., & Marder, S. R. (2002). In vivo amplified skills training: promoting generalization of independent living skills for clients with schizophrenia. *Psychiatry: Interpersonal and Biological Processes, Special Topic Issue: Historical Perspectives*, 65, 2, 137-155.
- Lindenmayer, J. P., McGurk, S. R., Khan, A., Kaushik, S., Thanju, A., Hoffman, L., ... Herrmann, E. (2013). Improving social cognition in schizophrenia: A pilot intervention combining computerized social cognition training with cognitive remediation. *Schizophrenia Bulletin*, 39, 3, 507–517.
- Lindenmayer, J. P., McGurk, S. R., Mueser, K. T., Kahn, A., Wance, D., Hoffman, L., ... Xie, H. (2008). A randomized controlled trial of cognitive remediation among inpatients with persistent mental illness. *Psychiatric Services*, 59, 3, 241–247.
- Lindsey, K. & Paul, G. (1989). Involuntary commitment in institutions: Issues involving the overrepresentation of Blacks and the assessment of relevant functioning. *Psychological Bulletin*, 106, 171–183.
- Linehan, M. M. (1993). *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press.
- Lipschitz, D. S., Kaplan, M. L., Sorkenn, J. B., Faedda, G. L., Chorney, P., & Asnis, G. M. (1996). Prevalence and characteristics of physical and sexual abuse among psychiatric outpatients. *Psychiatric Services*, 47, 2, 189–191.

- Lipton, F. R., Siegel, C., Hannigan, A., Samuels, J. & Baker, S. (2000). Tenure in supportive housing for homeless persons with severe mental illness. *Psychiatric Services*, 51, 479–486.
- Littrell, K. H., Hilligoss, N. M., Kirshner, C. D., Petty, R. G., & Johnson, C. G. (2003). The effects of an educational intervention on antipsychotic-induced weight gain. *Journal of Nursing Scholarship*, 35, 237–241.
- Livingston, J. D. & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, 71, 2150-2161.
- Lowe, M. R. & Cautela, J. R. (1978). A self-report measure of social skill. *Behavior Therapy*, 9, 4, 535-544.
- Lu, W., Yanos, P. T., Silverstein, S. M., Mueser, K. T., Rosenberg, S. D., Gottlieb, J. D., ... Giacobbe, G. (2013). Public mental health clients with severe mental illness and probable posttraumatic stress disorder: Trauma exposure and correlates of symptom severity. *Journal of Traumatic Stress*, 26, 266-273.
- Lucksted, A. & Drapalski, A. L. (2015). Self-stigma regarding mental illness: definition, impact, and relationship to societal stigma. *Psychiatric Rehabilitation Journal*, 38, 2, 99-102.
- Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice*, 20, 2, 137–160.
- Lyman, D. R., Braude, L., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Consumer and family psychoeducation: Assessing the evidence. *Psychiatric Services*, 65, 4, 416–428.
- Lyman, D. R., Kurtz, M. M., Farkas, M., George, P., Dougherty, R. H., Daniels, A. S., ... Delphin-Rittmon, M. E. (2014). Skill building: Assessing the evidence. *Psychiatric Services*, 65, 6, 727–738.
- Lynch, S. & Heath, N. (2017). Predictors of incarcerated women's postrelease PTSD, depression, and substance-use problems. *Journal of Offender Rehabilitation*, 56, 3, 157-172.
- Lynch, S. M., Heath, N. M., Matthews, K. C. & Cepeda, G. J. (2012). Seeking Safety: An intervention for trauma exposed incarcerated women? *Journal of Trauma and Dissociation*, 13, 88-101.
- Lyskowski, J. L., Menditto, A. A. & Csernansky, J. G. (2009). Treatment of violent behavior in patients with combined psychiatric illness and cognitive impairment: A case series. *Mental Health Aspects of Developmental Disabilities*, 12, 1-9.
- Mabe, P. A. & Fenley, G. (2008). *Project GREAT Recovery Based Training Procedures Manual: A Guide to Teaching Professionals the Recovery Model of Mental Health Care*. Augusta, GA: Department of Psychiatry and Health Behavior, Medical College of Georgia.
- Mackay, R., Bradstreet, S., McArthur, A., & Dunion, L. (2015). Dyad conversations about self-stigma in two Scottish communities. *Psychiatric Rehabilitation Journal*, 38, 194–200.

- Mahmood, S., Booker, I., Huang, J. & Coleman, C. I. (2013). Effect of topiramate on weight gain in patients receiving atypical antipsychotic agents. *Journal of Clinical Psychopharmacology*, 33, 1, 90-94.
- Mallinger, J. B., Fisher, S. G., Brown, T. & Lambert, S. (2006). Racial disparities in the use of second-generation antipsychotics for the treatment of schizophrenia. *Psychiatric Services*, 57, 33–136.
- Mancini, A. D., & Finnerty, M.T. (2005). Recovery Oriented Practices Index (ROPI). Unpublished manuscript, New York State Office of Mental Health.
- Mancini, M. A., Linhorst, D. M., Menditto, A. A. & Coleman, J. (2013). Statewide implementation of recovery support groups for people with serious mental illness: A multidimensional evaluation. *Journal of Behavioral Health Services & Research*, 40, 4, 391–403.
- Mandiberg, J. M. (2012). Commentary: The failure of social inclusion: An alternative approach through community development. *Psychiatric Services*, 63, 5, 458-460.
- Maniglio, R. (2009). Severe mental illness and criminal victimization: A systematic review. *Acta Psychiatrica Scandinavica*, 119, 3, 180-191.
- Manitoba Trauma Information and Education Centre. (2013). *Trauma Informed: The Trauma Toolkit, Second Edition*. Winnipeg, MB: Clinic Community Health Centre.
- Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., ... Hendin, H. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association*, 294, 16, 2064-2074.
- Manu, P. (2011). Medical complications of treatment with antipsychotic drugs. *Romanian Medical Reviews & Research*, 1, 1.
- Mares, A. S. & Rosenheck, R. A. (2009). Twelve-month client outcomes and service use in a multisite project for chronically homeless adults. *The Journal of Behavioral Health Services and Research*, 37, 2, 167–183.
- Margolese, H. C., Malchy, L., Negrete, J. C., Tempier, R., & Gill, K. (2004). Drug and alcohol use among patients with schizophrenia and related psychoses: levels and consequences. *Schizophrenia Research*, 67, 2-3, 257-166.
- Marshall, T., Goldberg, R. W., Braude, L., Dougherty, R. H. Daniels, A. S., Ghose, S. S. ... Delphin-Rittmon, M. E. (2014). Supported employment: Assessing the evidence. *Psychiatric Services*, 65, 1, 16–24.
- Marshall, M., Lewis, L., Lockwood, A., Drake, R., Jones, P. & Croudace, T. (2005). Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: a systematic review. *Archives of General Psychiatry*, 62, 9, 975-983.
- Marshall, M. & Lockwood, A. (1998). Assertive Community Treatment for People with Severe Mental Disorders. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No. CD001089.

- Marshall, M. & Rathbone, J. (2011) Early intervention for psychosis. *Cochrane Database of Systematic Reviews*, Issue 6. CD004718.
- Martin, M. S., Dorken, S. K., Wamboldt, A. D. & Wooten, S. E. (2012). Stopping the revolving door: A meta-analysis on the effectiveness of interventions for criminally involved individuals with major mental disorders. *Law and Human Behavior*, 36, 1, 1-12.
- Mason, L., Peters, E., Williams, S. C., & Kumari, V. (2017). Brain connectivity changes occurring following cognitive behavioural therapy for psychosis predict long-term recovery. *Translational Psychiatry*, 7, 1, e1001.
- Mazi-Kotwal, N. & Upadhyay, B. (2011). Physical health in schizophrenia. *Cutting Edge Psychiatry in Practice*, 1, 3, 74–77.
- McEvoy, J. P., Meyer, J. M., Goff, D. C., Nasrallah, H. A., Davis, S. M., Sullivan, L. ... Lieberman, J. A. (2005). Prevalence of the metabolic syndrome in patients with schizophrenia: Baseline results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. *Schizophrenia Research*, 80, 1, 19-32.
- McGinty, E. E., Kennedy-Hendricks, A., Choksy, S., & Barry, C. L. (2016). Trends in news media coverage of mental illness in the United States: 1995-2014. *Health Affairs*, 35, 6, 1121-1129.
- McGinty, E. E., Webster, D. W., & Barry, C. L. (2013). Effects of news media messages about mass shootings on attitudes toward persons with serious mental illness and public support for gun control policies. *American Journal of Psychiatry*, 170, 494-501.
- McGlashan, T. H. (2006). Is active psychosis neurotoxic? *Schizophrenia Bulletin*, 32, 609–613.
- McGlashan, T. H., Evensen, J., Haahr, J., Hegelstad, W., Joa, I., Johannessen, J., ... Friis, S. (2011). Early detection and intervention (EDI) in first episode psychosis: Can it increase the chance for full recovery? TIPS 10 year findings. *Schizophrenia Bulletin*, 37, (Supp 1), 273–274.
- McGlashan, T. H., Walsh, B. C., & Woods, S. W. (2010). *The psychosis-risk syndrome: Handbook for diagnosis and follow-up*. New York, NY: Oxford University Press.
- McGlashan, T. H., Walsh, B. C., & Woods, S. W. (2014). *Structured Interview for Psychosis Risk Syndromes – English language, Version 5.5*. New Haven, CT: PRIME Research Clinic, Yale School of Medicine
- McGorry, P. D. (2002). The recognition and optimal management of early psychosis: An evidence-based reform. *World Psychiatry*, 1, 76–83.
- McGorry, P. D., Alvarez-Jimenez, M. & Killackey, E. (2013). Antipsychotic medication during the critical period following remission from first-episode psychosis: Less is more. *JAMA Psychiatry*, 70, 9, 898–900.
- McGorry, P. D., Nelson, B., Goldstone, S. & Yung, A. R. (2010). Clinical staging: A heuristic and practical strategy for new research and better health and social outcomes for psychotic and related mood disorders. *Canadian Journal of Psychiatry*, 55, 486–497.

- McGurk, S. R., Mueser, K. T. & Pascaris, A. (2005). Cognitive training and supported employment for persons with severe mental illness: One-year results from a randomized controlled trial. *Schizophrenia Bulletin*, 31, 4, 898–909.
- McGurk, S. R., Mueser, K. T., Xie, H., Welsh, J., Kaiser, S., Drake, R. E., ... McHugo, G. J. (2015). Cognitive enhancement treatment for people with mental illness who do not respond to supported employment: A randomized controlled trial. *American Journal of Psychiatry*, 172, 9, 852-861.
- McGurk, S. R., Twamley, E.W., Sitzer, D. I., McHugo, G. J., & Mueser, K. T. (2007). A meta-analysis of cognitive remediation in schizophrenia. *American Journal of Psychiatry*, 164, 1791–1802.
- McHugo, G. J., Bebout, R. R., Harris, M., Cleghorn, S., Herring, G., Xie, H., ... Drake, R. E. (2004). A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin*, 30, 4, 969-982.
- McKenzie, W. & Wurr, C. (2001). Early suicide following discharge from a psychiatric hospital. *Suicide and Life Threatening Behavior*, 31, 358–363.
- McNiel, D. E., Binder, R. L. & Robinson, J. C. (2005). Incarceration associated with homelessness, mental disorder, and co-occurring substance abuse. *Psychiatric Services*, 56, 7, 840–846.
- Mechanic, D. & Bilder, S. (2004). Treatment of people with mental illness: A decade-long perspective. *Health Affairs*, 23, 4, 84–95).
- Meehan, J., Flynn, S., Hunt, I. M., Robinson, J., Bickley, H., Parsons, R., ... Shaw, J. (2006). Perpetrators of homicide with schizophrenia: A national clinical survey in England and Wales. *Psychiatric Services*, 57, 11, 1648–1651.
- Melfi, C., Croghan, T., Hanna, M. & Robinson, R. (2000). Racial variation in antidepressant treatment in a Medicaid population. *Journal of Clinical Psychiatry*, 61, 16–21.
- Menditto, A. A., Wallace, C. J., Liberman, R. E, VanderWal, J., Jones, N. T., & Stuve, P. (1999). Functional assessment of independent living skills. *Psychiatric Rehabilitation Skills*, 3, 2, 200-219.
- Merinder, L. B. (2000). Patient education in schizophrenia: A review. *Acta Psychiatrica Scandinavica*, 102, 98-106.
- Merikangas, K. R., He, J. P., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., ... Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 49, 980-989.
- Miklowitz, D. J., George, E. L., Richards, J. A., Simoneau, T. L. & Suddath, R. L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry*, 60, 904-912.
- Miklowitz, D. J., Simoneau, T. L., George, E. L., Richards, J. A., Kalbag, A., Sachs-Ericsson, N., & Suddath, R. (2000). Family-focused treatment of bipolar disorder: 1-year effects of a

- psychoeducational program in conjunction with pharmacotherapy. *Biological Psychiatry*, 48, 6, 582-592.
- Miles, J., Espiritu, R. C., Horen, N. M., Sebian, J. & Waetzig, E. (2010). *A Public Health Approach to Children's Mental Health: A Conceptual Approach*. Washington, DC: Georgetown University Center for Child and Human Development.
- Miller, W. R. & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist*, 64, 6, 527-537.
- Mitchell, A. J., Delaffon, V., & Lord, O. (2012). Let's get physical: Improving the medical care of people with severe mental illness. *Advances in psychiatric treatment*, 18, 216–225.
- Mitchell, A. J., Vancampfort, D., Sweers, K., van Winkel, R., Yu, W. & de Hert, M. (2013). Prevalence of metabolic syndrome and metabolic abnormalities in schizophrenia and related disorders—A systematic review and meta-analysis. *Schizophrenia Bulletin*, 39, 2, 306-318.
- Modestin, J., Dal Pian, D., & Agarwalla, P. (2005). Clozapine diminishes suicidal behavior: A retrospective evaluation of clinical records. *Journal of Clinical Psychiatry*, 66, 534-538.
- Moran, M. (2014). Overdiagnosis of schizophrenia said to be persistent among black patients. *Psychiatric Times*, December 29, 2014.
- Morosini, P. L., Magliano, L., Brambilla, L., Uglioni, S., & Piolo, R. (2000). Development, reliability and acceptability of a new version of the DSM-IV Social and Occupational Functioning Assessment Scale (SOFAS) to assess routine social functioning. *Acta Psychiatrica Scandinavica*, 101, 323–329.
- Morris, C. & Moore, E. (2009). An evaluation of group work as an intervention to reduce the impact of substance misuse for offender patients in a high security hospital. *Journal of Forensic Psychiatry and Psychology*, 20, 4, 559-576.
- Morrison, A. P. & Barrett, S. (2010). What are the components of CBT for psychosis? A Delphi study. *Schizophrenia Bulletin*, 36, 1, 136-142.
- Morrissey, J. P., Meyer, P. S. & Cuddeback, G. S. (2007). Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal*, 43, 527–544.
- Moy, E., Dayton, E. & Clancy, C. M. (2005). Compiling the evidence: The national health care disparities reports. *Health Affairs*, 24, 2, 376–387.
- Mueser, K. T. (2012). Evidence-based practices and recovery-oriented services: Is there a relationship? Should there be one? *Psychiatric Rehabilitation Journal*, 35, 4, 287–288.
- Mueser, K. T., Bond, G. R. & Drake, R. E. (2001). Community-based treatment of schizophrenia and other severe mental disorders: Treatment outcomes? *Medscape Mental Health*, 6, 1.
- Mueser, K. T., Corrigan, P. W., Hilton, D., Tanzman, B., Schaub, A., Gingerich, S., ... Herz, M. I. (2002). Illness management and recovery for severe mental illness: A review of the research. *Psychiatric Services*, 53, 10, 1272-1284.

- Mueser, K. T., Deavers, F., Penn, D. L. & Cassisi, J. E. (2013). Psychosocial treatments for schizophrenia. *Annual Review of Clinical Psychology*, 9, 465-497.
- Mueser, K. T., Drake, R. E., & Bond, G. R. (2016). Recent advances in supported employment for people with serious mental illness. *Current Opinion in Psychiatry*, 29, 3, 196–201.
- Mueser, K. T. & Glynn, S. M. (2000). *Behavioral Family Therapy for Psychiatric Disorders* (2nd ed.). Oakland, CA: New Harbinger.
- Mueser, K. T., Glynn, S. M., Cather, C., Xie, H., Zarate, R., Smith, L. F., ... Feldman, J. (2013). A randomized controlled trial of family intervention for co-occurring substance use and severe psychiatric disorders. *Schizophrenia Bulletin*, 39, 3, 658-672.
- Mueser, K. T., Goodman, L. A., Trumbetta, S. L., Rosenberg, S. D., Osher, F. C., Vidaver, R., ... Foy, D. W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 66, 3, 493-499.
- Mueser, K. T., Gottlieb, J. D., Xie, H., Lu, W., Yanos, P. T., Rosenberg, S. D., ... McHugo, G. J. (2015). Evaluation of cognitive restructuring for post-traumatic stress disorder in people with severe mental illness. *The British Journal of Psychiatry*, 206, 6, 501-508.
- Mueser, K. T. & Jeste, D. V. (Eds.). (2008). *Clinical Handbook of Schizophrenia*. New York, NY: Guilford Press.
- Mueser, K. T., Lu, W., Rosenberg, S. D. & Wolfe, R. (2010). The trauma of psychosis: Posttraumatic stress disorder and recent onset psychosis. *Schizophrenia Research*, 116, 2-3, 217-227.
- Mueser, K. T., Noordsy, D. L., Drake, R. E. & Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York, Guilford Press.
- Mueser, K. T., Rosenberg, S. D., Xie, H., Jankowski, M. K., Bolton, E. E., Lu, W., ... Wolff, R. (2008). A randomized controlled trial of cognitive-behavioral treatment for posttraumatic stress disorder in severe mental illness. *Journal of Consulting & Clinical Psychology*, 76, 259–271.
- Mueser, K. T., Salyers, M. P., Rosenberg, S. D., Goodman, L. A., Essock, S. M., Osher, F. C. ... 5 Site Health and Risk Study Research Committee. (2004). Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: Demographic, clinical, and health correlates. *Schizophrenia Bulletin*, 30, 1, 45–57.
- Najavits, L. M. (2006). Seeking Safety: An evidence-based model for trauma/PTSD and substance use disorder. In K. Witkiewitz & G. A. Marlatt (Eds.). *Evidence Based Relapse Prevention*. Amsterdam: Elsevier Press.
- Najavits, L. M. (2009). Seeking Safety: An implementation guide. In A. Rubin & D. W. Springer (Eds.). *The Clinician's Guide to Evidence-Based Practice*. Hoboken, NJ: John Wiley.
- Najavits, L. M. & Hien, D. (2013). Helping vulnerable populations: A comprehensive review of the treatment outcome literature on substance use disorder and PTSD. *Journal of Clinical Psychology: In Session*, 69, 433-479.

- Naslund, J. A., Grande, S. W., Aschbrenner, K. A., & Elwyn, G. (2014). Naturally occurring peer support through social media: The experiences of individuals with severe mental illness using YouTube. *PLoS ONE* 9, 10, e110171.
- Nasrallah, H. A., Keefe, R. S. E., & Javitt, D. C. (2014). Cognitive deficits and poor functional outcomes in schizophrenia: Clinical and neurobiological progress. *Current Psychiatry*, 13 (suppl 6), S1-S11.
- National Alliance for the Mentally Ill. (2005). *Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder*. Washington, DC: National Alliance for the Mentally Ill.
- National Health Policy Forum. (2009). *Children's Mental Health: Prevalence, Illness Burden, and Efforts at Prevention and Early Intervention*. Forum session presented November, 20, 2009, Washington, DC.
- National Institute of Mental Health. (2009). Expert panel addresses high rates of smoking in people with psychiatric disorders. Washington, DC: Author.
- National Institute of Mental Health. (2016). *Bipolar Disorder*. Downloaded from NIMH webpage October 25, 2016.
- National Institute of Mental Health. (2012). *Improving health and reducing premature mortality in people with severe mental illness*. Washington, DC: Author.
- Nelson, G., Aubry, T. & Lafrance, A. (2010). A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry*, 77, 3, 350–361.
- Nelson, G., Ochocka, J., Janzen, R. & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives. *Journal of Community Psychology*, 34, 3, 247-260.
- Nemec, P. B., Swarbrick, M., & Legere, L. (2015). Prejudice and discrimination from mental health service providers. *Psychiatric Rehabilitation Journal*, 38, 2, 203–206.
- Newbill, W. A., Paul, G. L., Menditto, A. A., Springer, J. R. & Mehta, P. (2011). Social-learning programs facilitate an increase in adaptive behavior in a forensic mental hospital. *Behavioral Interventions*, 26, 3, 214–230.
- Nielssen, O. B., Westmore, B. D., Large, M. M. & Hayes, R.A. (2007). Homicide during psychotic illness in New South Wales between 1993 and 2002. *Medical Journal of Australia*, 186, 301–304.
- Niendam, T. A., Bearden, C. E., Johnson, J. K., & Cannon, T. D. (2006). *Global Functioning: Role Scale (GF: Role)*. Los Angeles, CA: University of California.
- Niv, N., Cohen, A. N., Sullivan, G., & Young, A. S. (2007). The MIRECC version of the Global Assessment of Functioning Scale: Reliability and validity. *Psychiatric Services*, 58, 529-535.

- Niv, N., Hassell, J., Frousakis, N., & Glynn, S. (2013). Behavioral Family Therapy for Severe Mental Illness: Clinician Training DVD/CD Instructional Set. Washington, DC: Department of Veterans Affairs.
- Norman, R. M., Manchanda, R., Malla, A. K., Windell, D., Harricharan, R., & Northcott, S. (2011). Symptom and functional outcomes for a 5 year early intervention program for psychoses. *Schizophrenia Research*, 129, 111–115.
- Norris, F. H. (2005). Range, Magnitude, and Duration of the Effects of Disasters on Mental Health: Review Update. White River Junction, VT: National Center for PTSD.
- Norris, F. H., Byrne, C. M., Diaz, E. & Kaniasty, K. (2002). The Range, Magnitude, and Duration of Effects of Natural and Human-Caused Disasters: A Review of the Empirical Literature. White River Junction, VT: National Center for PTSD.
- Nuechterlein, K. H. & Green, M. F. (2006). MATRICS Consensus Cognitive Battery Manual. Los Angeles, CA: MATRICS Assessment, Inc.
- Olfson, M., Gerhard, T., Huang, C., Crystal, S. & Stroup, T. S. (2015). Premature mortality among adults with schizophrenia in the United States. *JAMA Psychiatry*, 72, 12, 1172-1181.
- Olfson, M., Wall, M., Wang, S., Crystal, S., Liu, S-M, Gerhard, T., & Blanco, C. (2016). Short-term suicide risk after psychiatric hospital discharge. *JAMA Psychiatry*. Published online September 21, 2016. doi:10.1001/jamapsychiatry.2016.2035.
- Onken, S., Dumont, J. M., Ridgway, P., Dornan, D. H. & Ralph, R. O. (2007). The Recovery Oriented System Indicators (ROSI) Measure. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center (NTAC).
- Osborn, D. P. J. (2001). The poor physical health of people with mental illness. *The Western Journal of Medicine*, 175, 329–332.
- Ösby, U., Correia, N., Brandt, L., Ekblom, A., & Sparen, O. (2000). Mortality and causes of death in schizophrenia in Stockholm County, Sweden. *Schizophrenia Research*, 45, 1, 21–28.
- Osher, F. C. & Steadman, H. J. (2007). Adapting evidence-based practices for persons with mental illness involved with the criminal justice system. *Psychiatric Services*, 58, 11, 1472–1479.
- Osher, F., Steadman, H. J. & Barr, H. (2002). A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model: Delmar, NY: The National GAINS Center.
- Padgett, D. K. (2007). There's no place like (a) home: Ontological security among persons with serious mental illness in the United States. *Social Science Medicine*, 64, 9, 1925–1936.
- Parkinson, S., Nelson, G. & Horgan, S. (1999). From housing to homes: A review of the literature on housing approaches for psychiatric consumers/survivors. *Canadian Journal of Community Mental Health*, 18, 145–164.

- Parks, J., Svendsen, D., Singer, P. & Foti, M. E. (Eds.). (2006). *Morbidity and Mortality in People with Serious Mental Illnesses*. Technical Report 13. Alexandria, VA: National Association of State Mental Health Program Directors Council.
- Parsons, J. & Sandwick, T. (2012). *Closing the gap: Using criminal justice and public health data to improve the identification of mental illness*. New York, NY: Vera Institute of Justice.
- Patterson, T., Goldman, S., Mckibbin, C., Hughs, T. & Jeste, D. V. (2001). UCSD Performance-Based Skills Assessment: Development of a new measure of everyday functioning for severely mentally ill adults. *Schizophrenia Bulletin*, 27, 2, 235-245.
- Patterson, T. L. & Leeuwenkamp, O. R. (2008). Adjunctive psychosocial therapies for the treatment of schizophrenia. *Schizophrenia Research*, 100, 108–119.
- Patterson, T. L., Moscona, S., McKibbin, C. L., Hughs, T., & Jeste, D.V. (2001). UCSD performance-based skills assessment (UPSA): Development of a new measure of everyday functioning for severely mentally ill adults. *Schizophrenia Bulletin*, 27, 235–245.
- Paul, G. L. & Lentz, R. J. (1977). *Psychosocial Treatment of Chronic Mental Patients: Milieu versus Social-learning Programs*. Cambridge, MA: Harvard University Press.
- Pearson, C., Montgomery, A. E. & Locke, G. (2009). Housing stability among homeless individuals with serious mental illness participating in housing first programs. *Journal of Community Psychology*, 37, 4, 404–417.
- Penn, D. L., Corrigan, P. W., Bentall, R. P., Racenstein, J. M., & Newman, L. (1997). Social cognition in schizophrenia. *Psychological Bulletin*, 121, 114–132.
- Penn, D. L. & Mueser, K. T. (1996). Research update on the psychosocial treatment of schizophrenia. *American Journal of Psychiatry*, 153, 5, 607-617.
- Perkins, D. O., Gu, H., Boteva, K., & Lieberman, J. A. (2005). Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: A critical review and meta-analysis. *American Journal of Psychiatry*, 162, 1785–1804.
- Pernice, F. M., Biegel, D. E., Kim, J.-Y., & Conrad-Garrisi, D. (2017). The mediating role of mattering to others in recovery and stigma. *Psychiatric Rehabilitation Journal*, 40, 4, 395-404.
- Perrin, S., Smith, P. & Yule, W. (2000). Practitioner review: The assessment and treatment of Post-traumatic Stress Disorder in children and adolescents. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, 41, 3, 277–289.
- Peters, E., Day, J. S., & Garety P. (2004). Measuring delusional ideation: the 21-item Peters et al. Delusions Inventory (PDI). *Schizophrenia Bulletin*, 30, 4, 1005-1022.
- Peters, R. H., Bartoi, M. G. & Sherman, P. B. (2008). *Screening and Assessment of Co-occurring Disorders in the Justice System*. Delmar, NY: CMHS National GAINS Center.
- Pfammatter, M., Brenner, H. D., Junghan, U. M. & Tschacher, W. (2011). The importance of cognitive processes for the integrative treatment of persons with schizophrenia. *Schizophrenia Bulletin*, 37 (suppl 2), 1–4.

- Pfammatter, M., Junghan, U. M. & Brenner, H. D. (2006). Efficacy of psychological therapy in schizophrenia: Conclusions From meta-analyses. *Schizophrenia Bulletin*, 32, S1, S64–S80.
- Phelan, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., Strathdee, G., Loftus, L., McCrone, P., & Hayward P. (1995). The Camberwell Assessment of Need: the validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry*, 167, 5, 589-595.
- Phillips, S. D., Burns, B. J., Edgar, E. R., Mueser, K. T., Linkins, K. W., Rosenheck, R. A., ... Mc Donel Herr, E. C. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services*, 52, 6. 771-779.
- Piat, M., Sabetti, J., Couture, A., Sylvestre, J., Provencher, H., Botschner, J., & Stayner, D. (2009). What does recovery mean for me? Perspectives of Canadian mental health consumers. *Psychiatric Rehabilitation Journal*, 32, 3, 199–207.
- Pickett, K. E. & Wilkinson, R. G. (2015). Income inequality and health: A causal review. *Social Science & Medicine*, 128, 316-326.
- Pinkham, A. & Harvey, P. D. (2013). Future directions for social cognitive interventions in schizophrenia. *Schizophrenia Bulletin*, 39, 3, 499–500.
- Pitschel-Walz, G., Leucht, S., Bauml, J., Kissling, W. & Engel, R. R. (2001). The effect of family interventions on relapse and rehospitalization in schizophrenia - A meta-analysis. *Schizophrenia Bulletin*, 27, 1, 73-92.
- Pompili, M., Amador, X. F., Girardi, P., Harkavy-Friedman, J., Harrow, M., Kaplan, K., ... Tatarelli, R. (2007). Suicide risk in schizophrenia: Learning from the past to change the future. *Annals of General Psychiatry*, 6, 10.
- Pompili, M., Serafini, G., Innamorati, M., Lester, D., Shrivastava, A., Girardi, P., & Nordentoft, M. (2011). Suicide risk in first episode psychosis: A selective review of the current literature. *Schizophrenia Research*, 129, 1, 1-11.
- Power, K. (2005). Strategies for transforming mental health care through data-based decision making. *International Journal of Mental Health*, 34, 26–36.
- Pratt, C. W., Gill, K. J., Barrett, N. M., & Roberts, M. M. (2007). *Psychiatric Rehabilitation*. Burlington MA: Elsevier Academic Press.
- Pratt, S. I., Bartels, S. J., Mueser, K. T., & Forester, B. (2008). Helping older people experience success: An integrated model of psychosocial rehabilitation and health care management for older adults with serious mental illness. *American Journal of Psychiatric Rehabilitation*, 11, 1, 41–60. <http://dx.doi.org/10.1080/15487760701853193>
- Pratt, S. I. & Mueser, K. T. (2011). Schizophrenia. In: M. M. Anthony & D. H. Barlow (Eds.). *Handbook of Assessment and Treatment Planning for Psychological Disorders*, 2nd ed. New York: The Guilford Press.

- President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: Author.
- Pretia, A. & Cella, M. (2010). Randomized-controlled trials in people at ultra high risk of psychosis: A review of treatment effectiveness. *Schizophrenia Research*, 123, 1, 30–36.
- Primm, A. B., Vasquez, M. J. T., Mays, R. A., Sammons-Posey, D., McKnight, L. R., Presley-Cantrell, L. R., ... Perry, G. S. (2010). The role of public health in addressing racial and ethnic disparities in mental health and mental illness. *Preventing Chronic Disease Public Health Research, Practice, and Policy*, 7, 1, A20, 1–7.
- Prins, S. J. & Draper, L. (2009). *Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research Informed Policy and Practice.* New York, NY: Council of State Governments Justice Center.
- Prins, S. J. & Osher, F. C. (2009). *Improving Responses to People with Mental Illnesses: The Essential Elements of Specialized Probation Initiatives.* New York, NY: Council of State Governments Justice Center.
- Psych Central. (2016). *An Overview of Dialectical Behavior Therapy.* Retrieved on October 27, 2016, from <http://psychcentral.com/lib/an-overview-of-dialectical-behavior-therapy>.
- Puyat, J. H., Daw, J. R., Cunningham, C. M., Law, M. R., Wong, S. T., Greyson, D. L. & Morgan, S. G. (2013). Racial and ethnic disparities in the use of antipsychotic medication: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*, 48, 12, 1861–1872.
- Quinn, J. & Kolla, N. J. (2017). From Clozapine to cognitive remediation: A review of biological and psychosocial treatments for violence in schizophrenia. *The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie*, 62, 2, 94-101.
- Rabinowitz, J., Levine, S. Z., Garibaldi, G., Bugarski-Kirola, D., Berardo, C. G., & Kapur, S. (2012). Negative symptoms have greater impact on functioning than positive symptoms in schizophrenia: Analysis of CATIE data. *Schizophrenia Research*, 137, 1-3, 147-150.
- Ralph, R. O., Kidder, K., & Phillips, D. (2000). *Can We Measure Recovery? A Compendium of Recovery and Recovery-related Instruments.* Cambridge, MA: The Evaluation Center @ Human Services Research Institute.
- Rapp, C. A. & Goscha, R. J. (2011). *The Strengths Model: A Recovery-Oriented Approach to Mental Health Services*, 3rd ed. New York: Oxford University Press.
- Rector, N & Beck, A. T. (2001). Cognitive behavioral therapy for schizophrenia: An empirical review. *Journal of Nervous and Mental Disease*, 189, 278-287.
- Reinhard, S. C., Gubman, G. D., Horwitz, A. V., & Minsky, S. (1994). Burden assessment scale for families of the seriously mentally ill. *Evaluation and Program Planning*, 17, 261–269.

- Remington, G., Foussias, G., Fervaha, G., Agid, O., Takeuchi, H., Lee, J., & Hahn, M. (2016). Treating negative symptoms in schizophrenia: An update. *Current Treatment Options in Psychiatry*, 3, 133-150.
- Reuland, M., Schwarzfeld, M. & Draper, L. (2009). *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research Informed Policy and Practice*. New York, NY: Council of State Governments Justice Center.
- Ritsher, J. B., Otilingam, P. G., & Grajales, M. (2003). Internalized stigma of mental illness: Psychometric properties of a new measure. *Psychiatry Research*, 121, 31-49.
- Robins, C. S, Sauvageot, J. A., Cusack, K. J., Suffoletta-Maierle, S. & Frueh, B. C. (2005). Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. *Psychiatric Services*, 56, 1134-1138.
- Roder, V., Mueller, D. R. & Schmidt, S. T. (2011). Effectiveness of Integrated Psychological Therapy (IPT) for schizophrenia patients: A research update. *Schizophrenia Bulletin*, 37 (suppl 2), 71–79.
- Rog, D. J. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal*, 27, 334–344.
- Rog, D. J., Marshall, T., Dougherty, R. H., George, P., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Permanent supportive housing: Assessing the evidence. *Psychiatric Services*, 65, 3, 287–294.
- Rogers. E. S., Kash, M. & Olschewski, A. (2009). *Systematic Review of Supported Housing Literature 1993–2008*. Boston, MA: Boston University, Center for Psychiatric Rehabilitation.
- Rollnick, S., Butler, C. C., Kinnersley, P., Gregory, J., & Mash, B. (2010). Competent novice motivational interviewing. *BMJ*, 340: C1900, doi: 10.1136/bmj.c1900.
- Rollinson, R., Smith, B., Steel, C., Jolley, S., Onwumere, J., Garety, P. A., ... Fowler, D. (2008). Measuring adherence in CBT for psychosis: A psychometric analysis of an adherence scale. *Behavioural and Cognitive Psychotherapy*, 36, 2, 163-178.
- Rosen, K., & Garety, P. (2005). Predicting recovery from schizophrenia: A retrospective comparison of characteristics at onset of people with single and multiple episodes. *Schizophrenia Bulletin*, 31, 735–50.
- Rosenberg, S. D., Lu, W., Mueser, K. T., Jankowski, M. K. & Cournos, F. (2007). Correlates of adverse childhood events among adults with schizophrenia spectrum disorders. *Psychiatric Services*, 58, 245–253.
- Rosenberg, S. D., Mueser, K. T., Friedman, M. J., Gorman, P. G., Drake, R. E., Vidaver, R. M., ... Jankowski, M. K. (2001). Developing effective treatments for posttraumatic disorders among people with severe mental illness. *Psychiatric Services*, 52, 11, 1453-1461.
- Rosenhan, A. (1984). Race differences in involuntary hospitalization: Psychiatric vs. labeling perspectives. *Journal of Health and Social Behavior*, 25, 14–23.

- Rost, K., Hsieh, Y., Xu, S., Menachemi, N., & Young, A. S. (2011). Potential disparities in the management of schizophrenia in the United States. *Psychiatric Services*, 62, 6, 613–618.
- Rotter, M., McQuiston, H. L., Broner, N. & Steinbacher, M. (2005). The impact of the “Incarceration Culture” on re-entry for adults with mental illness: A training and group treatment model. *Psychiatric Services*, 56, 3, 265–267.
- Roy, L., Crocker, A. G., Nicholls, T. L., Latimer, E. A. & Ayllon, A. R. (2014). Criminal behavior and victimization among homeless individuals with severe mental illness: A systematic review. *Psychiatric Services*, 65, 6, 739-750.
- Rözer, J., Kraaykamp, G., & Huijts, T. (2016). National income inequality and self-rated health: The differing impact of individual social trust across 89 countries. *European Societies*, 18, 3, 245-263.
- Rush, B. & Koegl, C. J. (2008). Prevalence and profile of people with co-occurring mental and substance use disorders within a comprehensive mental health system. *The Canadian Journal of Psychiatry*, 53, 12, 810–821.
- Rubak, S., Sandbaek, A., Lauritzen, T. & Christensen, B. (2005). Motivational interviewing: A systematic review and meta-analysis. *British Journal of General Practice*, 55, 305 – 312.
- Rybarczyk, B. (2011). Social and Occupational Functioning Assessment Scale (SOFAS). (2011). *Encyclopedia of Clinical Neuropsychology*. New York, NY: Springer.
- Saakvitne, K., Gamble, S., Pearlman, S. & Tabor Lev, B. (2000). *Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse*. Brooklandville, MD: Sidran Institute.
- Sabbag, S., Twamley, E. W., Vella, L., Heaton, R. K., Patterson, T. L., & Harvey, P. D. (2012). Predictors of the accuracy of self assessment of everyday functioning in people with schizophrenia. *Schizophrenia Research*, 137, 190-195.
- Sabol, W. J. & Minton, T. D. (2008). *Jail Inmates at Midyear 2007*. Washington, DC: Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Saha, S., Chant, D., & McGrath, J. (2007). A systematic review of mortality in schizophrenia: Is the differential mortality gap worsening over time? *Archives of General Psychiatry*, 64, 1123–31.
- Salcedo, S., Gold, A. K., Sheikh, S., Marcus, P. H., Nierenberg, A. A., Deckersbach, T., & Sylvia, L. G. (2016). Empirically supported psychosocial interventions for bipolar disorder: Current state of the research. *Journal of Affective Disorders*, 201, 203-214.
- Saleebey, D. (Ed.). (2008). *The Strengths Perspective in Social Work Practice*, 5th ed. Boston: Allyn & Bacon.
- Salina, D. D., Lesondak, L. M., Razzano, L. A., & Weilbaeher, A. (2007). Co-occurring mental disorders among incarcerated women: Preliminary findings from an integrated health treatment study. *Journal of Offender Rehabilitation*, 45, 1-2, 207-225.

- Salisbury, E. J. & Van Voorhis, P. (2009). Gendered pathways: A quantitative investigation of women probationers' paths to incarceration. *Criminal Justice and Behavior*, 36, 541-566.
- Sanchez, P., Pena, J., Bengoetxea, E., Ojeda, N., Elizagarate, E., Ezcurra, J., Gutierrez, M. (2014). Improvements in negative symptoms and functional outcome after a new generation cognitive remediation program: A randomized controlled trial. *Schizophrenia Bulletin*, 40, 3, 707–715.
- Sareen, J., Cox, B. J., Goodwin, R. D. & Asmundson, G. J. G. (2005). Co-occurrence of posttraumatic stress disorder with positive psychotic symptoms in a nationally representative sample. *Journal of Traumatic Stress*, 18, 4, 1-10.
- Saxena, P., Messina, N., & Grella, C. E. (2014). Who benefits from gender responsive treatment? Accounting for abuse history on longitudinal outcomes for women in prison. *Criminal Justice and Behavior*, 41, 4, 417–432.
- Saxena, P., Grella, C. E., & Messina, N. P. (2016). Continuing care and trauma in women offenders' substance use, psychiatric status, and self-efficacy outcomes. *Women & Criminal Justice*, 26, 2, 99–121.
- Schizophrenia Working Group of the Psychiatric Genomics Consortium. (2014). Biological insights from 108 schizophrenia-associated genetic loci. *Nature*, 511, 421–427.
- Schneider, L. C., Struening, E. L. (1983). SLOF: A behavioral rating scale for assessing the mentally ill. *Social Work Research Abstracts*, 19, 9-21.
- Schooler, N., Hogarty, G., & Weissman, M. (1979). Social Adjustment Scale II (SAS-II). In W. A. Hargreaves, C. C. Atkisson, & J. E. Sorenson (Eds.), *Resource Materials for Community Mental Health Program Evaluations* (pp. 290-303). Rockville, MD: NIMH.
- Schroeder, S. A. & Morris, C. D. (2010). Confronting a neglected epidemic: Tobacco cessation for persons with mental illnesses and substance abuse problems. *Annual Review of Public Health*, 31, 297–314.
- Sciar, D. A., Robinson, L. M., Skaer, T. L. & Galin, R. S. (1999). Ethnicity and the prescribing of antipsychotic pharmacotherapy: 1992–1995. *Harvard Review of Psychiatry*, 7, 29–36.
- Sekar, A., Bialas, A. R. de Rivera, H., Davis, A., Hammond, T. R., Kamitaki, N., ... Handsaker, R. E. (2016). Schizophrenia risk from complex variation of complement component 4. *Nature* 530, 177–183.
- Shad, M. U., Keshavan, M. S., Tamminga, C. A., et al. (2007). Neurobiological underpinnings of insight deficits in schizophrenia. *International Review of Psychiatry*, 19, 4, 437–446.
- Shepherd, S. M., Adams, Y., McEntyre, E., & Walker, R. (2014). Violence risk assessment in Australian Aboriginal offender populations: A review of the literature. *Psychology, Public Policy, and Law*, 20, 3, 281-293.
- Shepherd, S. M. & Lewis-Fernandez, R. (2016). Forensic risk assessment and cultural diversity: Contemporary challenges and future directions. *Psychology, Public Policy, and Law*, 22, 4, 427-438.

- Shevlin, M., Dorahy, M. J. & Adamson, G. (2007). Trauma and psychosis: An analysis of the National Comorbidity Survey. *American Journal of Psychiatry*, 164, 166–169.
- Sikich, L. (2005). Psychotherapy and school interventions. In R. L. Findling & S. C. Schultz (Eds.). *Juvenile-onset Schizophrenia*. Baltimore, MD: Johns Hopkins University Press.
- Silverstein, S. M. (2000). Psychiatric rehabilitation of schizophrenia: Unresolved issues, current trends, and future directions. *Applied and Preventive Psychology*, 9, 227–248.
- Silverstein, S. M., Hatashita-Wong, M., Wilkniss, S., Bloch, A., Smith, T., Savitz, A. J. ... Terkelsen, K. (2006). Behavioral rehabilitation of the “treatment refractory” schizophrenia patient: Conceptual foundations, interventions, and outcome data. *Psychological Services*, 3, 145–169.
- Silverstein, S. M., Spaulding, W. D., Menditto, A. A., Savitz, A., Liberman, R. P., Berten, S. & Starobin, H. (2009). Attention shaping: A reward-based learning method to enhance skills training outcomes in schizophrenia. *Schizophrenia Bulletin*, 35, 222–232.
- Simpson, A. I. & Penney, S. R. (2011). The recovery paradigm in forensic mental health services. *Criminal Behaviour and Mental Health*, 21, 5, 299–306.
- Sinclair, J. M. A., Mullee, M. A., King, E. A. & Baldwin, D. S. (2004). Suicide in schizophrenia: A retrospective case-control study of 51 suicides. *Schizophrenia Bulletin*, 30, 4, 803–811.
- Siu, A. L. for the U.S. Preventive Services Task Force. (2015). Behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults, including pregnant women: U.S. Preventive Services Task Force recommendation statement. *Annals of Internal Medicine*, 163, 8, 622-634.
- Skeem, J. L., Manchak, S., & Peterson, J. K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior*, 35, 110-126.
- Slade, M. (2010). Mental illness and well-being: The central importance of positive psychology and recovery approaches. *BMC Health Services Research*, 10, 26.
- Smith, B. V., Simonian, N. M. & Yarussi, J. (2006). The health concerns of incarcerated women—Part 2: Communicable diseases and treatment issues. *Women, Girls & Criminal Justice*, 7, 49-64.
- Smith, R. J., Jennings, J. L., & Cimino, A. (2010). Forensic continuum of care with assertive community treatment (ACT) for persons recovering from co-occurring disabilities: Long-term outcomes. *Psychiatric Rehabilitation Journal*, 33, 3, 207-218.
- Smith, T. E., Abraham, M., Bivona, M., Brakman, M. J., Brown, I. S., Enders, G., ... Swinford, J. W. (2017). “Just be a light”: Experiences of peers working on acute inpatient psychiatric units. *Psychiatric Rehabilitation Journal*, 40, 4, 387-394.
- Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health*, 93, 2, 239-243.

- Snowden, L. & Pingatore, D. (2002). Frequency and scope of mental health service delivery to African Americans in primary care. *Mental Health Services Research*, 4, 123–130.
- Society for Research in Child Development. (2009). Report of Healthy development: A summit on young children's mental health: Partnering with communication scientists, collaborating across disciplines and leveraging impact to promote children's mental health. Washington, DC: Author.
- Spaulding, W. & Deogun, J. (2011). A pathway to personalization of integrated treatment: Informatics and decision science in psychiatric rehabilitation. *Schizophrenia Bulletin*, 37 (suppl 2), 129–137).
- Stafford, M. R., Jackson, H., Mayo-Wilson, E., Morrison, A. P., & Kendall, T. (2013). Early interventions to prevent psychosis: Systematic review and meta-analysis. *Bmj*, 346, f185.
- Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B. & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60, 761–765.
- Stein, L. L. & Test, M. A. (1980). Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, 37, 392-397.
- Stirman, S. W., Bhar, S. S., Spokas, M., Brown, G. K., Creed, T. A., Perivoliotis, D., ... Beck, A. T. (2010). Training and consultation in evidence-based psychosocial treatments in public mental health settings: The access model. *Professional Psychology: Research and Practice*, 41, 48–56.
- Strauss, J. S. (2014). Psychological interventions for psychosis: Theme and variations. *The American Journal of Psychiatry*, 171, 5, 479-481.
- Strauss, G. P., Horan, W. P., Kirkpatrick, B., Fischer, B. A., Keller, W. R., Miski, P., ... Carpenter, W. T. (2013). Deconstructing negative symptoms of schizophrenia: Avolition-apathy and diminished expression clusters predict clinical presentation and functional outcome. *Journal of Psychiatric Research*, 47, 6, 783-790.
- Stroul, B. A., & Friedman, R. M. (1986). A System of Care for Severely emotionally Disturbed Children & Youth. CASSP Technical Assistance Center, Washington, DC: Georgetown University Child Development Center.
- Substance Abuse and Mental Health Services Administration GAINS Center for Behavioral Health and Justice Transformation. (undated). Treatment of People with Co-occurring Disorders in the Justice System. Available at: <http://www.gainscenter.samhsa.gov/html/>
- Substance Abuse and Mental Health Services Administration. (2007). Homelessness. Rockville, MD: National Mental health Information Center.
- Substance Abuse and Mental Health Services Administration GAINS Center for Behavioral Health and Justice Transformation. (2011). Trauma-Specific Interventions for Justice-Involved Individuals. Available at: <http://www.gainscenter.samhsa.gov/html/>
- Sullivan, G., Han, X., Moore, S., & Kotrla, K. (2006). Disparities in hospitalization for diabetes among persons with and without co-occurring mental disorders. *Psychiatric Services*, 57, 1126–1131.

- Swanson, J. W., Swartz, M. S. & Elbogen, E. B. (2004). Effectiveness of atypical antipsychotic medications in reducing violent behavior among persons with schizophrenia in community-based treatment. *Schizophrenia Bulletin*, 30, 3-20.
- Swartz, H. A., Levenson, J. C., & Frank, E. (2012). Psychotherapy for bipolar II disorder: The role of interpersonal and social rhythm therapy. *Professional Psychology, Research and Practice*, 43, 2, 145–153.
- Sylvestre, J., Aubry, T., Smith, J. & Bridger, T. (2010). An evaluation of the implementation of a court outreach program for people with severe and persistent mental illness who are legally involved. *Canadian Journal of Community Mental Health*, 29 (Suppl. 5), 139-156.
- Szreter, S., & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology*, 33, 4, 650-667.
- Tandon, R., Keshavan, M. S. & Nasrallah, H. A. (2008). Schizophrenia, “Just the Facts”: What we know in 2008 part 1: Overview. *Schizophrenia Research*, 100, 4–19.
- Tapp, J., Perkins, D., Warren, F., Fife-Schaw, C. & Moore, E. (2013). A critical analysis of clinical evidence from high secure forensic inpatient services. *International Journal of Forensic Mental Health*, 12, 1, 68-82.
- Tapp, J., Warren, F., Fife-Schaw, C., Perkins, D. & Moore, E. (2013). What do the experts by experience tell us about 'what works' in high secure forensic inpatient hospital services? *Journal of Forensic Psychiatry and Psychology*, 24, 2, 160-178.
- Tarrier, N. (2007). Schizophrenia and other psychotic disorders. In D. Barlow (Ed.), *Clinical Handbook of Psychological Disorders: A Step-By-Step Treatment Manual* (pp. 463-491). New York: Guilford Press.
- Tauber, R., Wallace, C. J. & Lecomte, T. (2000). Enlisting indigenous community supporters in skills training programs for persons with severe mental illness. *Psychiatric Services*, 51, 1428-1432.
- Tempier, R., Balbuena, L., Garety, P. & Craig, T. J. (2012). Does assertive community outreach improve social support? Results from the Lambeth study of early episode psychosis. *Psychiatric Services*, 63, 3, 216–222.
- Teplin, L. (1984). Criminalizing mental disorder: The comparative arrest rate of the mentally ill. *American Psychologist*, 39, 794–803.
- Teplin, L. A. (2000). Keeping the peace: Police discretion and mentally ill persons. *National Institute of Justice Journal*, July, 8-15.
- Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, 148, 10-20.
- Tessler, R., & Gamache, G. (1996). *Toolkit for Evaluating Family Experiences with Severe Mental Illness*. Amherst, MA: The Evaluation Center at HSRI.

- Tew, J., Dixon, L., Harkins, L. & Benett, A. (2012). Investigating changes in anger and aggression in offenders with high levels of psychopathic traits attending the Chromis violence reduction programme. *Criminal Behaviour and Mental Health*, 22, 191–201.
- The National Coalition for the Homeless and the National Law Center on Homelessness & Poverty. (2002). *Illegal to be Homeless: The Criminalization of Homelessness in the United States*. Washington, DC: Authors.
- The Research Committee of the International Association of Psychosocial Rehabilitation Services. (1995). *The Psychosocial Rehabilitation Services Toolkit*. Columbia, MD: The Evaluation Center @ HSRI: Author.
- Thompson, M. (2011). Gender, race, and mental illness in the criminal justice system. *Corrections & Mental Health*, 1, 1, 1–8.
- Thompson, A. D., Nelson, B., Yuen, H. P., Lin, A., Amminger, G. P., McGorry, P. D., ... Yung, A. R. (2014). Sexual trauma increases the risk of developing psychosis in an ultra high-risk “prodromal” population. *Schizophrenia Bulletin*, 40, 3, 697–706.
- Thornicroft, G. (2011). Physical health disparities and mental illness: the scandal of premature mortality. *The British Journal of Psychiatry*, 199, 6, 441-442.
- Thornicroft, G. (2013). Premature death among people with mental illness. *British Medical Journal*, 346, Article F2969.
- Thornicroft, G., Brohan, E., Kassam, A. & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: Candidate interventions. *International Journal of Mental Health Systems*, April, 1–7.
- Tondora, J. (2011). *Person-centered Care: From Theory to Practice*. [Training curriculum and tools]. Available from: <http://www.ct.gov/dmhas/cwp/view.asp?a=2913&q=456036>.
- Tondora, J. & Davidson, L. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. Hartford, CT: Connecticut Department of Mental Health and Addiction Services.
- Torrey, W. C., Drake, R. E., Dixon, L., Burns, B. J., Flynn, L., A. J. Rush, ... Klatzker, D. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services*, 52,1, 45-50.
- Toussaint, L., Shields, G. S., Dorn, G., & Slavich, G. M. (2016). Effects of lifetime stress exposure on mental and physical health in young adulthood: How stress degrades and forgiveness protects health. *Journal of Health Psychology*, 21, 6, 1004-1014.
- Trauffer, N. & Spatz Widom, C. (2017). Child abuse and neglect, and psychiatric disorders in nonviolent and violent female offenders. *Violence and Gender*, 4, 4.
- Turner, D. T., van der Gaag, M., Karyotaki, E. & Cuijpers, K. (2014). Psychological interventions for psychosis: A meta-analysis of comparative outcome studies. *The American Journal of Psychiatry*, 171, 5, 523–538.

- U.K. National Collaborating Centre for Mental Health. (2006). Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care. National Clinical Practice Guideline No. 38. Leicester, U.K.: The British Psychological Society & The Royal College of Psychiatrists.
- U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services and National Institutes of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health and Human Services. (2012). Principles of Drug Abuse Treatment for Criminal Justice Populations. Rockville, MD: National Institute on Drug Abuse.
- U.S. Department of Veterans Affairs and U.S. Department of Defense. (2010). VA/DoD Clinical Practice Guideline for The Management of Post-Traumatic Stress. Version 2.0, available from the National Center for PTSD.
- U.S. Government Accountability Office. (2007). Poverty in America: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions as well as the Economic Growth Rate. Washington, DC: Author.
- Van Dijk, S., Jeffrey, J., & Katz, M. R. (2013). A randomized, controlled, pilot study of dialectical behavior therapy skills in a psychoeducational group for individuals with bipolar disorder. *Journal of Affective Disorders*, 145, 3, 386-393.
- Van Dorn, R. A., Desmarais, S. L., Petrila, J., Haynes, D., & Singh, J. P. (2017). Effects of outpatient treatment on risk of arrest of adults with serious mental illness and associated costs. *Psychiatric Services*, 64, 9, 856-862.
- van Erp, N., Femke, M., Giesen, M., van Weeghel, J., Kroon, H., Michon, H. W. C., ... Drake, R. E. (2007). A multisite study of implementing supported employment in the Netherlands. *Psychiatric Services*, 58, 11, 1421–1426.
- van Gestel-Timmermans, H., Brouwers, E. P., van Assen, M. A., & van Nieuwenhuizen, C. (2012) Effects of a peer-run course on recovery from serious mental illness: A randomized controlled trial. *Psychiatric Services*, 63, 54–60.
- Varese, F., Smeets, F., Drukker, M., Lieveerse, R., Lataster, T., Viechtbauer, W., ... Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective and cross-sectional cohort studies. *Schizophrenia Bulletin*, 38, 4, 661–671.
- Vaughan, G. & Hansen, C. (2004). Like minds, like mine: A New Zealand project to counter the stigma and discrimination associated with mental illness. *Australian Psychiatry*, 12, 113–117.

- Venters, H. & Keller, A. S. (2012). Diversion of patients with mental illness from court-ordered care to immigration detention. *Psychiatric Services*, 63, 4, 377–379.
- Ventura J., Lukoff, D., Nuechterlein, K. H., Liberman, R. P., Green, M., Shaner, A. (1993). Appendix 1: Brief Psychiatric Rating Scale (BPRS) Expanded version (4.0) scales, anchor points and administration manual. *International Journal of Methods in Psychiatric Research*, 3, 227–244.
- Ventura, J., Reise, S. P., Keefe, R. S., Hurford, I., Wood, R., Bilder, R. (2013). The Cognitive Assessment Interview (CAI): Reliability and validity of a brief-based measure of cognition. *Schizophrenia Bulletin*, 39, 3, 583–591.
- Walker, A. M., Klein, M. S., Hemmens, C., Stohr, M. K., & Burton, V. S. (2016). Further examination of the rights lost by the mentally ill and mentally incompetent. *Community Mental Health Journal*, 52, 3, 272–280.
- Walkup, J. T., McAlpine, D. D., Olfson, M., Labay, L. E., Boyer, C. & Hansell, S. (2000). Patients with schizophrenia at risk for excessive dosing. *Journal of Clinical Psychiatry*, 61, 344–348.
- Wallace, C. J., Lecomte, T., Wilde, J. & Liberman, R. P. (2001). Client Assessment of Strengths Interests and Goals (CASIG): A consumer-centered assessment for planning individualized treatment and evaluating program outcomes. *Schizophrenia Research*, 50, 105–119.
- Wallace, C., Mullen, P., Burgess, P., Palmer, S., Ruschena, D., & Browneet, C. (1998). Serious criminal offending and mental disorder: Case linkage study. *British Journal of Psychiatry*, 172, 477–484.
- Walter, F., Carr, M. J., Mok, P. L., Astrup, A., Antonsen, S., Pedersen, C. B., ... & Webb, R. T. (2017). Premature mortality among patients recently discharged from their first inpatient psychiatric treatment. *JAMA psychiatry*, doi:10.1001/jamapsychiatry.2017.0071.
- Wang, P. S., Berglund, P. & Kessler, R. C. (2001). Recent care of common mental disorders in the United States. *Journal of General Internal Medicine*, 15, 284–292.
- Wang, P. S., Demler, O. & Kessler, R. C. (2002). Adequacy of treatment for serious mental illness in the United States. *American Journal of Public Health*, 92, 92–98.
- Watkins, K., Hunter, S., Wenzel, S., Tu, W., Paddock, S. M., Griffin, A., & Ebener, P. (2004). Prevalence and characteristics of clients with co-occurring disorders in outpatient substance abuse treatment. *American Journal of Drug and Alcohol Abuse*, 30, 4, 749-764.
- Weber, M. & Wyne, K. (2006). A cognitive/behavioral group intervention for weight loss in patients treated with atypical antipsychotics. *Schizophrenia Research*, 83, 95–101.
- Wenzel, S. L., Koegel, P. & Gelberg, L. (2000). Antecedents of physical and sexual victimization among homeless women: A comparison to homeless men. *American Journal of Community Psychology*, 28, 367-390.
- Wetherell, J. L. & Jeste, D. V. (2004). Older adults with schizophrenia. *Elder Care*, 3. 2. 8-11.
- Whitley, R. & Lawson, W. B. (2010). The psychiatric rehabilitation of African Americans with severe mental illness. *Psychiatric Services*, 61, 508–511.

- Wilk, C. M., Gold, J. M., Humber, K., Dickerson, F., Fenton, W. S. & Buchanan, R. W. (2004). Brief cognitive assessment in schizophrenia: normative data for the Repeatable Battery for the Assessment of Neuropsychological Status. *Schizophrenia Research*, 70, 2-3, 175-186.
- Wilkinson, G., Hedson, B., Wild, D., Cookson, R., Farina, C., Sharma, V., ... Jenkinson, C. (2000). Self-report quality of life measure for people with schizophrenia: The SQLS. *British Journal of Psychiatry*, 177, 42–46.
- Williams, D. R. & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*, 32, 1, 20.
- Williams, E., Ferrito, M. & Tapp, J. (2014). Cognitive-behavioural therapy for schizophrenia in a forensic mental health setting. *Journal of Forensic Practice*, 16, 1, 68-77.
- Wilson, F. R. (2004). Ecological psychotherapy. In R. K. Conyne & E. P. Cook (Eds.). *Ecological Counseling: An Innovative Approach to Conceptualizing Person-Environment Interaction*. Alexandria, VA: American Counseling Association.
- Wolff, N., Blitz, C. L., & Shi, J. (2007). Rates of sexual victimization in prison for inmates with and without mental disorders. *Psychiatric Services*, 58, 8, 1087-1094.
- Wolff, N., Frueh, B. C., Shi, J., & Schumann, B. E. (2012). Effectiveness of cognitive-behavioral trauma treatment for incarcerated women with mental illnesses and substance abuse disorders. *Journal of Anxiety Disorders*, 26, 703-710.
- Wong, K. K., Chiu, R., Tang, B., Mak, D., Liu, J., & Chiu, N. (2008). A randomised controlled trial of a supported employment program for persons with long-term mental illness in Hong Kong. *Psychiatric Services*, 59, 1, 84–90.
- World Health Organization. (Undated). Information sheet: Premature death among people with severe mental illness. Geneva, Switzerland: Author.
- World Health Organization. (2001). *World Health Report, 2001. Mental Health: New Understanding, New Hope*. Geneva, Switzerland: Author.
- World Health Organization. (2002). *World report on violence and health*. Geneva, Switzerland: Author.
- Wright, E. M., Van Voorhis, P., Salisbury, E. J., & Bauman, A. (2012). Gender-responsive lessons learned and policy implications for women in prison. *Criminal Justice and Behavior*, 39, 1612-1632.
- Wu, M. K., Wang, C. K., Bai, Y. M., Huang, C. Y., & Lee, S. D., (2007) Outcomes of obese Clozapine-treated inpatients with schizophrenia placed on a six-month diet and physical activity program. *Psychiatric Services*, 58, 4, 544–550.
- Wu, R. R., Zhao, J. P., Jin, H., Fang, S. P., Guo, X. F., He, Y.Q., ... Li, L. H. (2008). Lifestyle interventions and Metformin for treatment of antipsychotic-induced weight gain: A randomized controlled trial. *Journal of the American Medical Association*, 299, 185–193.

- Wunderlink, L., Nieboer, R. M., Wiersma, D., Sytema, S. & Nienhuis, F. J. (2013). Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy: Long-term follow-up of a 2-year randomized clinical trial. *JAMA Psychiatry*, 70, 9, 913–920.
- Wyatt, R. J. & Hunter, I. (2001). Rationale for the study of early intervention. *Schizophrenia Research*, 51, 69–76.
- Wyatt, G. E., Myers, H. F., Williams, J. K., Kitchen, C. R., Loeb, T., Carmona, J. V., & Presley, N. (2002). Does a history of trauma contribute to HIV risk for women of color? Implications for prevention and policy. *American Journal of Public Health*, 92, 660–665.
- Wykes, T., Huddy, V., Cellard, C., McGurk, S. R., & Czobor, P. (2011). A meta-analysis of cognitive remediation for schizophrenia: Methodology and effect sizes. *American Journal of Psychiatry*, 168, 5, 472–485.
- Wykes, T., Reeder, C., Landau, S., Everitt, B., Knapp, M., Patel, A., & Romeo, R. (2007). Cognitive remediation therapy in schizophrenia. *The British Journal of Psychiatry*, 190, 421–427.
- Wykes, T., Steel, C., Everitt, B. & Tarrier, N. (2008). Cognitive behavior therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin*, 34, 3, 523-537.
- Wykes, T. & Sturt, E. (1986). The measurement of social behaviour in psychiatric patients: An assessment of the reliability and validity of the SBS schedule. *British Journal of Psychiatry*, 148, 1–11.
- Yale Program for Recovery and Community Health. Recovery Self-Assessment (RSA)
https://medicine.yale.edu/psychiatry/prch/tools/rec_selfassessment.aspx
- Yanos, P. T., Lucksted, A., Drapalski, A. L., Roe, D., & Lysaker, P. (2015). Interventions targeting mental health self-stigma: A review and comparison. *Psychiatric Rehabilitation Journal*, 38, 171–178.
- Yanos, P. T., Roe, D., & Lysaker, P. H. (2010). The impact of illness identity on recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation*, 13, 2, 73–93.
- Young, S. L., & Bullock, W. A. (2003). *The Mental Health Recovery Measure*. University of Toledo, Dept. of Psychology, Toledo OH: author.
- Young, A. S., Klap, R., Sherbourne, C. D. & Wells, K. B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*, 58, 55–61.
- Yung, A. R., Woods, S. W., Ruhrman, S., Addington, J., Schultze-Lutter, F., Cornblatt, B. A. ... McGlashan, T. H. (2012). Whither the attenuated psychosis syndrome? *Schizophrenia Bulletin*, 38, 6, 1130-1134.
- Yung, A. R., Yuen, H. P., McGorry, P. D., Phillips, L. J., Kelly, D., Dell'Olio, M., ... Buckby, J. (2005). Mapping the onset of psychosis: the Comprehensive Assessment of At-Risk Mental States. *Australian and New Zealand Journal of Psychiatry*, 39, 11-12, 964-971.

Zarit, S., Reever, K., & Bach-Peterson, J. (1980). Relatives of the impaired elderly: Correlates of feelings of burden. *The Gerontologist*, 20, 649-655.

Zimmerman, G., Favrod, J., Trieu, V. H. & Pomini, V. (2005). The effect of cognitive behavioural treatment on the positive symptoms of schizophrenia spectrum disorders: A meta-analysis. *Schizophrenia Research*, 77, 1-9.

Zlotnick, C., Johnson, J. & Najavits, L. M. (2009). Randomized controlled pilot study of cognitive-behavioral therapy in a sample of incarcerated women with substance use disorder and PTSD. *Behavior Therapy*, 40, 4, 325-336.

Criterion VII. Structures and Models of Education and Training in the Specialty

The specialty has structures and models to implement the education and training sequence of the specialty. The structures are stable, sufficient in number, and geographically distributed. Specialty education and training may occur at the doctoral, postdoctoral, or both.

Commentary:

A) Sequence of Training. *A petition describes a typical sequence of training, including curriculum, research, and supervision.*

B) History and Geographic Distribution. *A specialty has at least four identifiable psychology programs providing education and training in the specialty in more than one region of the country that are geographically distributed and which have produced an identifiable body of graduates over a period of years.*

C) Psychology Faculty. *Specialty programs have an identifiable psychology faculty responsible for the education and, training of students and their socialization into the specialty. The faculty has expertise relevant to the education and training offered. Faculty may include individuals from other disciplines as appropriate. Specialty programs also have a designated psychologist who is clearly responsible for the integrity and quality of the program and who has administrative authority commensurate with those responsibilities. This psychologist has credentials of excellence (e.g., the diplomate from one of the specialty boards affiliated with the American Board of Professional Psychology, or status as a fellow of the American Psychological Association or the Canadian Psychological Association, or other evidence of equivalent professional recognition) and a record of scholarly productivity as well as other clear evidence of professional competence and leadership.*

D) Procedures for Evaluation. *Specialty programs regularly monitor the progress of trainees to ensure the relevance and adequacy of the curriculum and integration of the various training components. Attention focuses on the continuing development of the trainee's knowledge, skills, attitudes, and values. Formal performance based feedback is provided to trainees in the program.*

E) Admission to the Program. *Program descriptions specify the nature and content of the program and whether they are designed to satisfy current licensing and certification requirements for psychologists as well as whether or not graduates can satisfy the education and training requirements for advanced recognition in the specialty. Postdoctoral programs have procedures that take into account the trainees' prior academic and professional record. These programs design an education and training experience that builds upon the doctoral program and internship and the professional experiences of the postdoctoral residents as they prepare for meeting the guidelines of preparation for the specialty.*

1. How are education and training programs in the specialty recognized? How many programs exist in the specialty?

Since this is a petition for initial recognition of this post-doctoral Specialty area, there are no existing training programs that are recognized by APA as a Specialty in this area. However, there are some accredited doctoral and internship programs (primarily in clinical and counseling) that provide training in this area of specialization; these are not the focus of this petition but do indicate growth of the Specialty, evidenced by increased interest in, and recognition of the importance of, the Specialty area of training. Additionally, we know that approximately 60% of graduates from post-doctoral residencies in this Specialty secured employment in the field (Stacy, Klee & Jansen, 2018) and based on an informal national survey, the national average falls between 50 – 60 percent. As we indicated earlier in the petition, the terms psychosocial rehabilitation and/or psychiatric rehabilitation (PSR) are interchangeable.

These practices are specific to the population under consideration in this Specialty. In other words, the identified evidence-based PSR practices are those that have been developed and found effective specifically for the population of persons with SMI/SED. While some programs highlight SMI in their official titles, others refer to themselves as PSR programs, but these are equivalent in their focus in this Specialty.

With regard to post-doctoral training, there are an increasing number of post-doctoral residencies in this area; these programs are not officially recognized as a Specialty in this area because that recognition does not currently exist. In addition to the four model programs provided in response to question 7 of this Criterion, we have listed some other post-doctoral programs in the Specialty at the end of this question 1.

As we discussed in Criterion II, NIMH and several eminent psychologists have called attention to the need for specialized training to treat persons with SMI/SED since the 1990s and current psychologists continue to do so (Carr, Bhagwat, Miller, & Ponce, 2014; Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Hargrove, 1990; Klee, et al., 2016; National Institute of Mental Health, 1990; Mueser, Silverstein, & Farkas, 2013; Stacy, Klee, & Jansen, 2018). Despite this, the number of programs offering training in this area of specialization is relatively small but growing. We speculate about the major reasons for the small number of existing programs below.

Firstly, a 2010 survey of training directors of CUDCP clinical psychology programs found that more than half of the training directors believed the factor that most discouraged training in this area is that psychologists prefer “clients with ‘insight and motivation for treatment” (Reddy, et al, 2010, p. 259), further reinforcing the stereotypical beliefs that people with SMI/SED have no insight and are not motivated for treatment – beliefs that are inevitably passed on to trainees.

The concept of recovery from severe mental illnesses such as schizophrenia, schizoaffective disorders, bipolar disorder, and other illnesses severe enough to include psychotic episodes in their symptomatology, was foreign to most mental health providers until the mid-1970s. Psychologists and other providers generally believed that individuals with SMI/SED would be chronically ill and would not be able to function in society – and many still hold these beliefs (Charles, 2013; Stuber, Rocha, Christian, & Link, 2014). The fact is that despite the long held and pervasive beliefs about the deteriorating course of SMI/SED, several meta analyses and summaries of well conducted studies have been published and all continue to document that many individuals with SMI/SED can, and do recover from the effects of their illness (Warner, 2010), and indeed have the potential to achieve long-term remission and functional recovery (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harding, Zubin, & Strauss, 1987; President’s New Freedom Commission on Mental Health, 2003; Zipursky, Reilly & Murray, 2012).

Secondly, until very recently, few psychologists had the specialized expertise needed to work with people who have SMI/SED. Many psychologists do not feel prepared to treat those with SMI/SED and are uncomfortable doing so (Buck, Romeo, Olbert, & Penn, 2014) because most do not fully understand the underlying concepts nor do they have the skills to use the evidence-based and promising practices needed to treat people with SMI/SED effectively (Mueser, 2012). This is because most training programs provide training in traditional methods of working with the population – methods that were not designed and evaluated specifically for this population and for the most part, have not been demonstrated to be effective. Aspiring psychologists are trained by mentors, i.e., faculty members who have existing areas of specialization and research that are often well funded and well publicized. Many of these mentors were trained before the advent of the recovery paradigm and the development of specialized PSR interventions and they themselves often know little about how to help people with these serious illnesses regain their full functional capacity (Mueser, et al., 2013). These mentors and by extension, their trainees, are reluctant to work with those with SMI/SED resulting in little exposure to the population, perhaps because, as we mentioned above, most believe that persons with SMI/SED will be chronically ill with little chance of recovery (Corrigan, et al., 2001). The effect is transgenerational, i.e., trainees have been taught traditional methods and when these trainees become trainers, they teach the next generation of

trainees the same methods they were taught, often passing on the pessimism seen about the recovery potential of persons with these disorders (Slade, 2010). Ongoing mentorship and support are also needed but without a larger pool of mentors, this is difficult to achieve (Drake, Mueser, & Brunette, 2007). As a result, most psychologists continue to be unprepared to provide the interventions that are most helpful to people with these illnesses, i.e., those interventions that can help people live successful lives in the community (Reddy, Spaulding, Jansen, Menditto, & Pickett, 2010; Roe, Yanos, & Lysaker, 2006; Rollins & Bond, 2001).

We also know that in addition to Specialized didactic and experiential training, “To achieve client change, it is necessary for therapists to reach proficiency levels in knowledge, adherence, competence, and skill. This perspective speaks to the importance of training therapists to criteria prior to implementing treatments” (Beidas & Kendall, 2010, p. 20), and that ongoing mentorship and support are needed (Beidas & Kendall, 2010; Drake, et al., 2007). Similarly to the paucity of mentors in doctoral or post-doctoral training programs, there are few practicum, internship, and residency programs that have supervisors who themselves have been trained and or have sufficient experience in the newer intervention methods to provide the level of supervision needed for trainees to become skilled in the provision of these services. Knowing how to implement the concepts and having the ability to appropriately use the proper interventions are skills that continue to be foreign to most psychologists (Mueser, 2012). Thus, while doctoral or internship programs may provide exposure to, or some experience with the SMI/SED population, specialized, concentrated post-doctoral training as a Major Area of Study is needed if psychologists are to feel comfortable and competent to treat the SMI/SED population.

Thirdly, many currently practicing psychologists believe that existing clinical psychology or counseling psychology training programs are teaching what is needed to work with this population. This is especially true if the program indicates that it offers training in serious mental health disorders, as some currently accredited programs do. We can see from the websites of APA accredited doctoral and post-doctoral programs that relatively few mention SMI/SED, but among those that do, most of the topics covered and the discussion of those topics center on highly traditional models of diagnosis and treatment according to traditional methods. Very few include any mention of the newer evidence-based interventions or the increasingly accepted, recovery paradigm. Most psychologists continue to be trained to arrive at a diagnosis and provide traditional mental health treatment, i.e., medications, psychotherapy, etc. (Mueser, et al., 2013). While these may be of some assistance, they are not sufficient to help those with SMI/SED overcome the functional deficits caused by their illness and learn to live successfully in the community. According to Corrigan, et al. (2001), “students in some psychological training programs learn projective testing and psychodynamic therapy techniques (Corrigan, 1995; Corrigan, Hess, & Garman, 1998), neither of which has been shown to be useful in treating disabilities among people with serious mental illness (Mueser & Berenbaum, 1990)” (Corrigan, et al., 2001, p 1599-1600). In order to work effectively with people with these conditions, psychologists must not only recognize the symptoms of the disorder and be able to correctly diagnose each person, but they must also recognize and understand the unique aspects of these illnesses and the challenges faced by those with them, including additional challenges that may co-exist or interact with the primary disorder. Factors such as co-occurring physical and or mental health conditions, gender identity/preference concerns, socioeconomic status, homelessness, and stigma can affect the behaviors and needs of an individual and can affect the way others, including health and mental health professionals, respond to them.

The comment from training directors presented above is at odds with the growing interest among trainees and early career psychologists in knowing how to better assess and treat people with SMI and SED (evidenced in part by very well attended [primarily by younger attendees] APA convention sessions on topics related to SMI/SED) and may be reflective of the training directors' thoughts rather than those of trainees. These results and the continuing dearth of training in EBPs and functional assessment methods have led to the following call to action:

Professional organizations overseeing the training and licensure of clinical psychologists in the

United States, starting with American Psychological Association (APA) as the most influential such organization, should make a public commitment to increasing the competence of the workforce treating individuals with serious mental illness by mandating training for all students in APA approved clinical psychology programs. Such mandated training is a moral imperative incumbent upon our professional responsibilities to society based on the existing need of this population and the emergence of effective interventions to meet the need. In addition, such required training is economically strategic in light of trends in health care policy suggesting a potentially expanded role for psychologists, as the funding of health care moves toward demanding greater accountability for the delivery of evidence based services to persons with a serious mental illness (Mueser, et al., 2013, p. 54).

Lastly, since the area is not yet an APA recognized specialty, programs may be reluctant to offer or advertise training in an area not officially recognized as a specialty for fear that doing so might put their accreditation in jeopardy. Although this should not happen unless training became sub-standard or outside the purview of post-doctoral training in psychology, this is a stated reason of some programs. Currently accredited clinical and or counseling psychology programs may be waiting for the Specialty in SMI Psychology to achieve recognition before developing a post-doctoral Major Area of Study Specialty in SMI/SED.

It may be worth citing a quote from a 2005 APA Monitor article by Karen Kersting:

A growing number of psychology training programs are homing in on the treatment of serious mental illness--an area where relatively few psychologists are specialized despite evidence that their psychosocial interventions boost recovery rates.

“It’s vitally important that psychologists play a much more prominent role in the care of people with serious mental illness,” says APA President Ronald F. Levant, EdD. “Outside the U.S. Department of Veterans Affairs and public care systems, there are actually very few psychologists involved.”

However, there are signs of progress. Several pre-and postdoctoral training programs have popped up and sharpened their focus, Levant notes. Yale University, Nova Southeastern University in Florida and the University of Maryland at College Park are examples of institutions preparing new psychologists to be a vital part of SMI rehabilitation. (Kersting, 2005, p. 42).

Additional evidence for the need for specially trained psychologists comes from Mueser, Silverstein, & Farkas, (2013):

In an article on multidisciplinary teamwork for psychiatric rehabilitation, Liberman and colleagues (2001) suggested that psychologists are qualified to deliver more of the appropriate interventions for this population than any other discipline. Given that nearly all best practices were developed by psychologists, that these reflect basic psychological principles, and that even other disciplines have recognized the expertise psychologists have in working with people with a serious mental illness, it is not unreasonable to speculate that further infusion of psychologists into the field of psychosocial treatment and rehabilitation would lead to the further development of effective interventions and to improved outcomes. (p. 56).

With the above in mind, in addition to those listed under question 7, examples of other APA accredited programs offering post-doctoral Specialized training with a Major Area of Study in SMI Psychology include:

- Harbor UCLA Assertive Community Treatment/Corrections, Los Angeles, CA
- Central Arkansas VA Healthcare System, Little Rock, AR
- Alpert Medical School of Brown University Recovery Program, Providence, RI

- Institute of Living / Hartford Hospital Residency, Hartford, CT
- VA Long Beach Healthcare System, Long Beach, VA
- Miami VA Healthcare System, Miami FL
- Louis Stokes Cleveland VA Medical Center, Cleveland, OH
- Puget Sound VA Health Care System, Seattle, WA
- University of Oklahoma, Oklahoma City, OK
- VA Palo Alto Healthcare System, Palo Alto, CA
- Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA
- Durham VA Medical Center, Durham, NC
- University of Michigan / VA Serious Mental Illness Treatment, Research and Evaluation Center, Ann Arbor, MI

2. Describe the qualifications necessary for faculty who teach in these programs. Describe the qualifications required for the director of such programs.

Core faculty who teach in a clinical area of a post-doctoral residency program in SMI Psychology must be licensed in their respective discipline (e.g., psychology, psychiatry, occupational therapy, nursing, social work, etc.), or if in the process of becoming licensed, they must be directly supervised by a licensed practitioner in their discipline. All teaching faculty should have training, experience, or exposure in the area of SMI/SED and have expertise in the specific courses or areas in which they are teaching. Faculty who are not yet fully qualified would not qualify as core faculty but they too should have some training and experience, although may be continuing their learning experiences.

Faculty who teach in the research component of the program do not have to be licensed but should also have experience in the area of SMI/SED and would typically be affiliated with an active SMI/SED research program. In model programs, licensed research faculty would also engage with individuals with SMI/SED in a clinic or other setting.

Directors of Training may oversee several training programs including those in this area of specialization. They should be experienced psychologists who have advanced academic and experiential qualifications such as an ABPP, Fellow status in APA, other recognized status in APA, ABPP, APPIC, certification from the Psychiatric Rehabilitation Association (CPRP), or similar recognition of their advanced qualifications. Where the program is university affiliated, they should have an academic appointment and be active in the university program. While they may not have direct experience or expertise in SMI/SED (if they oversee programs in addition to those in this Specialty), they should have familiarity and a working knowledge of the principles and practices in the field and be able to provide oversight and guidance to faculty.

3. If programs are doctoral level, what are the requirements for admission? Provide sample evaluation forms.

NA

4. If programs are postdoctoral, what are the requirements for admission? Provide sample evaluation forms.

In accord with APA's Standards of Accreditation for Health Service Psychology (American Psychological Association, Commission on Accreditation, 2015), (downloaded from APA website December, 2017):

- i. The program has procedures for resident selection that ensure residents are appropriately prepared for the training offered.

ii. At the initiation of training, residents will have completed doctoral and internship training in programs accredited by an accrediting body recognized by the U.S. Secretary of Education or by the Canadian Psychological Association. If the program accepts residents who attended unaccredited programs, the residency must describe how the program ensures that selected residents are otherwise qualified and appropriately prepared for advanced training in the residency program. (p. 38).

Accordingly, residency programs are advised to ensure that residents have completed doctoral and internship training that meets these requirements.

Applicants for post-doctoral residency programs in SMI Psychology must have completed a doctoral degree and training in health service psychology or appropriate re-specialization, either of which must have included the completion of an appropriate internship. At the initiation of the residency program, residents will have completed doctoral and internship training in programs accredited by an accrediting body recognized by the U.S. Secretary of Education or by the Canadian Psychological Association (CPA). If the program accepts residents who attended unaccredited programs, the residency must describe how the program ensures that selected residents are otherwise qualified and appropriately prepared for advanced training in this Specialty.

Post-doctoral residency programs in SMI/SED require official transcripts from the doctoral or re-specialization program and from the internship program, a cover letter indicating previous clinical experience with persons with SMI/SED or in settings where persons with SMI/SED are seen, commitment to a career working with those diagnosed with SMI/SED, statement of future goals as they relate to SMI/SED, letters of recommendation, and the applicant's CV. Programs may also have other requirements such as submission of a work sample, etc.

Please Note: Sample admission evaluation forms and guiding questions specific to SMI Psychology post-doctoral residency programs are provided at the end of this criterion narrative. These sample forms were provided by the post-doctoral programs listed under question 7 of this criterion; each form identifies the program from which it came. Programs should ensure their forms comply with current guidance and requirements from APA.

5. Include or attach education and training guidelines, for this specialty as appropriate for doctoral training, postdoctoral training, or both. (In this context, education and training guidelines may be found in documents or websites including, but not limited to, those bearing such a title or as described in a variety of published textbooks, chapters, and/or articles focused on such contents.)

The Education and Training Guidelines for this Specialty are attached as Appendix I and are also available on the Specialty Council's website (www.psychtrainingsmi.com).

6. Provide sample curriculum expected of model programs.

Post-doctoral residency training in the SMI Psychology Specialty is based on a Major Area of Study with at least 80% of time fully dedicated to learning about SMI/SED and providing clinical services to persons with SMI/SED. The curriculum encompasses clinical experiences, didactic training, supervision, and related experiences with graduated levels of responsibility leading to competency and the ability to function autonomously.

Training in a Major area of Study in an SMI Psychology Specialty program must integrate both knowledge and practice to be useful. Practice training for post-doctoral residents in this Specialty occurs in several main areas: primary and secondary placements, seminars, didactics, research, supervision, consultation, teaching, and administration. While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training experiences should exist

across all programs. Training in an SMI Psychology Specialty program must integrate both knowledge and practice to be useful. Applications of cultural knowledge acquired in the classroom take place during practice training experiences. Thus, diversity training when working with the SMI/SED population is primarily practical and applied, with cultural competence defined as a foundational competency. In addition to participation in the diversity seminar, fellows should receive clinical training in sites which serve 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.

A detailed explanation of the residency including clinical, research, didactic, supervision, teaching, etc., is provided in Criterion V. Please also see the Training Guidelines included as Appendix I and also present on the Specialty Council website (www.psychtrainingsmi.com).

Following is a listing of topics and experiences to be included in model post-doctoral residency programs in SMI Psychology. Additional details and the scientific bases for residency training and the didactic topics included can be found in Criteria V.

Didactic information presented in seminars, workshops, other training experiences with information, discussion, and supervision that form the scientific basis for understanding the problems faced by those with SMI/SED and developing competency to assist those individuals as they work to ameliorate those problems:

- Principles of PSR
- Research / Program Evaluation and Dissemination
- Interprofessional Case Assessment
- Assessments and Interventions specific to SMI/SED
- Goal Setting and Treatment Planning
- Implementation and Dissemination Strategies Specific to SMI/SED Interventions
- Etiology / epidemiology
- Physical health/common health problems/health behaviors
- Co-occurring conditions (substance use, trauma, suicidality, personality disorders)
- Psychopharmacology for SMI/SED (medications, side effects / iatrogenic effects of treatment, treatment adherence)
- History/community advocacy/other issues
- Systems Change
- Diversity
- Laws and Ethics
- Consultation
- Teaching and Supervision
- Supervision Meetings
- Professional Development

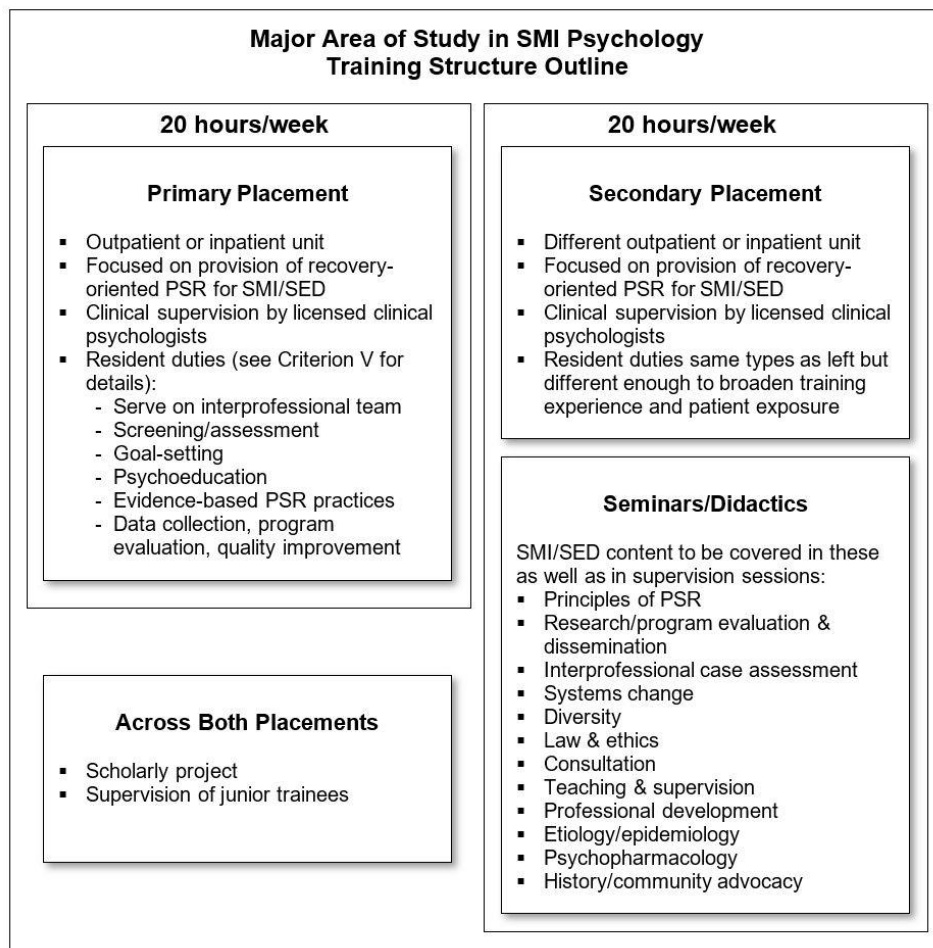
Clinical placements, where the concepts of the didactic components of the residency are realized in practice, including:

- Individualized assessment/re-assessment to include: intakes, diagnostic clarifications, cognitive

screening, functional assessment, rehabilitation readiness assessment, etc., and recovery/treatment planning;

- Evidence-based and promising practices such as: family psychoeducation, assertive community treatment, supported education and supported employment particularly the individual placement and support model, CBT for psychosis (CBTp), co-occurring disorders treatment, social cognition and cognitive remediation, early intervention and PSR treatments for recent onset psychosis, cognitive behavioral social skills training (CBSST), cognitive enhancement therapy, trauma informed and trauma specific care, illness management, issues and interventions for those in criminal justice and forensic settings, among others;
- Individual or group psychotherapy such as: intensive case management, anger management skills, relationship skills, interpersonal psychotherapy, weight and smoking interventions, and solution-focused approaches including Wellness Recovery Action Planning (WRAP), etc.;
- Community integration skills including: interviewing skills, leisure/recreation skills, finding and retaining housing, practice applying the skills learned or developed in groups; working with community partners.

A short table depicting the major areas of training for the SMI Psychology Specialty is below:



Source: Dimitri Perivoliotis, Ph.D., UCSD San Diego / VA San Diego Healthcare System

Information Concerning Post-doctoral Fellowship Clinical Training

The post-doctoral Specialty in SMI Psychology is a Major Area of Study where residents should expect to spend approximately at least 20 hours per week in a supervised, primary placement setting working with persons who have SMI/SED. This and all placements should operate based on a recovery orientation and utilize PSR practices as primary interventions. As residents increase their skill, confidence, and levels of responsibility, they should receive more complex cases, more independent clinical work, the ability to pursue their own training goals, and take on additional cases if desired. Residents also typically work with pre-doctoral interns and practicum students (where these are present), and are involved with the hierarchical supervision of these interns and students along with their clinical responsibilities on their rotations. The intensity and level of these activities would be determined in a collaborative nature between trainee, supervisors, and the Director of Training.

Required Clinical Placements

Across all placements, the post-doctoral resident should be the primary psychologist responsible for several individual clients. Residents should conduct a range of EBPs and promising practices, with fidelity to the models measured when fidelity criteria exist. Residents should also oversee at least one or more skills training group(s). Post-doctoral residents also conduct several assessments that include cultural, strengths-based, and functional assessments, and use those assessments to develop treatment plans or recommendations from those assessments. Residents should also work provide psychoeducation for several families or support systems of their clients. Given that much of the PSR work focuses on community integration, residents should have at least one ongoing experience outside the clinic (ACT, home-based interventions, etc.).

Required Primary Placement

Residents should expect to spend at least 80% time in the Major Area of Study with approximately 20 hours per week for the full year in a supervised, primary placement setting that is focused on the scientific understanding and treatment of the SMI/SED population. A secondary rotation, also focused on the SMI/SED population (see below) will be part of the post-doctoral learning opportunity to broaden the experience of settings and patient types. Residents participate as members of an interprofessional team for approximately 20 hours per week for their primary clinical placement for the duration of the training year. The primary placement could take place in an outpatient unit or on an in-patient unit. The focus of the unit or team should be on recovery oriented PSR for those with SMI/SED. Residents conduct screening, provide diagnostic clinical and strength based functional and resource assessments, conduct a cultural formulation interview; the DSM-5 Cultural Formulation Interview (American Psychiatric Association, 2013), work with clients/patients on goal-setting, provide psychoeducation to meet the person's expressed needs, help motivate individuals to engage in PSR treatment, provide evidence-based and promising practices specific to persons with SMI/SED, and assist in data collection, program evaluation, and quality improvement. As residents increase their competencies, confidence, and levels of responsibility, they should receive more complex cases, provide more independent clinical work, pursue their own training goals, and take on additional roles if desired. Residents will also participate in one-to-one (and possibly group) supervision regarding specialized PSR and related clinical activities for an SMI/SED population. In settings such as these, residents learn about recovery-driven systems and the kinds of services provided and are members of interprofessional teams. Residents should be expected to offer case presentations that include a cultural case formulation, and residents and other trainees also typically meet to review cases and process their experiences. They would also have the opportunity to lead rounds and facilitate discussions, offering supervision and team leading experiences.

Required Secondary Placement

For their secondary placement during the remaining 20 hours of the week, SMI Psychology post-

doctoral residents in this Major Area of Study (SMI Psychology Specialty) participate in an additional rotation as members of an interprofessional team on one or more units or teams that are different from the primary placement but that also focus on recovery and provision of PSR services to persons with SMI/SED. These should be selected to broaden the resident's training experiences and develop the competencies specific to this Specialty. Examples could include: outpatient clinics, community programs, a short stay unit where treatment services for acute episodes of psychiatric illness are offered and where an individual is helped to stabilize, his or her level of functioning is improved, and connections with outpatient treatments that will help promote community integration are established, e.g., social skills training groups, providing family psychoeducation, etc. A number of distinct clinical programs should be available to residents for secondary placements. Within each of these, residents work closely with a wide range of allied healthcare providers (nurses, social workers, psychiatrists, occupational therapists, vocational specialists, recreational therapists, medical residents, dietitians, art therapists, peer support specialists, etc.), family members, and other partners. Clinical supervision should be provided by a licensed psychologist.

Also during the remaining 20 hours per week, residents attend weekly didactic seminars, have supervisory sessions, and participate in other experiences designed to round out their understanding and knowledge of SMI/SED service provision. All are focused on SMI/SED and designed to round out their scientific understanding and knowledge of SMI/SED and fully develop their competence in service provision for this population. These are described fully in Criterion V and in our Training Guidelines.

An SMI Psychology post-doctoral residency is fully focused on the SMI/SED population. Though doctorally prepared psychologists may have had some exposure and experience with individuals in this population, post-doctoral training in this Specialty is intense and concentrated; this concentration is required to develop the competencies needed to manage the complexities of the illnesses within the SMI/SED population.

A resident's clinical training follows a progression that evolves from less to increasingly autonomous service delivery with persons with SMI/SED. Depending on the experience and competence of the trainee this progression may include observing supervisor modeling (in vivo service delivery with persons with SMI/SED and role plays in supervision), to delivering services to persons with SMI/SED with periodic direct observation of resident-delivered services by the supervisor and/or with supervisor and resident as co-therapists, to increasingly autonomous, albeit monitored and supervised, service delivery. Residents with prior experience in providing recovery and rehabilitation oriented services to persons with SMI/SED may need to spend less time observing supervisors, depending on their demonstrated competence level. All services should be provided within the context of the recovery orientation building on the individual's strengths, and focused around the person's goals and PSR services designed to meet those goals.

As with any post-doctoral residency, caseloads are lower in the beginning of the training year, and increase as the year progresses. Unlike residency training in clinical psychology (which may be an extension of what was learned during doctoral training), residency training in SMI Psychology is considerably different and more complex. Due to the fact that persons with SMI/SED very often have multiple problems and deficits, specialized assessments are required and residents will need to learn how to administer and score them. Interventions are also very different and frequently more than one intervention is needed; as we have indicated, residents need to learn about these different procedures and must learn how to implement them. This often requires considerable time. Further, assessment and intervention for those diagnosed with SMI/SED are often provided in community settings, which requires additional supervision and skill development.

Similarly to other residency training, resident progress is assessed by clinical supervisors during the course of informal and formal supervision, and supervisors and residents are expected to exchange feedback routinely as a part of the supervisory process; the evaluation procedures are meant to formalize this continuous information flow. While it is the responsibility of the training director and supervisors to

ensure that evaluation occurs in a timely and constructive fashion, residents are encouraged and expected to take an active role. As trainees progress and increase their confidence and levels of responsibility, they receive more complex cases, more independent clinical work, the ability to pursue their own training goals, and take on additional cases if desired. This is all determined in a collaborative nature between trainee, supervisors, and the Director of Training.

Residents' competence 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. This 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. Further, 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 colleagues, behavioral observation, structured observation checklist ratings, and ratings based on record or chart review. 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. Evaluation feedback needs to be given early enough in the program to serve as a basis for correction and should include documentation about intended corrective actions. Subsequent feedback involves the extent to which these corrective actions are, or are not successful in addressing any areas of concern.

While training will build on and enhance the foundation of knowledge, skills, and proficiencies that define the practice of professional psychology, post-doctoral training in this Specialty must be of sufficient depth to develop more focused competence and expertise in the specific area of SMI/SED. This is accomplished through involvement in focused didactics and clinical experiences on teams and units devoted to working with persons with SMI/SED. These are more fully described in Criterion V, and include the specialized training needed to develop competence to treat persons with SMI/SED that builds on, and expands doctoral level foundational and functional competencies, and includes: additional, specialized assessment methods that assess strengths and functional capability rather than solely symptomatology and deficits, evidence-based and promising practices designed specifically for this population, interventions modified and found to be effective with people in this population within the forensic mental health system, research methods adapted for populations such as this, systems transformation methods specific to large mental health systems that serve this population, ethical, legal, and diversity issues and concerns that impact this population specifically, to name but a few – these are the major areas of specialized training needed by psychologists to work with individuals with SMI/SED. Residents may also take part in more general secondary placements and didactics with post-doctoral psychology residents in other specialty areas where these exist at a given academic training site, but not at the expense of the SMI/SED focus.

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

Detailed information covering the scientific foundations, topics to be covered, in seminars,

workshops, lecture presentation, learning outcomes, etc., is presented in Criterion V

A sample curricula in table format, which is a composite from model programs is provided at the end of this criterion narrative. Details regarding the topics in these curricula are provided in Criterion V. The literature supporting these topics is included in Criteria V and VI.

A typical sequence of training, a sample training plan, and an example of a graduated levels of responsibility form are also presented at the end of this criterion narrative.

A sample suggested reading list is also offered at the end of this criterion narrative.

Supervision, resident and program evaluation

Post-doctoral education and training programs in SMI Psychology should have a formal, ongoing evaluation program directly linked to the competency goals and the training curriculum. Further, each program should collect and analyze data on residents and on program structure, process and outcome elements.

At a minimum, residency programs should provide at least two formal evaluations of performance each training year. This 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. Further, 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 colleagues, behavioral observation, structured observation checklist ratings, and ratings based on record or chart review. 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. Evaluation feedback needs to be given early enough in the program to serve as a basis for correction and should include documentation about intended corrective actions. Subsequent feedback involves the extent to which these corrective actions are, or are not successful in addressing any areas of concern.

Residents should be evaluated on their knowledge, skills, and abilities in relation to: understanding and applying didactic and seminar information, participating in supervision, supervising others, providing consultation, teaching and/or providing training, working in interprofessional and discipline-specific teams, and conducting research/evaluation activities. A developmental training approach is to be used in which learning objectives are achieved through didactic and experiential clinical placements under observation, supervision and mentoring by one or more supervisors. Competence is evaluated through components of knowledge, skills, and attitudes/values. 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 instrument, the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*, is attached as Appendix III. This instrument is a modification (modified and used with permission) of the excellent *Pikes Peak Geropsychology Knowledge and Skill Assessment Tool* (Karel, et al., 2012). This instrument was pilot tested by several postdoctoral SMI Psychology training programs. Users' feedback was largely positive, with trainees praising the instrument for covering specialized areas of competence in SMI/SED that were not assessed by the general clinical psychology competence measures the programs had utilized previously.

At the end of each rotation, residents should complete an evaluation of supervisors and rotations, and at the end of the residency, evaluations of the residency overall, research opportunities, didactics,

seminars and other components. This feedback will be used to modify, improve, and/or enhance the quality of residency training.

With respect to clinical supervision, at least two hours of individual supervision must be conducted weekly by doctoral-level licensed psychologists who are involved in an ongoing supervisory relationship with the resident and have professional clinical responsibility for the cases on which they provide supervision. A postdoctoral resident must have a minimum of two doctoral level licensed psychologist supervisors, at least one of whom serves as the resident's primary supervisor. All clinical supervisors are encouraged to address diversity issues routinely in supervision with fellows.

Supervisory hours beyond the two hours of individual supervision may be provided either individually or via group supervision and must be provided by professionals who are appropriately credentialed for their role/contribution to the program. The primary doctoral-level licensed psychologist supervisor maintains overall responsibility for all supervision, including oversight and integration of supervision provided by other mental health professionals with psychological research and practice.

During each rotation, there should be a written evaluation of the residents' progress as well as verbal feedback given to the residents by each supervisor and the Director of Training. Feedback should be provided at several times during the rotation with the exact timing dependent on the duration of the rotation. Competency evaluations would typically be behaviorally based and any deficit areas addressed with the resident. Particular attention should be paid to ensuring that residents act ethically and with understanding of and respect for the full range of diversity issues particularly as these relate to persons with SMI/SED. Additionally, rotation learning objectives would be reviewed mid and end of rotation to determine appropriateness and status.

A sample evaluation form and an example of a professional identity and confidence evaluation are provided at the end of this criterion narrative.

7. Select four exemplary doctoral and/or postdoctoral level geographically distributed, and publicly identified programs in psychology in this specialty and provide the requested contact information. If no example programs that are APA accredited are available, please complete the appropriate Attachment (A or B) for the level of the program. If the specialty education and training occurs at both the doctoral and postdoctoral levels, provide examples of both and not from the same institution.

We list four exemplary post-doctoral SMI Psychology residency programs below. Each provides a residency with a Major Area of Study focused on serious mental illness (SMI) using the evidence based interventions known as PSR, where a minimum of 80% of the resident's time is spent in clinical, research, supervision, and didactic training in SMI/PSR.

In addition to providing the information required on the petition form, we also provide:

- a) the detailed brochure for each program which provides site specific information about the residency – these are attached as appendices
- b) a letter from the Training Director of the overall post-doctoral residency indicating support for the post-doctoral fellowship in SMI/PSR – these are included at the end of this criterion
- c) a short synopsis of the program precedes the information provided in the requested form.

Program One

Doctoral

XX Postdoctoral

Both

The Minneapolis VA Healthcare System (MVAHCS) offers psychology postdoctoral training in Serious Mental Illness (SMI) where residents spend at least 80% of their time devoted to training in PSR approaches for persons with SMI. Specialized mental health care is provided to approximately 800 veterans with serious mental illness, such as Schizophrenia, Schizoaffective Disorder, and Bipolar Affective Disorder, although veterans with other diagnoses are also treated. The team consults throughout the medical facility and offers services to veterans from other mental health teams. Time spent on activities in this major area of study specifically in SMI is at least 80% of the resident's time. Residents will be prepared to leave their residency well-prepared to function successfully as an independent scientist/practitioner with requisite expertise in working with persons with SMI. Another goal of the residency is to train the resident to function in leadership positions and systems focusing on work with persons with SMI.

Our training philosophy is strongly based in the scientist-practitioner model. Our program endorses the view that good clinical practice is based on the science of psychology. In turn, the science of psychology is influenced by the experience of working with complex cases. As a consequence, our approach to training encourages clinical practice that is evidence-based and consistent with the current state of scientific knowledge. Residents are trained to implement evidence-based practices for persons with SMI and critically evaluate new interventions. This approach is based on the belief that clients deserve access to treatments that have been proven to be effective for their specific concerns and condition(s). At the same time, we acknowledge the considerable complexities of clients in this setting and the limitations of our empirical base, especially in regards to SMI. We aim to produce psychologists who are capable of contributing to the profession by investigating clinically relevant questions through their own clinical research. While individual residents may ultimately develop careers that emphasize one aspect of the scientist-practitioner model more than the other, our expectation is that clinicians will practice from a scientific basis and that scientists will practice with a strong and informed clinical sensibility.

Name of University, School, or Institution offering program: Minneapolis VA Healthcare System

Name of Program: Postdoctoral Fellowship in Clinical Psychology, Serious Mental Illness

Address: One Veterans Drive

City/State/Zip: Minneapolis, MN 55417-2300

Contact Person: Wayne Siegel, Ph.D., ABPP, Director of Training Telephone: (612) 467-4024, E-mail address: Wayne.Siegel@va.gov

Contact Person: Bridget Hegeman, Ph.D., Program Director Telephone: (612) 467-1782, E-mail address: Bridget.Hegeman@va.gov

Website: https://www.minneapolis.va.gov/education/psychology/postdoc/post_overview.asp#SMI

APA Accreditation: Yes.

The fellowship brochure is included as Appendix IV.

A letter from Wayne Siegel, Ph.D., ABPP supporting the post-doctoral fellowship in SMI is included

Program Two

Doctoral

XX Postdoctoral

Both

The VISN 5 MIRECC - VA Advanced Fellowship Program in Mental Illness Research and Treatment is a two year post-doctoral residency in SMI/PSR and is affiliated with the University of Maryland, School of Medicine (UMSOM), Department of Psychiatry; this provides an outstanding collaborative and interdisciplinary setting for fellows. "The VISN 5 MIRECC has active collaborations with the Department of Psychiatry at the UMSOM with extensive communications and a strong working relationship across institutions. Our program has been in existence and offering postdoctoral training since 2003. Our fellows have established careers as experts in serious mental illness research and clinical care in VA, academic, and hospital settings."

In 2015, The program was named one of four "exemplary training sites" in SMI in the nation by Division 18 of the American Psychological Association.

The brochure states: "The primary goal of the VA Advanced Fellowship Program in Mental Illness Research and Treatment at the VISN 5 MIRECC is to develop outstanding academic, clinical service, and healthcare system leaders. We strive to train fellows who will lead mental health research and service in the 21st century and build the evidence base for mental health interventions by effectively translating research findings into clinical practice and programming, large-scale training of service providers, and focused educational activities. The program provides fellows with advanced training in mental health research, clinical experience in settings that serve individuals with serious mental illness, and opportunities to develop their skills in teaching and training in didactic, academic, and clinical venues."

Name of University, School, or Institution offering program: VA Maryland Healthcare System

Name of Program: VISN 5 MIRECC - VA Advanced Fellowship Program in Mental Illness Research and Treatment

Address: 209 West Fayette Street

City/State/Zip: Baltimore, MD 21201

Contact Person: Richard Goldberg, Ph.D., Director, VISN 5 MIRECC; Professor, Department of Psychiatry, University of Maryland School of Medicine Telephone No. 410-637-1851, E-mail address: rwgoldberg@som.umaryland.edu or richard.goldberg@va.gov

Contact Person: Melanie Bennett, Ph.D. Associate Director, Education Core and Director, VA VISN 5 Advanced Fellowship Program in Mental Illness Research and Treatment, VISN 5 MIRECC; Associate Professor, Department of Psychiatry, University of Maryland School of Medicine, Telephone No. 410-637-1859, E-mail address: mbennett@som.umaryland.edu or Melanie.bennett@va.gov

Website: <https://www.mirecc.va.gov/visn5/research/fellowship.asp>

APA Accreditation: Yes.

The fellowship brochure is included as Appendix V

A letter from Richard Goldberg, Ph.D., Director of the Mental Illness Research and Treatment Center supporting the post-doctoral fellowship in SMI is included

Program Three

Doctoral

XX Postdoctoral

Both

The University of California San Diego (UCSD) / VA San Diego Healthcare System (VASDHS) PSR Fellowship offers a major area of study in serious mental illness (SMI) to clinical psychology and other residents and is part of the UCSD/VASDHS Clinical Psychology Postdoctoral Residency Program, which has been APA-accredited since 2010. Training is based on the scientist-practitioner model, focused on creating a foundation in clinical and research/dissemination practices that prepares psychologists for careers as independent SMI practitioners able to translate the scientific literature into sound, evidenced-based interventions and to evaluate and disseminate these approaches. Residents learn to develop, deliver, and disseminate high quality, recovery-oriented psychosocial rehabilitation practices for people with SMI and become experts in this area, often subsequently attaining leadership roles. The PSR Fellowship was recognized as an “exemplary training site” in SMI with a Certificate of Commendation from Division 18 of the APA in 2017 and in 2018 won the APA Division 18 President’s Excellence in Training Award “in recognition as an outstanding psychology training program, preparing learners to provide recovery-oriented, evidence-based services to adults diagnosed with SMI.” PSR Fellowship residents work primarily at the Center of Recovery Education (CORE), the VASDHS’s CARF-accredited Psychosocial Rehabilitation and Recovery Center. CORE was awarded the 2017 Jeffrey Christopher Memorial Award by the San Diego County Wellness and Recovery Summit “for excellence in improving the quality of life and connection to care for the people who live with mental health challenges and their families.” Most of the PSR Fellowship psychology faculty have academic appointments at the UCSD School of Medicine Department of Psychiatry, and both UCSD and the VASDHS are nationally recognized leaders in research on SMI.

Name of University, School, or Institution offering program: University of California, San Diego / VA San Diego Healthcare System

Name of Program: Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery Oriented Services

Address: 8989 Rio San Diego Drive Suite 360

City/State/Zip: San Diego, CA 92108

Contact Person: Dimitri Perivoliotis, Ph.D., Director of Training, Interprofessional Fellowship Program, Telephone No. (619) 228-8028, E-mail address: dperivol@ucsd.edu

Contact Person: Brian Buzzella, Ph.D., ABPP, Director of Training of parent post-doctoral residency program Telephone No. (858) 552-8585, ext. 2187 E-mail address: babuzzella@ucsd.edu

Website: http://www.sandiego.va.gov/careers/psychology_training.asp

APA Accreditation: Yes.

The fellowship brochure is included as Appendix VI

A letter from Brian Buzzella, Ph.D., ABPP, Director of the overall post-doctoral residency program supporting the post-doctoral fellowship in SMI is included

<u>Program Four</u>	Doctoral	XX Postdoctoral	Both
----------------------------	----------	-----------------	------

The VA Connecticut Healthcare System / Yale University School of Medicine Postdoctoral Residency in Clinical Psychology offers a Major Area of Study in Serious Mental Illness (SMI) and Psychosocial Rehabilitation (PSR). This one year program is affiliated with the Yale University School of Medicine's Department of Psychiatry, and most, if not all, of the psychology faculty have academic appointments within the medical school. This relationship contributes to a high level of expertise within the training program, access to high-quality research and program evaluation experiences, and outstanding mentoring and supervision.

Training faculty have been awarded education and training awards locally and nationally, including the Distinguished Psychologist Award for Education at the VA Connecticut Healthcare System, and the Psychiatric Rehabilitation Association Educator Award of Distinction.

The training program resulted from a Veterans Health Administration (VHA) initiative first announced in 2002 as part of the U.S. Department of Veterans Administration's national initiative to promote PSR training, research, and program development. The residency follows the scientist-practitioner model and is an interdisciplinary fellowship providing training in clinical services, program development, research, and education for individuals diagnosed with SMI. Our fellows have established careers as experts in SMI treatment and research in a variety of settings including PSR and recovery centers, inpatient units, and VA mental health clinics, among others.

Name of University, School, or Institution offering program: VA Connecticut Healthcare System / Yale University School of Medicine

Name of Program: Post-doctoral Residency in Clinical Psychology, with an emphasis in Psychosocial Rehabilitation

Address: Errera Community Care Center, 114-52 Boston Post Road

City/State/Zip: West Haven, CT 06516

Contact Person: Anne Klee, Ph.D., CPRP, Director of Interprofessional Fellowship (APA CoR, Past President, APA Division 18), Telephone No. (203) 932-5711 x 2231; E-mail address: anne.klee@yale.edu

Contact Person: Meaghan Stacy, Ph.D., Director of Psychology Training (Division 18 Chair-elect, Section on SMI/SED), Telephone No. (203) 932-5711 x 2916, E-mail address: Meaghan.stacy@yale.edu

Websites: <http://psychiatry.yale.edu/psychology/education/postdoc/va.aspx>
<http://www.connecticut.va.gov/careers/psychologytraining.asp>

APA Accreditation: Yes.

The fellowship brochure is included as Appendix VII

A letter from Anne Klee, Ph.D., Director of the overall Interprofessional Fellowship program supporting the post-doctoral fellowship in SMI is included

List of Training Director Support Letters

Wayne Siegel, Ph.D., ABPP, VA Minneapolis

Richard Goldberg, Ph.D., VISN 5 MIRECC

Brian Buzella, Ph.D., ABPP, UCSD/VA SCD

Anne Klee, Ph.D., VA Connecticut/Yale University School of Medicine



DEPARTMENT OF VETERANS AFFAIRS
Minneapolis VA Health Care System
Section of General Internal Medicine 1110
One Veterans Drive
Minneapolis, MN 55417



January 1, 2019

To: Council for Psychological Training in Assessment and Treatment of Persons with Serious Mental Illness and Severe Emotional Disturbance (SMI/SED).

RE: Letter of Support

From: Wayne G. Siegel, Ph.D., ABPP

Please accept this letter as an indication of full support for the recognition of Serious Mental Illness as a formally recognized specialty area.

The Minneapolis VA Health Care System (MVAHCS) is a tertiary care center for the VA's Upper Midwest Network. As the director of the MVAHCS Psychology Training programs, I can attest to the need for specialty services in for those with severe mental illness and severe emotional disturbance. To meet these needs, the Health Service Psychology profession needs programs that provide advanced and specialized clinical training in empirically supported interventions as well as training in how to conduct research in SMI/SED.

Our psychology postdoctoral residency program has been providing specialized postdoctoral training in Serious Mental Illness since 2001. For our and similar programs nationally, recognition of SMI/SED as a formal specialty would give SMI/SED the attention and legitimacy it deserves. This would likely lead to expansion of needed training positions, expand research interests and productivity, and improve upon the overall care to the SMI/SED population.

Sincerely,

A handwritten signature in purple ink, appearing to read "Wayne G. Siegel".

Wayne G. Siegel, Ph.D., ABPP
Psychology, Training Director
Psychology Supervisor



**VA Capitol Health Care Network VISN 5
Mental Illness Research Education and Clinical Center**

September 6, 2018

TO: Specialty Council for the Psychological Assessment and Treatment of Persons with Serious Mental Illness/Severe Emotional Disturbance (SMI/SED)

FROM: Richard W. Goldberg, Ph.D.

Dear Specialty Council:

I am writing to express strong support for the Specialty Council's petition to the American Psychological Association for recognition of the post-doctoral specialty in SMI/SED Psychology.

As the Director of the VA's Psychosocial Rehabilitation (PSR) Fellowship Hub Site (comprised of six fellowship sites) and the Director of the VISN 5 Mental Illness Research, Education and Clinical Center (MIRECC), I can attest to the need for specialized training for psychologists who work with those with SMI/SED as well as the added value and enhanced outcomes seen by individuals who receive PSR services from psychologists with such specialized training. Without specialized science based didactic and experiential training, most psychologists lack the recovery orientation and skills needed to deliver the evidence-based PSR interventions that enable persons with SMI/SED to recover and regain their full functional capability. Post-doctoral fellowship programs with a Major Area of Study in SMI/SED and PSR approaches provide psychology residents with the highly specialized and empirically validated clinical, research, consultation and advocacy training needed to help individuals with SMI/SED achieve their functional potential and lead satisfying and productive lives. The SMI/SED Psychology Specialty is essential to help develop the psychology cohort of scientists and clinicians needed for the future of healthcare in the United States.

Thank you for the opportunity to provide support for this specialty. Please do not hesitate to contact me if you need additional information or assistance.

Sincerely,

Richard W. Goldberg, Ph.D.,
Director, VISN 5 Mental Illness Research, Education, and Clinical Center (MIRECC)
Director, Psychosocial Rehabilitation Fellowship Hub Site
Professor, Division of Psychiatric Services Research-Department of Psychiatry, University of Maryland, School of Medicine
E mail: RWgoldberg@som.umaryland.edu or Richard.Goldberg@va.gov



DEPARTMENT OF PSYCHIATRY
UCSD SCHOOL OF MEDICINE
(858) 552-8585 ext. 2187
brian.buzzella@va.gov

PSYCHOLOGY SERVICE (116B)
VA SAN DIEGO HEALTHCARE SYSTEM
3350 LA JOLLA VILLAGE DRIVE
SAN DIEGO, CALIFORNIA 92161

October 19, 2018

Pamela Remer, Ph.D.
American Psychological Association
Commission for the Recognition of Specialties and
Proficiencies in Professional Psychology

Dear Dr. Remer:

I am the training director of the APA-accredited VA San Diego Healthcare System (VASDHS)/University of California San Diego (UCSD) Clinical Psychology Postdoctoral Residency Program. The VASDHS/UCSD Interprofessional Fellowship in Psychosocial Rehabilitation & Recovery Oriented Services ("PSR Fellowship") is a specialized program within the above that provides advanced training in serious mental illness to an interdisciplinary group of trainees. Our PSR Fellowship is being included as one of four exemplary serious mental illness (SMI) training sites in a petition for the recognition of psychological assessment and treatment of persons with SMI and severe emotional disturbance (SED). I have learned about this process through discussions with the PSR Fellowship's training director, my colleague Dimitri Perivoliotis, Ph.D., who also directs our medical center's SMI clinic.

I am writing to express my enthusiastic support for formal recognition of the SMI/SED specialty based on my positive experiences with both our PSR Fellowship and our SMI clinic. Both are incredibly valued resources that serve vital functions; the clinic provides the specialized treatments that our patients with SMI need and the fellowship provides specialized and rigorous training to professionals who often go on to become leaders in SMI. The specialized training provided by the PSR Fellowship is unique, and complementary to, that provided by our general clinical psychology training program. We are proud that the PSR Fellowship was recently awarded the APA Division 18 President's Excellence in Training Award.

The formal recognition of SMI/SED as a specialty is an exciting prospect that I believe will have an enormous impact on developing the psychologist scientists and providers of the future, and that will lead to improved outcomes in people with SMI/SED.

Sincerely,

Brian Buzzella, Ph.D., ABPP
Assistant Clinical Professor of Psychiatry, UCSD
Training Director, Clinical Psychology Postdoctoral Residency Program, VASDHS
Director, Family Mental Health Program, VASDHS

Yale University

Anne S. Klee, Ph.D., CPRP

Assistant Professor

Department of Psychiatry, School of Medicine

Director, Peer Support Services

Director, Psychosocial Rehabilitation Residency

Errera Community Care Center/116A-3

VA Connecticut Healthcare System

114 Boston Post Road

West Haven, Connecticut 06516

203.479.8035

anne.klee@yale.edu

October 3, 2018

Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP)
American Psychological Association
750 First Street NE
Washington, DC 20002

Dear CRSPPP Commission Members:

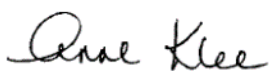
I am writing to express strong support for the petition for recognition of the post-doctoral Specialty in Serious Mental Illness Psychology (SMI Psychology).

For the past fifteen years, I have directed the Psychosocial Rehabilitation Residency Program and have seen first-hand the need for specialized training of doctoral level clinicians who are working with individuals with serious mental illnesses (SMI). Despite the excellent preparation psychologists receive at the doctoral level, the unique problems presented by those with SMI require highly specialized didactic and experiential training based on the latest empirical literature. The relatively recent advances in treatment approaches and practices designed and validated specifically for this population are not routinely taught in doctoral or internship programs, yet these are needed to successfully treat persons with SMI.

In addition to the growing empirical basis for specialized approaches for this population, we repeatedly hear from students and early career psychologists that they feel unprepared to work with individuals with SMI despite their desire to do so. If the profession of psychology is to keep pace with the growing demand for evidence-based medicine and the emphasis on interprofessional provision of health care, the SMI Psychology Specialty will be essential to develop the psychology cohort of scientists and clinicians needed for the future of healthcare in the United States.

Thank you for your time and consideration.

Sincerely,



Anne Klee, Ph.D., CPRP

APA Division 18 Representative to APA Council of Representatives

President, Connecticut Psychological Association

List of Forms Included at the End of This Criterion VII

(Each of these forms is in use at one or more of the model programs listed in this Criterion. The post-doctoral residency program that submitted the form is listed next to its title – in some cases, more than one example is included)

PSR/SMI/SED Fellow Applicant Rating Form: Minneapolis VA Healthcare System

Admission Evaluation Form: VA Connecticut Healthcare System / Yale University School of Medicine

Suggested Criteria for Evaluating PSR Fellowship Candidates: University of California, San Diego / San Diego VA Healthcare System

Typical SMI/SED Recovery and Psychosocial Rehabilitation Interprofessional Fellowship Curriculum for Post-Doctoral Specialty: University of California, San Diego/San Diego VA Healthcare System

Sequence of Training for Post-Doctoral Psychology Residents in SMI/SED Specialty: University of California, San Diego/San Diego VA Healthcare System

Training Plan: VA Connecticut Healthcare System / Yale University School of Medicine

Training Plan: Minneapolis VA Healthcare System

Graduated Levels of Responsibility for Post-Doctoral Psychology Residents in SMI/SED Specialty: VA Connecticut Healthcare System / Yale University School of Medicine

PSR Fellow/Resident Competency Assessment Form: VA Connecticut Healthcare System / Yale University School of Medicine

Professional Identity and Confidence Evaluation for Post-Doctoral Psychology Residents in SMI/SED Specialty: VA Connecticut Healthcare System / Yale University School of Medicine

End of Fellowship Program Evaluation Survey: VISN 5 MIRECC – VA Advanced Fellowship Program in Mental Illness Research and Treatment

SMI/SED PSR Competencies

Broad, General Descriptive Narrative of the SMI/SED PSR Competencies

Recommended Readings for Post-Doctoral Specialty in SMI Psychology

List of Appendices for Criterion VII

Appendix I: Education and Training Guidelines for Post-Doctoral Residencies in SMI Psychology

Appendix III: Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)

Appendix IV: Minneapolis VA Post-Doctoral Residency in SMI Brochure

Appendix V: MIRECC Post-Doctoral Fellowship in Mental Illness Research and Treatment Brochure

Appendix VI: UCSD/VASD Post-Doctoral Fellowship in PSR Brochure

Appendix VII: VACT/Yale University Post-Doctoral Residency in PSR Brochure

References

- American Psychiatric Association. (2013). Cultural formulation. In: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association, 749-759.
- American Psychological Association, Commission on Accreditation. (2015). *Standards of Accreditation for Health Service Psychology*. Washington, DC: American Psychological Association. Retrieved from <http://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf>.
- Beidas, R. S. & Kendall, P. C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology*, 17, 1, 1–30.
- Buck, B., Romeo, K. H., Olbert, C. M., & Penn, D. L. (2014). Self-reported comfort treating severe mental illnesses among pre-doctoral graduate students in clinical psychology. *Journal of Mental Health*, 23, 6, 297-302.
- Carr, E. R., Bhagwat, R., Miller, R., & Ponce, A. N. (2014). Training in mental health recovery and social justice in the public sector. *The Counseling Psychologist*, 42, 8, 1108-1135.
- Charles, J. L. K. (2013). Mental health provider-based stigma: Understanding the experience of clients and families. *Social Work in Mental Health*, 11, 4, 360-375.
- Corrigan, P. W. (1995). Wanted: Champions of rehabilitation for psychiatric hospitals. *American Psychologist*, 50, 514–521.
- Corrigan, P. W., Hess, L., & Garman, A. N. (1998). Results of a job analysis of psychologists working in state hospitals. *Journal of Clinical Psychology*, 54, 1–8.
- Corrigan, P. W., Steiner, L., McCracken, S. G., Blaser, B., & Barr, M. (2001). Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. *Psychiatric Services*, 52, 12, 1598-1606.
- Drake, R. E., Mueser, K. T., Brunette, M. F. (2007). Management of persons with co-occurring severe mental illness and substance use disorder: Program implications. *World Psychiatry*, 6, 131-136.
- Falender, C. & Shafranske, E. (2004). *Clinical Supervision: A Competency-Based Approach*. American Psychological Association: Washington, DC.
- Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S. & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness: I. Methodology, study, sample, and overall status 32 years later. *American Journal of Psychiatry*, 144, 718-726.
- Harding, C., Zubin, J. & Strauss, J. (1987). Chronicity in Schizophrenia: Fact, Partial Fact, or Artifact? *Psychiatric Services*, 38, 477–486.

- Hargrove, D. S. (1990). Key issues in training in psychology for service to the seriously mentally ill. In Lefley, H. P. (Ed.). *Clinical Training in Serious Mental Illness*. Washington, DC: National Institute of Mental Health, DHHS Pub No (ADM) 90-1679.
- Karel, M. J., Holley, C., Whitbourne, S. K., Segal, D. L., Tazeau, Y., Emery, E., ... Zweig, R. (2012). Preliminary validation of a tool to assess knowledge and skills for professional geropsychology practice. *Professional Psychology: Research & Practice*, 43, 2, 110-117.
- Klee, A., Adams, L., Beesley, N., Fisk, D., Hunt, M. G., Kalaczniak, M., ... Harkness, L. (2016). Clinical competence for outreach and for special populations. In Jacobs, S. C. & Steiner, J. L. (Eds.). *Yale Textbook of Public Psychiatry*. New York, NY: Oxford University Press.
- Kersting, K. (January, 2005). Filling a training gap - Specialized training programs give new psychologists a leg up in treating and researching serious mental illnesses. *APA Monitor*, 36, 1, 42.
- Mueser, K. T. (2012). Evidence-based practices and recovery-oriented services: Is there a relationship? Should there be one? *Psychiatric Rehabilitation Journal*, 35, 4, 287–288.
- Mueser, K. T., & Berenbaum, H. (1990). Psychodynamic treatment of schizophrenia: Is there a future?. *Psychological Medicine*, 20, 02, 253-262.
- Mueser, K. T., Silverstein, S. M., & Farkas, M. D. (2013). Should the training of clinical psychologists require competence in the treatment and rehabilitation of individuals with a serious mental illness?. *Psychiatric Rehabilitation Journal*, 36, 1, 54-59.
- National Institute of Mental Health. (1990). *Clinical Training in Serious Mental Illness*. (1990). Lefley, H. P. (Ed). DHHS Pub. No. (ADM) 90-1679. Washington, DC: Supt. of Docs., U.S. Govt. Printing Office. Available from <http://babel.hathitrust.org/cgi/pt?id=mdp.39015050781247;view=1up;seq=3>
- President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: Author.
- Reddy, F., Spaulding, W., Jansen, M., Menditto, A., & Pickett, S. (2010). Psychologists' roles and opportunities in rehabilitation and recovery for serious mental illness: A survey of council of university directors of clinical psychology (CUDCP) clinical psychology training and doctoral education. *Training and Education in Professional Psychology*, 4, 4, 254-263.
- Roe, D., Yanos, P. T., & Lysaker, P. H. (2006). Overcoming barriers to increase the contribution of clinical psychologists to work with persons with severe mental illness. *Clinical Psychology: Science and Practice*, 13, 376–383.
- Rollins, A. L. & Bond, G. R. (2001). Psychology curriculum and psychiatric rehabilitation. *Psychiatric Rehabilitation Skills*, 5, 3, 514-533.
- Slade, M. (2010). Mental illness and well-being: The central importance of positive psychology and recovery approaches. *BMC Health Services Research*, 10, 26.
- Stacy, M, Klee, A., & Jansen, M. A. (2018). Post-doctoral psychology training in preparation for specialization in serious mental illness. *Training and Education in Professional Psychology*, 12, 2, 96-104.
- Stoltenberg, C. & McNeill, B. (2010). *IDM Supervision: An Integrative Developmental Model for Supervising Counselors and Therapists*. Rutledge, Taylor & Francis Group: New York, NY.

- Stuber, J. P., Rocha, A., Christian, A. & Link, B. G. (2014). Conceptions of mental illness: Attitudes of mental health professionals and the general public. *Psychiatric Services*, 65, 4, 490-497.
- Warner, R. (2010). Does the scientific evidence support the recovery model? *The Psychiatrist Online*, 34, 3-5.
- Zipursky, R. B., Reilly, T. J. & Murray, R. M. (2012). The myth of schizophrenia as a progressive brain disease. *Schizophrenia Bulletin*, 39, 6, 1363–1372.

PSR/SMI/SED Fellow Applicant Rating Form: Minneapolis VA Healthcare System

Applicant Name:

Graduate Program:

Internship Program:

Domain	Score	Comments
Intervention (recovery-focused? EBPs for SMI?)	Very strong Neither Deficient	
Assessment (experience with assessing psychosis?)	Very strong Neither Deficient	
Scholarly Potential (specific to SMI? Integrate recovery focus?)	Very strong Neither Deficient	Research Interests Research Mentor
Letters of Recommendation	Very strong Neither Deficient	
Sensitivity to Diversity	Very strong Neither Deficient	

Cover Letter (recovery orientation? Career plans with SMI? Previous work with persons with SMI?)	Very strong Neither Deficient	
Work Sample (SMI population? Measures consistent with what we use? Strengths-based approach?)	Very strong Neither Deficient	
Match with SMI Residency	Very strong Neither Deficient	Career goals Clinical mentor

Total Very Strong: _____

Total Neither: _____

Total Deficient: _____

Overall: 1) Interview

2) Marginal

3) Cut

Admission Evaluation Form: VA Connecticut Healthcare System / Yale University Medical School

Note: This form is specific to an SMI/SED post-doctoral residency application evaluation form and can be used in addition to a more general, overall post-doctoral residency admission evaluation form

Total Score: _____

PSR Residency Interview (Revised January 2017)

Applicant: _____

Date of Interview: _____

Panel/Rater: _____

Today we will be asking you several complex questions. Given that we have approximately sixty minutes for the interview, we ask that you limit your initial response to each question to five minutes.

1. What is your understanding of the Recovery Model / PSR model for working with people with serious mental illness? Please describe the key elements of the model and provide an example of the way you have utilized these concepts while working with clients. How do you differentiate Recovery from Psychosocial Rehabilitation?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) _____

2. Much of the work we do here involves clinical case management and support with life skills, including going into the community to meet with clients in their homes, taking them to medical appointments, or helping them with basic needs such as grocery shopping, banking, etc.
 - What experiences have you had with this type of work and what benefit can you see of this kind of work?
 - What positives and negatives would you anticipate working as a clinical staff member in community settings?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) _____

3. When working with a client in the community, the client will be interacting with you in more ways than in a traditional office setting and may see sides of you that are not always apparent in an office.
- How would you handle personal questions that might come up?
 - How might your boundaries differ in the community versus in the office?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) _____

4. Tell us about a time when a team member or a supervisor challenged your decision-making and how you went about resolving the issue (and what was the resolution?).

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) _____

5. Fellows have overlapping deadlines, tasks in different locations throughout the day, and oftentimes interruptions by other clinicians or Veteran issues will disturb your work. How do you typically prioritize work, manage multi-tasking and shifting from one task to another? Can you provide an example of how you have done this on internship?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) _____

6. How would you handle the following situation? You are meeting a client, Mr. Smith, at his home, but he is not there when you arrive. You call Mr. Smith who says he is on his way, but stuck in traffic. He asks you to wait for him. Mr. Smith arrives at 2:30pm. You have a twenty-five minute drive back to the hospital/agency for your 3pm seminar. What factors would help you determine how much time (if any at all) to spend with Mr. Smith, and how would you proceed?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) _____

7. Please describe interventions that have been shown by research to be effective when working with people with SMI particularly with schizophrenia, and your experiences with these approaches.

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) _____

8. How does this fellowship fit in with your short term and long term career plans?

Score on a scale of 0 – 5 (with 5 reflecting highest quality response) _____

Suggested Criteria for Evaluating PSR Fellowship Candidates: University of California San Diego / San Diego VA Healthcare System

PSR Fellowship Purpose:

To develop future mental health leaders with vision, knowledge, and commitment to transform mental health care systems in the 21st century by emphasizing functional capability, rehabilitation, and recovery.

- 1. Psychosis Experience/Commitment.** Experience with, and commitment to, working with people with psychosis. Have they done this before? Do they know what this is like and its unique challenges? Moreover, do they have a passion for working with this population so that they can become future leaders?
- 2. Clinical/EBP Experience.** Do they have at least intermediate knowledge and experience with the concept of recovery from serious mental illness and with evidence-based interventions (both individual and group) in general? Do they have a recovery orientation that they can articulate and are they familiar with and committed to providing recovery-oriented care? Do they have unique expertise or interests that would contribute to a SMI/SED team—e.g., ideas for new groups, expertise in trauma, SUD, ACT, personality disorders, community integration ideas/enthusiasm?
- 3. Leadership Potential:** Do they have potential to become future leaders in the area of psychosocial rehabilitation for people with SMI (as this is the PSR Fellowship's mission)? For example, have they been involved in leadership activities? Do they have big exciting ideas for the future? Do they have a promising research trajectory that could have impact on the field?
- 4. Professionalism and Interpersonal Effectiveness.** Are they kind, respectful, professional? Can you envision them fitting well with the PSR team? Can you imagine getting along with them easily and collaborating with them? Do you like them as a person? Would they work effectively with clients, including those who might be guarded, paranoid, or otherwise challenging (i.e., can they show empathy, be engaging, communicate succinctly, etc.)? Do they demonstrate professional skills necessary to do well (e.g., time management, initiative, ethics)?

Example of Typical SMI/SED Recovery and Psychosocial Rehabilitation Interprofessional Fellowship Curriculum for Post-Doctoral Specialty: University of California San Diego / San Diego VA Healthcare System

This table outlines in chart form typical post-doctoral residents' duties, e.g., one example of a typical curriculum. See Criteria V and VII for full explanation and detail.

Location	Duty	Explanation	Requirement
Outpatient Recovery and PSR Unit	Serve as Recovery Psychologist	Assist individuals in developing and following Recovery Plans on outpatient PSR unit	All Residents
Outpatient Recovery and PSR Unit	Provide individual/family assessment and psychosocial rehabilitation services	Services may vary and may include: <ul style="list-style-type: none"> ▪ Assessments (e.g., biopsychosocial diagnostic intake assessments, vocational assessments) ▪ Psychotherapy ▪ Family therapy ▪ Supported Employment (SE) ▪ Crisis intervention (e.g., suicide assessment and safety planning) ▪ Case management 	Supported Employment (SE): Different discipline trainees carry varying number of cases; Psychology Residents carry at least 1 case
Outpatient Recovery and PSR Unit	Provide group-based psychosocial rehabilitation services	Services may vary and may include: <ul style="list-style-type: none"> ▪ Psychoeducational groups ▪ Psychotherapy & skills training classes ▪ Community integration groups ▪ Wellness groups ▪ Support groups 	All Residents
Inpatient Psychiatry Unit	Complete rotation on inpatient psychiatry unit	<ul style="list-style-type: none"> ▪ Facilitate weekly transition/bridging group ▪ Conduct intakes on unit when needed ▪ Conduct other assessments or short term psychotherapy, as needed and if possible during the rotation time ▪ Occasionally attend staff meetings to conduct outreach/provide consultation about recovery-oriented care for individuals when transitioned to outpatient 	All Residents
Outpatient Recovery and PSR Unit	Conduct outreach activities	Educational trainings in the principles and strategies of psychosocial rehabilitation and recovery-oriented services for other staff and/or trainees	At least 1 per Resident

Outpatient Recovery and PSR Unit	Design and implement a research/dissemination project	Spend 8 hours per week on a research/dissemination project and (at minimum) present as poster at annual conference	1 independent project per Resident
Outpatient Recovery and PSR Unit	Assist in clinic administration	Select a clinic administration task and provide assistance to director and staff in this area	All Residents select 1 role
Outpatient Recovery and PSR Unit	Provide supervision	Provide supervision to a junior trainee or peer support specialist	Psychology Residents only
Outpatient Recovery and PSR Unit	Attend supervision and didactics	Attend individual supervision (with 2 supervisors), group supervision (including team meeting) and attend required didactics	All Residents (didactic requirements vary by discipline)

**Sequence of Training for Post-Doctoral Psychology Residents in SMI/SED Specialty:
University of California San Diego / San Diego VA Healthcare System**

Beginning of Training Year

1. Complete initial self-evaluation to identify training needs
2. Construct Training Plan in collaboration with supervisors to organize and guide training experience
3. Complete orientation to rotation procedures
4. Undertake introductory trainings and readings on SMI/SED-related topics (e.g., recovery planning, specialized assessments for this population, cognitive behavioral therapy for psychosis, supported employment, suicide and violence risk management, etc.)
5. Observe licensed providers conducting SMI/SED clinical practice, (e.g., strengths based, readiness, assessment intakes and screening, recovery planning, interventions), or be observed by licensed providers (depends on experience level); attend grand rounds where applicable
6. With supervisor and training committee, make preliminary decisions regarding rotations
7. Begin providing outpatient and/or inpatient psychosocial rehabilitation services independently and with other residents, under supervision
8. Participate in seminars, didactics, consultation meetings, etc.
9. Brainstorm research/dissemination projects via discussions with supervisors and clinical team
10. Complete evaluation of resident's professional identity, confidence, and competency evaluation/assessment to identify knowledge/skills/abilities with respect to SMI/SED clinical practice in order to inform future training goals and independence

Middle of Training Year

11. Complete mid-year competency evaluations along with supervisors to measure progress and identify training needs
12. Continue providing outpatient and inpatient psychosocial rehabilitation services independently and with other trainees, under supervision
13. Continue participation in seminars, didactics, consultation meetings, etc.
14. May begin supervising junior-level trainees in their provision of psychosocial rehabilitation services where possible including intakes, specialized assessments, recovery planning, individual and group therapies, specialized interventions, etc.
15. Execute research/dissemination project
16. Conduct outreach to educate colleagues and community on SMI/SED and recovery-oriented care
17. Provide consultation to other staff and trainees on recovery orientation and interventions for persons with SMI/SED, as needed
18. Prepare for EPPP and other professional credentials (CPRP, etc.)
19. Complete evaluation of resident's professional identity and confidence to inform future training goals and independence

End of Training Year

20. Continue providing outpatient and inpatient psychosocial rehabilitation services independently and with other trainees, under supervision
21. Continue participation in seminars, didactics, consultation meetings, etc.
22. Continue providing consultation to other staff and trainees on recovery paradigm and interventions for persons with SMI/SED, as needed
23. Submit research/dissemination project findings for presentation at 1 conference and/or present if accepted; possibly submit manuscript for publication
24. Take licensing (EPPP) and other professional examinations
25. Prepare for and take state license exam
26. Apply for and obtain licensure (where jurisdiction permits prior to residency completion)
27. Complete end of year competency evaluations along with supervisors to measure progress and outcome of training

Throughout the Training Year

28. Participate in supervision, consultation, self and supervisory evaluations. Fulfill training requirements specific to residency program.

Training Plan: VA Connecticut VA Healthcare System / Yale University Medical School

Training goals are established by discussing required and desired experiences. Plans are developed by residents in conjunction with supervisors and training directors. Training plans should be revised accordingly to reflect new goals and objectives. This process is highly interactive between the resident and faculty. It is also further structured and monitored by the Residency Training Committee, which meets monthly.

Resident: _____

Date: _____

GOALS *Based on self-assessment of training needs to meet residency competencies	CLINICAL ROTATIONS & TRAINING ACTIVITIES *Where Resident will gain skills/knowledge and experiences to work toward listed goals
1. Conduct clinical work with individuals, groups and/or family members, work as part of interprofessional team, have exposure to community mental health experiences and receive clinical supervision.	Select primary clinical placement (20 hours per week) <ul style="list-style-type: none"> • Behavioral Health Recovery Clinic "Recovery from the Start" 4 month assessment rotation • Facilitating ACT groups. 4 month rotation • Facilitating Social Skills Training groups, 8 month rotation
2. Develop understanding and skill in the principles of psychosocial rehabilitation and evidence-based and promising practices for working with individuals with severe and persistent mental illnesses.	Participate in didactics <ul style="list-style-type: none"> • PSR Principles Seminar, weekly • Leadership Development Seminar (monthly) • Diversity Seminar (meets every other month) • SST and ACT Consultation Meetings • Program Evaluation and Research Seminar (monthly) • Interprofessional Case Assessment & Presentation Seminar (monthly)
3. Scholarly inquiry (research, program development, impact statement)	<ul style="list-style-type: none"> • Educational Dissemination Project (EDP) – design and develop a project that can be presented at the United States Psychiatric Rehabilitation Association's Annual Conference. An EDP can include designing a new psycho-educational group or program, research, a policy initiative.
4. Teaching and supervision	<ul style="list-style-type: none"> • Teach two seminars (possibilities include: ECCC professional development colloquia, PSR Residency Seminars, Peer Specialist seminars.) • Provide supervision and co-supervision to trainees

5. Consultation	<ul style="list-style-type: none"> • Provide consultation to two community providers (examples may include providing training, technical assistance, case consultation.) • Attend Continuum of Care meeting with other teams/units
6. Professional development	Participate in <ul style="list-style-type: none"> • Leadership Seminar Series • Quarterly mentorship meetings with supervisors and leadership from community agencies • Monthly individual meetings with each of the directors of training
7. Explore issues surrounding cultural diversity (mode of learning and skill building is up to individual)	<ul style="list-style-type: none"> • Attend monthly Diversity Seminar • Discuss cultural diversity issues in group and individual supervision

(Add additional rows as needed)

Training plan to be reviewed every four months with supervisor or as needed

Resident

Director of Psychology Training, PSR Residency

Director, Interprofessional Fellowship

B. Supervision of Junior Trainees

<u>Dates</u>	<u>Clinical Settings/Rotations</u>	<u>Supervisor(s)</u>

C. Research (1 project required). Describe the research project and expected product(s)

<u>Projects</u>	<u>Supervisor(s)</u>

II. Individualized Training Goals Describe the goal and check the relevant training program required competencies that might be reflected in that goal. Then describe the plan (through what activities will the goal be accomplished? Although there is not a specific number of individual goals that a trainee should have, most trainees have more than a few. Not all competency areas need to be checked. Goals should be phrased in terms a skill, ability, or proficiency you want to attain rather than just doing something or patiating in something (e.g., develop competence in the full DBT model). The Plan should state what you will do during the training year to accomplish the goal (e.g., supervised experience providing DBT. Attend the DBT 3 day training. Attend the DBT consultation group. Read DBT related literature).

Goal 1:	<u>Click to enter text.</u>
<u>Competency/Competencies:</u>	
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>
<input type="checkbox"/> <u>Communication and Interpersonal</u>	<input type="checkbox"/> <u>Intervention</u>
<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Supervision</u>
<input type="checkbox"/> <u>Consultation and Interprofession al</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>
<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>	

<u>Skills</u>
<i>Plan:</i> <u>Click to enter text.</u>

<u>Goal 2:</u>	<u>Click to enter text.</u>			
<u>Competency/Competencies:</u>				
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>
<input type="checkbox"/> <u>Communication and Interpersonal Skills</u>	<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Consultation and Interprofessional</u>	<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>	
<i>Plan:</i> <u>Click to enter text.</u>				

<u>Goal 3:</u>	<u>Click to enter text.</u>			
<u>Competency/Competencies:</u>				
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>
<input type="checkbox"/> <u>Communication and Interpersonal Skills</u>	<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Consultation and Interprofessional</u>	<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>	
<i>Plan:</i> <u>Click to enter text.</u>				

Goal 4:	<u>Click to enter text.</u>				
<u>Competency/Competencies:</u>					
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>	
<input type="checkbox"/> <u>Communication and Interpersonal Skills</u>	<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Consultation and Interprofessional</u>	<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>		
<u>Plan:</u> <u>Click to enter text.</u>					

Goal 5:	<u>Click to enter text.</u>				
<u>Competency/Competencies:</u>					
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>	
<input type="checkbox"/> <u>Communication and Interpersonal Skills</u>	<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Consultation and Interprofessional</u>	<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>		
<u>Plan:</u> <u>Click to enter text.</u>					

Goal 6:	<u>Click to enter text.</u>				
<u>Competency/Competencies:</u>					
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>	
<input type="checkbox"/> <u>Communication</u>	<input type="checkbox"/> <u>Individual and Cultural</u>	<input type="checkbox"/> <u>Consultation and</u>	<input type="checkbox"/> <u>Professional Values,</u>		

<u>and Interpersonal Skills</u>	<u>Diversity</u>	<u>Interprofession al</u>	<u>Attitudes, and Behaviors</u>
Plan: <u>Click to enter text.</u>			

Goal 7:	<u>Click to enter text.</u>			
Competency/Competencies:				
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>
<input type="checkbox"/> <u>Communication and Interpersonal Skills</u>	<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Consultation and Interprofession al</u>	<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>	
Plan: <u>Click to enter text.</u>				

Goal 8:	<u>Click to enter text.</u>			
Competency/Competencies:				
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>
<input type="checkbox"/> <u>Communication and Interpersonal Skills</u>	<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Consultation and Interprofession al</u>	<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>	
Plan: <u>Click to enter text.</u>				

Goal 9:	<u>Click to enter text.</u>				
<u>Competency/Competencies:</u>					
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>	
<input type="checkbox"/> <u>Communication and Interpersonal Skills</u>	<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Consultation and Interprofessional</u>	<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>		
<u>Plan:</u> <u>Click to enter text.</u>					

Goal 10:	<u>Click to enter text.</u>				
<u>Competency/Competencies:</u>					
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>	
<input type="checkbox"/> <u>Communication and Interpersonal Skills</u>	<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Consultation and Interprofessional</u>	<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>		
<u>Plan:</u> <u>Click to enter text.</u>					

Goal 11:	<u>Click to enter text.</u>				
<u>Competency/Competencies:</u>					
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>	
<input type="checkbox"/> <u>Communication</u>	<input type="checkbox"/> <u>Individual and Cultural</u>	<input type="checkbox"/> <u>Consultation and</u>	<input type="checkbox"/> <u>Professional Values,</u>		

<u>and Interpersonal Skills</u>	<u>Diversity</u>	<u>Interprofessional</u>	<u>Attitudes, and Behaviors</u>
Plan: <u>Click to enter text.</u>			

Goal 12:	<u>Click to enter text.</u>			
<u>Competency/Competencies:</u>				
<input type="checkbox"/> <u>Research</u>	<input type="checkbox"/> <u>Assessment</u>	<input type="checkbox"/> <u>Intervention</u>	<input type="checkbox"/> <u>Supervision</u>	<input type="checkbox"/> <u>Ethical and Legal Standards</u>
<input type="checkbox"/> <u>Communication and Interpersonal Skills</u>	<input type="checkbox"/> <u>Individual and Cultural Diversity</u>	<input type="checkbox"/> <u>Consultation and Interprofessional</u>	<input type="checkbox"/> <u>Professional Values, Attitudes, and Behaviors</u>	
Plan: <u>Click to enter text.</u>				

**Graduated Levels of Responsibility for Post-Doctoral Psychology Residents in SMI Specialty:
VA Connecticut Healthcare System / Yale University Medical School**

Supervisee: _____

Supervision Types:

Room. The supervising practitioner (SP) is physically present in the same room while the resident is engaged in health care services.

Area. The SP is in the same physical area and is immediately accessible to the resident. SP meets and interacts with patients/clients as needed. Resident and SP discuss, plan, or review evaluation or treatment. Area supervision is available only when the resident has formally been assigned a Graduated Level of Responsibility commensurate with this type of supervision.

Available. Services furnished by resident under SP's guidance. SP's presence is not required during the provision of services. SP available immediately by phone or pager and able to be physically present as needed. This type of supervision is permissible only when the resident has formally been assigned a Graduated Level of Responsibility commensurate with this type of supervision.

Only circle a Level of Supervision for activities the supervisee is performing

Clinical Activity (supervisors are to identify the specific tasks that will be accomplished by the individual e.g., individual therapy, assessment, etc).	Level of Supervision (circle the level)	Supervisor Initials & Date
1.	Room Area Available	
2.	Room Area Available	
3.	Room Area Available	
4.	Room Area Available	
5.	Room Area Available	
6.	Room Area Available	

Ultimately, the SP determines which specific activities the resident will be allowed to perform within the context of these assigned levels of responsibility.

Supervising Licensed Psychologist

Supervisee Signature

**PSR Fellow/Resident Competency Assessment Form: VA Connecticut Healthcare System /
Yale University Medical School**

Trainee: _____

Supervisor: _____

Training Year: _____

Rotation: _____

Date: _____ **Trimester (circle one):** *First* *Second* *Third*

General Framework for Competency Ratings (Half points are permitted):

- 1 Substantial supervision required on all cases or related work; limited to no autonomous judgment.
- 2 Supervision on most straightforward cases or related work; minimal autonomous judgment (Intern Entry Level).
- 3 Supervision on intermediate level cases or related work, or when learning a new skill area; autonomous judgment on routine cases.
- 4 Score represents readiness for practice at the entry level. Supervision on advanced cases or related work; autonomous judgment (Intern Exit Level/ Postdoc Entry Level).
- 5 Consultation only expected on advanced, unusual cases or related work
- 6 Readiness at the entry level for advanced specialized practice. Consultation only expected on highly atypical, advanced cases or related work that requires focused knowledge; autonomous judgment (Postdoc Exit Level).
- 7 Clinical Psychologist at the expert level (e.g., Diplomate/ABPP)

Exit criteria: For the last evaluation period, no competency item can be rated below a “6” for a trainee to pass the residency/fellowship. Grievance procedures will be followed if a trainee disputes any competency rating.

SUPERVISORS: At each evaluation interval, the evaluation must be based in part on direct observation of the competencies evaluated (APA Standards of Accreditation, page 39, item D.1.ii). Please indicate how direct observation was completed:

- Observed resident’s individual or group clinical work
 Co-facilitated clinical work with resident
 Other form of direct observation:
-

This evaluation is also based on the following:

- Discussion with team members or colleagues
 Case discussion in supervision
 Other form of evaluation:
-

1. Integration of Science and Practice

Trainees must demonstrate the ability to critically evaluate and disseminate research or other scholarly activities (presentations, publications, program evaluation), and demonstrate understanding of the influence of science on practice, and practice on science.

	Self	Supervisor
Seeks out current literature to enhance clinical work or current research project. Cites references appropriately (when indicated)		
Identifies and applies appropriate evidence-based practices		
Engages in scholarly inquiry, such as literature review, program development, program evaluation, or research to inform clinical practice		
Demonstrates critical thinking in scholarly activities (e.g., EDP)		
Is able to effectively summarize relevant literature in supervision, case conferences, research presentations, or professional talks		
Total Competency Section Score (5-35)		

2. Individual and Cultural Diversity

Trainees must develop and demonstrate the ability to conduct all professional activities with sensitivity to issues of individual diversity as appropriate to the setting, population served, and focus/specialty area.

	Self	Supervisor
Committed to providing clinical services that are sensitive to cultural and other individual differences.		
Possesses an understanding of how their own personal/cultural history, attitudes, and biases may affect how they understand and interact with others		
Integrates awareness and knowledge (including current theoretical and empirical knowledge) of individual and cultural diversity <i>across the full range of professional roles</i> (e.g., assessment, intervention, research, communication)		
Total Competency Section Score (3-21)		

3. Ethics and Legal Standards

Trainees act professionally and ethically. This includes behavior in accordance with the APA Code and relevant laws, regulations, rules, policies, standards and guidelines.

	Self	Supervisor
Discusses all applicable confidentiality issues openly with clients and others		
Demonstrates the ability to think critically about ethical issues, recognizes ethical dilemmas as they arise, and applies ethical decision-making processes in order to resolve them, seeking consultation when necessary.		
Demonstrates good knowledge of and acts in accordance with the APA Ethical Principles of Psychologists and Code of Conduct in <i>all</i> professional endeavors (e.g., assessment, intervention, research, consultation, communication, teaching, supervision, etc.)		
Knowledgeable of and acts in accordance with relevant laws, regulations, rules, and policies governing health service psychology at the organizational, local, state, regional, and federal levels		
Appropriately manages boundaries in all professional contexts		
Total Competency Section Score (5-35)		

4. Professional Values, Attitudes, and Behaviors

Trainees demonstrate integrity, dependability, and responsibility. They also must demonstrate reflective practice and self-assessment of strengths, weaknesses, and continued efforts for improvement.

	Self	Supervisor
Writes well-organized notes that accurately capture the clinical encounter, and document client's mental status, risk assessment, goals and preferences, and psychoeducational interventions.		
All client contacts and care tasks (including scheduled and unscheduled appointments, and phone contacts) are documented and meet agency/organization expectations for timeliness and content.		
Seeks consultation/supervision and uses it productively by coming prepared to supervision meetings.		
Conducts self in a professional manner. Is accountable, dependable, responsible, and shows initiative while managing workload effectively.		
Acknowledges own competencies and limitations (i.e. has good self-appraisal skills) and recognizes how personal characteristics influence work performance		
Total Competency Section Score (5-35)		

5. Interprofessional Systems

Trainees are aware of relevant issues and constructs when working with other disciplines and organizations. Possess an understanding of key interactions with other agencies, settings, disciplines, and professions.

	Self	Supervisor
Demonstrates a good understanding of larger organizational dynamics as well as system influences within programs and appreciating how such forces influence clinical care.		
Collaborates effectively in interprofessional treatment planning		
Collaborates respectfully and effectively with individuals of other disciplines, teams and programs		
Total Competency Section Score (3-21)		

6. Communication and Interpersonal Skills

Trainee demonstrates effective communication skills and the ability to form and maintain successful professional relationships

	Self	Supervisor
Consistently achieves a good rapport with clients.		
Achieves and maintains positive and professional working relationships with relevant stakeholders, treatment teams, peers and supervisors.		
Writes and speaks in a clear and concise manner		
Effectively communicates results or feedback (e.g., clients, family members, other professionals)		
Effectively manages difficult interpersonal challenges and conflicts		
Total Competency Section Score (5-35)		

6. Assessment Please do not leave this section blank. Please request feedback from assessment supervisors (Screening Clinic or Interprofessional Case Assessment Rotation).

Names of assessment supervisors who assisted in completing this section

Trainees must demonstrate competence in evidence-based psychological assessment with a variety of diagnoses, problems, and needs

	Self	Supervisor
Autonomously selects appropriate tests to answer referral question.		
Promptly and proficiently conducts interviews, assessments, and evaluations.		
Appropriately administers, scores, and interprets test instruments		
Writes a well-organized psychological report, incorporating information from the medical record, answering the referral question clearly, and providing referral source with specific recommendations for care.		
Plans and carries out a feedback interview. Explains the test results in terms the client and/or caregiver can understand, provides suitable recommendations and responds to issues raised by client, team, or caregiver.		
Performs risk assessments consistent with standards of practice		
Total Competency Section Score (6-42)		

7. Intervention

Trainees demonstrate competence in case conceptualization, evidence-based interventions for various of diagnoses, problems, and needs across a range of therapeutic orientations, techniques, and approaches.

	Self	Supervisor	
Individual Interventions	Formulates a well thought out case conceptualization that draws on theoretical and research knowledge.		
	Collaborates with client to form appropriate treatment and rehabilitation goals that addresses client needs and preferences.		
	Conducts interventions that are well timed, effective, and consistent with sound clinical practice and evidence-based practices.		
	Monitors the effectiveness of interventions and impact on outcomes.		
	Effectively evaluates, manages, and documents risk by assessing concerns such as suicidality, homicidality, and safety issues. Collaborates with clients and providers to develop short-term safety plans, intensifying treatment as needed.		
Group Interventions	Explains the limits of confidentiality in the context of group therapy.		
	Demonstrates ability provide evidence-based, clinically sound group interventions		
	Arrives prepared with material and content to discuss in group and facilitates or co-facilitates group.		
	Intervenes in group skillfully, and attends to member participation and needs		
	Manages group dynamics well, and facilitates respectful communication		
	Effectively evaluates, manages and documents client risk by assessing immediate safety concerns that arise in group context.		
Total Competency Section Score (11-77)			

8. Consultation

Consultation and interprofessional skills are reflected in the intentional collaboration with other individuals or groups to address a problem, seek or share knowledge, or promote effectiveness in

professional activities with individuals and their families, other professionals, groups, or systems related to health and behavior.

	Self	Supervisor
Exhibits a comfort and proficiency in providing effective consultation and feedback to clinical programs and interprofessional staff.		
Communicates well with referral sources or relevant providers		
Is able to perform case consultation/conceptualization in interprofessional contexts, with appreciation and integration of contributions of other professions		
Demonstrates an ability to provide program or systems level consultation using their understanding of their own professional role and expertise		
Total Competency Section Score (4-28)		

9. Teaching and Supervision

Competence in supervision and teaching is reflected in effective communication of psychological principles, procedures, and/or data. Supervisor ratings are based on direct observation, case discussions, case presentations, feedback from peers or junior trainees, and rating is of trainee's broad abilities as a supervisor.

	Self	Supervisor
Demonstrates the ability to give presentations in a formal setting.		
Mentors small groups or individuals to teach skills, communicate knowledge and provide feedback to clients, families, and other professionals		
Demonstrates knowledge of supervision theory/strategies		
Builds good rapport with supervisee/audience/peers and establishes a safe learning environment		
Establishes clear goals, objectives, and agendas for supervision, teaching activities, or presentations		
Total Competency Section Score (5-35)		

10. Advocacy

Trainees engage in systemic advocacy to impact policy/procedure to benefit individuals at an institutional or community level. Trainees advocate for and empower individual recipients of the services provided.

	Self	Supervisor
Notices and champions for the change of situations in the community that discriminate against individuals or groups		
Teaches, supports, and encourages self-advocacy, including connecting individuals to legal and advocacy resources as needed or requested		
Combats stigma, oppression, discrimination, and prejudice in all forms		
Advocates for improved access, inclusion and integration with public services and resources and integration to facilitate an individual's recovery, improved quality of life, and full community integration		
Advocates for system changes to make services responsive to the needs of individuals receiving services.		
Total Competency Section Score (5-35)		

11. Psychosocial Rehabilitation and Recovery-Oriented Services

Trainees must demonstrate competence in therapeutic approaches that encourage individuals with SMI to develop their fullest capacities through learning and environmental supports. Trainees must demonstrate an understanding of recovery-oriented services, and how to provide recovery-oriented, person-centered treatment.

	Self	Supervisor
Collaboratively assesses preferences, strengths, and needs, and promotes individual choice to help clients achieve goals, participate in treatment, or deal with crises.		
Develops linkages to natural supports in the community, and facilitates practical and meaningful activities for individuals to live, learn, work and socialize in the environments of their choice.		
Collaborates with individuals to develop effective rehabilitation plans using goals with specific, measurable, time-framed action steps.		
Instills hope via verbal and non-verbal communication regarding a client's potential for recovery. Identifies, assesses, and plans opportunities that empower clients to transition from professional services to natural community supports.		
Facilitates and encourages skill building, self-discovery, and learning across all life domains to assist individuals in achieving their goals and develop strategies for relapse prevention for mental and physical health.		
Assists individuals in modifying their living, learning, working, and social environments to enhance recovery.		
Total Competency Section Score (6-42)		

SUPERVISOR COMMENTS:

Summary of Strengths:

Areas of additional development or remediation, including goals for next rotation:

OVERALL ASSESSMENT

_____ Trainee has made sufficient progress toward completion of training goals specific to this rotation.

_____ Trainee has not made sufficient progress this rotation, as skills have not been rated at an appropriate level of competence. Will speak with DOT and/or invoke Due Process.

Hours of weekly supervision scheduled with this supervisor: Individual:_____ Group:_____

Supervisor Signature_____

Date _____

Trainee Signature_____

Date _____

Trainee Comments *(optional, use additional sheet if necessary)*

Acknowledgement. This document is based on examples provided by Training Directors, as well as language from APA's Standards of Accreditation for Health Service Psychology, the American Board of Professional Psychology's Clinic Psychology Competencies, and Psychiatric Rehabilitation Association's Certification for Psychiatric Rehabilitation.

**Professional Identity and Confidence Evaluation for Post-Doctoral Psychology Residents in
SMI/SED Specialty: VA Connecticut Healthcare System / Yale University Medical School**

Resident: _____ Date: _____

The following questions ask you to rate your current level of comfort on a variety of issues related to professional self-confidence and identity. Each question will ask you to rate yourself twice: first with regard to your identity as a health care provider working from a Psychosocial Rehabilitation (PSR) – Recovery oriented practice model, and then with regard to your identity as a Professional Psychologist.

1. I am confident that my clinical and research skills are sufficient to allow me to perform effectively.

a. As a Psychosocial Rehabilitation - Recovery oriented provider

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

b. As a Professional Psychologist

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

Comments:

2. I am confident that I can work collaboratively with health care professionals from other disciplines and participate effectively on interprofessional health care teams.

a. As a Psychosocial Rehabilitation - Recovery oriented provider

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

b. As a Professional Psychologist

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

Comments:

3. I am confident in my ability to provide training to others in my discipline and to interprofessional staff.

a. As a Psychosocial Rehabilitation - Recovery oriented provider

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

b. As a Professional Psychologist

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

Comments:

4. I am confident that I can stay informed about advances in my profession and in PSR through reading literature and attendance at professional conferences and other educational offerings.

a. As a Psychosocial Rehabilitation - Recovery oriented provider

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

b. As a Professional Psychologist

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

Comments:

5. I am confident that I can join and actively participate in professional organizations.

a. As a Psychosocial Rehabilitation - Recovery oriented provider

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

b. As a Professional Psychologist

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

Comments:

6. I am confident that I have the background and knowledge to prepare effectively for relevant specialty examinations.

a. As a Psychosocial Rehabilitation - Recovery oriented provider (i.e., ABPP, USPRA CPRP certification)

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

b. As a Professional Psychologist (i.e., progressing toward licensure examination)

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

Comments:

7. I am confident in my ability to provide culturally sensitive services.

a. As a Psychosocial Rehabilitation - Recovery oriented provider

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

b. As a Professional Psychologist

1	2	3	4	5
not at all	somewhat	moderately	very well	extremely well

Comments:

As residents increase their confidence and levels of responsibility, they receive more complex cases, more independent clinical work, the ability to pursue own training goals, and take on additional cases if desired. This is all determined in a collaborative nature between the resident, supervisors, and the Director of Training.

End of Fellowship Program Evaluation Survey: VISN 5 MIRECC – VA Advanced Fellowship Program in Mental Illness Research and Treatment

The purpose of this survey is to collect information from Fellows in our program about their experiences in the fellowship and their opinions regarding the utility of program activities in achieving their Fellowship goals. We appreciate your taking the time to provide this information and will use it to inform the fellowship and its focus on relevant activities for its Fellows.

Name:

Year of Entry to The Fellowship:

Goal 1: Scholarly Inquiry and Research. Since starting the fellowship, have you*:

Authored/Co-Authored a PAPER/PRESENTATION at a professional meeting?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, approximately how many papers/presentations have you authored/authored at a meeting?		
Authored/Co-Authored a POSTER at a professional meeting?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, approximately how many posters have you authored/authored at a meeting?		
Authored/Co-Authored a PAPER in a scientific journal?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, approximately how many papers have you authored/authored in a journal?		
Received a Federal Grant or Other Federal Award for research funding?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, approximately how many federal grants/awards have you received for research funding?		
Received a State or Local Grant or Contract for research funding?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, approximately how many state/local grants/contracts have you received for research funding?		
Done work in program implementation, evaluation, or dissemination?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

*Work published (or in press)/presented during fellowship training. Books may be included.

Since starting the fellowship, the VISN 5 MIRECC Fellowship has so far provided me with sound training in Scholarly Inquiry and Research:

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neither Agree nor Disagree
- 4 - Agree
- 5 - Strongly Agree

Goal 2: Application of Scientific Knowledge to Clinical Practice. Since starting the fellowship, have you:

Received formal training or implemented empirically-supported treatments and manualized interventions in your clinical practice?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which ones?		

Since starting the fellowship, the VISN 5 MIRECC Fellowship has so far provided me with sound training in Application of Scientific Knowledge to Clinical Practice:

- 1 - Strongly Disagree
 2 - Disagree
 3 - Neither Agree nor Disagree
 4 - Agree
 5 - Strongly Agree

Goal 3: Consultation, Supervision, and Teaching. Since starting the fellowship, have you:

Provided consultation to individuals or programs on topics related to psychological research or practice?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		
Supervised psychology trainees (externs, interns)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		
Taught undergraduate or graduate classes in psychology or related disciplines?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		

Since starting the fellowship, the VISN 5 MIRECC Fellowship has so far provided me with sound training in Consultation, Supervision, and Teaching:

- 1 - Strongly Disagree
 2 - Disagree
 3 - Neither Agree nor Disagree
 4 - Agree
 5 - Strongly Agree

Goal 4: Organizational Management and Administration. Since starting the fellowship, have you:

Been involved in any managerial or administrative tasks as part of research activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		

Been involved in any managerial or administrative tasks as part of clinical services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		
Been involved in any activities related to program evaluation or performance improvement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		

Since starting the fellowship, the VISN 5 MIRECC Fellowship has so far provided me with sound training in Organizational Management and Administration:

- 1 - Strongly Disagree
 2 - Disagree
 3 - Neither Agree nor Disagree
 4 - Agree
 5 - Strongly Agree

Goal 5: Professional Conduct, Ethics, and Legal Matters. Since starting the fellowship, have you:

Completed additional training in ethics or legal matters as part of your research or clinical work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		
Applied knowledge of ethics and legal matters in clinical service activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		
Applied knowledge of ethics and legal matter to the conduct of human subjects research?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		

Since starting the fellowship, the VISN 5 MIRECC Fellowship has so far provided me with sound training in Professional Conduct, Ethics, and Legal Matters:

- 1 - Strongly Disagree
 2 - Disagree
 3 - Neither Agree nor Disagree
 4 - Agree
 5 - Strongly Agree

Goal 6: Cultural and Individual Diversity Issues. Since starting the fellowship, have you:

Completed additional training in cultural and individual diversity issues?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		
Applied knowledge of cultural and individual diversity issues in clinical service activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		
Applied knowledge of cultural and individual diversity issues in research activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please describe or provide an example.		

Since starting the fellowship, the VISN 5 MIRECC Fellowship has so far provided me with sound training in Cultural and Individual Diversity Issues:

- 1 - Strongly Disagree
 2 - Disagree
 3 - Neither Agree nor Disagree
 4 - Agree
 5 - Strongly Agree

Goal 7: Confidence and Professional Identity. Since starting the fellowship, have you:

Been a member of a NATIONAL professional organization or society?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, approximately how many?		
Had a leadership role/s in a national professional organization?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, approximately how many?		
Been a member of a STATE/PROVINCIAL/REGIONAL professional organization?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, approximately how many?		
Had a leadership role/s in state/Provincial, regional or National Organizations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, approximately how many?		

Since starting the fellowship, the VISN 5 MIRECC Fellowship has so far provided me with sound training in Confidence and Professional Identity:

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neither Agree nor Disagree
- 4 - Agree
- 5 - Strongly Agree

General questions:

1. What did you do (or wish you would have done) during your first AND second years (if relevant) of fellowship to prepare you for your current role(s)?

2. Is there anything that would be helpful for fellows to know regarding thinking about career trajectories while on fellowship (i.e., what did you wish someone had told you at the start of fellowship that would have helped or improved your experience)?

3. What would have made the program better and/or more responsive to your goals and areas of interest?

SMI/SED PSR Functional Competencies

The specialized training needed to develop competence to treat persons with SMI/SED includes: very different assessment methods that assess functional capability rather than symptomatology, EBPs and promising practices designed specifically for this population, interventions modified and found to be effective with people in this population in the forensic mental health system, research methods adapted for populations such as this, and systems transformation methods specific to large mental health systems that serve this population, to name but a few – these are the major areas of specialized training needed by psychologists to work with individuals with SMI/SED. With funding from a Board of Educational Affairs grant and from Division 18, a meeting was convened following the 2016 APA convention to identify the specific competencies that are needed to meet the training needs of psychologists. While it is recognized that not every post-doctoral specialty program could include all of these, the following competencies are those that would ideally be included or available to trainees (a broad, general descriptive narrative follows the listing):

Assessment

- Comprehensive knowledge of strengths based and functional capability assessments and ability to use these
- Ability to utilize standardized assessments in ways that may require modification in light of the fact that these assessments were not developed or normed using persons with SMI/SED
- Ability to competently utilize specialty assessments such as the Structured Clinical Interview (SCID for DSM), the Positive and Negative Syndrome Scale (PANSS), the Brief Psychiatric Rating Scale (BPRS), and the Brief Psychiatric Rating Scale for Children (BPRS-C) as needed and appropriate
- Ability to conduct an assessment of an individual's readiness and desire for PSR interventions
- Ability to conduct an assessment of internal and external resource availability and the individual's ability to utilize available resources
- Ability to assess perceived recovery and life satisfaction/quality of life
- Ability to assess and address positive and negative symptoms
- Ability to recognize psychosis and thought disorder and understand in depth the nuances of each condition considered within the purview of SMI/SED
- Ability to recognize and screen for potential cognitive deficits that are core areas of dysfunction for people with SMI/SED including processing speed, verbal memory, and attention
- Ability to recognize and screen for social deficits that often accompany these disorders
- Ability to recognize the limitations posed by cognitive impairments and the potential for lessened insight and, as needed, ability to conduct behavioral observational assessments that accurately account for these
- Ability to assess for the potential risk for suicide and violence to self or others
- Ability to recognize and understand etiology of comorbid trauma and substance use disorders in SMI/SED disorders and be competent in differential diagnosis of similarly presenting diagnoses such as PTSD and personality disorders
- Knowledge of medication side effects especially those specific to psychotropic medications and ability to assess for medication adherence and barriers to adherence
- Ability to integrate the intersection of diversity related to age, cultural, spiritual/religious beliefs, etc. specifically related to the presentation of symptoms unique to SMI/SED
- Ability to recognize the level of capacity and competence of an individual with SMI/SED in order to make appropriate recommendations regarding interventions or to refer to appropriate specialty

services including those provided by other disciplines

Interventions

Comprehensive knowledge of PSR interventions designed to foster recovery and meet the needs identified by each person:

- Schizophrenia PORT evidence based and promising practices (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010):
- Assertive Community Treatment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
- Supported Employment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
- Cognitive Behavioral Therapy (CBT) and CBT for psychosis (CBTp) – knowledge of differences between CBT and CBTp and ability to competently practice and supervise others in both interventions
- Family intervention/psychoeducation – knowledge of fidelity criteria and ability to implement intervention and supervise others
- Social learning program (Token Economy) – knowledge of intervention, its appropriate use, ability to implement and train and supervise others
- Integrated dual diagnosis treatment/Co-occurring disorders treatment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
- Weight management approaches and Smoking cessation approaches – ability to competently implement appropriate interventions and supervise others
- Illness self-management including Wellness Recovery Action Planning (WRAP), behavioral tailoring for medication – knowledge of interventions, how to implement and supervise others
- Cognitive Remediation and Social Cognition Training – knowledge of interventions, ability to competently practice and supervise others
- PSR interventions for first episode psychosis – knowledge of recent research indicating the effectiveness of a set of interventions (RAISE) and ability to implement interventions, participate on teams, and supervise others
- Peer support/peer delivered services – knowledge of interventions and ability to implement and supervise peers and other professionals

Additional interventions to address critically important problems for people with SMI/SED including:

- Stigma/Self-stigma interventions – knowledge of, and ability to implement interventions to change attitudes and decrease discriminatory behaviors among health providers and the public at large
- Trauma interventions (trauma informed and trauma specific care) – ability to competently implement trauma interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care
- Suicide prevention – ability to recognize when individuals may be at risk and provide high levels of support, refer for medical intervention and provide treatment for depression in order to reduce hopelessness
- Violence prevention – ability to recognize when individuals may be at risk and refer for medical intervention while providing high levels of support
- Interventions to decrease homelessness – ability to provide a comprehensive array of services designed to facilitate supported housing, e.g., trauma informed care, relapse prevention for

substance abuse, and other supports to maintain housing

- Motivational interviewing for those with SMI/SED – ability to competently implement motivational interviewing as appropriate and to supervise others in practice

Specialized interventions for forensic/criminal justice populations with SMI/SED including:

- Knowledge of the factors that impact the success of interventions for forensic and criminal justice populations with SMI/SED
- Forensic Assertive Community Treatment (FACT) – ability to ability to implement intervention, participate on team, and supervise others
- CBT for those in criminal justice/forensic settings – ability to competently provide specialized CBT services and to supervise others in practice
- IDDT/Co-occurring disorders treatment for those in criminal justice/forensic settings – knowledge of the specialized needs of people with SMI/SED in these settings, ability to provide integrated mental health and substance use services targeted to the population, and supervise others in practice
- Trauma interventions for those in criminal justice/forensic settings (trauma informed and trauma specific care) – recognition of trauma as the norm for those with SMI/SED in the forensic and criminal justice system, ability to competently provide trauma specific interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care, including services for those at highest risk and to supervise others in provision of services
- Supported housing interventions for those in criminal justice/forensic settings – ability to implement comprehensive services to assure supported housing is available for individuals being released into the community
- Transition planning and follow-up for criminal justice/forensic settings – ability to implement adequate and appropriate transition planning and follow up for individuals being released into the community

Specialized interventions for people with bipolar disorder - in addition to demonstrating competence with the above interventions for people with SMI/SED (several of which are also recommended specifically for this population):

- Demonstrate an ability to competently provide interpersonal and social rhythm therapy (IPSRT) and Family Focused Treatment (FFT) for bipolar disorder and to supervise others in practice
- Understand the potential of Dialectical behavior therapy (DBT) which may also be helpful for individuals with bipolar disorder and personality disorders

Consultation

- Ability to effectively present information and develop treatment recommendations that are understandable to the person, his or her support team, and in accord with his or her goals
- Ability to competently work with an interprofessional team and present information about persons with SMI/SED so that team members can understand and learn from the presentation
- Ability to apply specialty knowledge and expertise concerning SMI/SED symptomatology and diagnosis to problems that arise in professional settings
- Comprehensive knowledge of psychosocial functioning and recovery and ability to describe this to team members, other colleagues, and members of the public
- Ability to provide education and training for mental health staff on all aspects of the recovery paradigm and PSR assessments and interventions

- Ability to integrate all information into a case formulation that presents an opportunity for use of PSR interventions designed to promote recovery and attainment of the goals articulated by each person
- Ability to assist supervisees and team members in the management of difficult behaviors that may be exhibited by persons with SMI/SED
- Ability to integrate the knowledge, values, and attitudes critical for successful work with people with SMI/SED into interprofessional team settings to facilitate shared decision making
- Ability to work with staff in specialized facilities such as supported housing, etc. to help them recognize and respond appropriately to symptoms and problem behaviors to help individuals with SMI/SED thrive in the community
- Ability to educate, train and supervise staff at all levels of training from front line behavioral health staff through to highly trained staff and managers/administrators, in the best ways to help people with SMI/SED manage symptoms, set and achieve goals for themselves, and use resources available to them. Some examples of potential issues and difficult behaviors include limit setting, stigma, empathy, delusions/hallucinations, crisis intervention
- Ability to consult with families about their family member's illness and the role of family in treatment
- Knowledge of resources to help with access to care (e.g., family members trying to get members into care and navigate a complex healthcare system)
- Ability to educate and train staff in facilities and on specialized units for youth, young adults, and older persons where knowledge and expertise is lacking about behavioral health particularly SMI/SED

Research and Evaluation

- Recognition of the importance of incorporating persons with lived experience of SMI/SED into all aspects of research and evaluation from conception to completion and publication. This includes formulation of hypotheses, study questions and design, determination of statistical methods, participants to be recruited, etc.
- Knowledge of and ability to use mixed methods research designs
- Familiarity with and ability to use single case designs (disorders may be persistent over time and multiple baselines provides a clearer picture of the impact of different treatment components and their helpfulness to individuals)
- Recognition of ability to incorporate family members and first degree relatives into designs (research provides insight into how the illness manifests in individuals vs. family members looking at the phenotypes in individual and family)
- Recognition of importance of involvement of caregivers and other stakeholders in research and willingness to incorporate them into designs
- Ability to collaborate with other disciplines (e.g., psychiatry, rehabilitation services, nursing, etc.)
- Up to date knowledge of the latest assessments and interventions for this population
- Ability to utilize research/evaluation knowledge to adapt/modify assessments and interventions that have excluded persons with SMI/SED and to do so appropriately recognizing when fidelity to the original practice is essential
- Recognition and understanding the needs of vulnerable populations vis a vis their participation in research efforts
- Recognition and understanding of the ability of persons with SMI/SED to provide informed consent
- Ability to inform and educate IRBs about the type of intervention research common with SMI/SED populations such as PSR interventions

- Understanding of the unique needs of persons with SMI/SED vis a vis research/evaluation and ability to apply this knowledge to prevent/minimize drop out as typically this is different for SMI/SED 1) drop outs tend to be doing worse and 2), severe economic disadvantages impact people with SMI/SED disproportionately 3), follow up studies need to include more time (>1 year) due to the nature of the illness
- Knowledge of and ability to conduct multifactorial designs of programs as these are the norm with SMI/SED populations; understanding of the importance of controls for non-specific factors
- Ability to identify appropriate outcomes for program evaluation efforts due to broad nature of quality of life, psychosocial functioning, and recovery
- Ability to undertake program evaluation which is critical so that a developed program can be improved - systems within which SMI/SED persons are seen may be more difficult to work with than structured research settings due to presence of multiple stakeholders
- Ability to obtain buy-in from multiple under-resourced clients and stakeholders

Supervision/Teaching

- Comprehensive knowledge of all PSR assessments and interventions and ability to impart knowledge about these and to supervise others in practice
- Ability to provide education and training for mental health staff on all aspects of the recovery paradigm and PSR interventions
- Ability to impart knowledge and help others develop an understanding of, and ability to convey the importance of hope, respect, positive regard, and acceptance of person's goals, wishes, and preferences in the development of the therapeutic relationship (which is key and sometimes difficult to form) and to supervise others in their development of these factors
- Ability to impart an understanding of the pace and non-linear process for recovery and ability to develop positive expectations for the person's progress despite the combination of social, functional, and cognitive impairments that are commonly observed
- Ability to help trainees and supervisees recognize incremental improvements and utilize the process of shaping in goal setting and recovery
- Ability to impart knowledge of the phenomenology of the disorders of SMI/SED (e.g., auditory hallucinations, negative symptoms such as diminutions of basic drives, etc.)
- Ability to supervise effective goal setting with people with SMI/SED that is often different in quality (i.e., level of difficulty) and outcome (i.e., type of goals set) than in those without SMI/SED
- Ability to promote self-examination of fear and pre-conceptualization of people with SMI/SED including stigma and self-efficacy
- Ability to teach and supervise trainees about appropriate boundaries and differences in working with this population
- Knowledge of standard tools for fidelity measures and ability to supervise trainees in their use
- Ability to use live or audiotape feedback to understand the often complex nuances of work with persons with SMI/SED
- Ability to supervise a range of other mental health providers (e.g., psychiatrists, peers, nurses, social workers, occupational therapists)
- Knowledge of the complexity of systems change issues and ability to promote resiliency as resistance is encountered

Management/Administration

- Knowledge of the complexity of systems change issues and ability to promote resiliency as

resistance is encountered

- Knowledge of needed systems of care and the importance of integration and interprofessional cooperation
- Familiarity with reimbursement structures and with PSR services that are not funded or are partially funded and ability to secure funding for needed specialized services
- Knowledge of Commission on Accreditation of Rehabilitation Facilities (CARF) requirements for accreditation and ability to implement policies and procedures needed to secure and maintain accreditation
- Knowledge of Joint Commission and Centers for Medicare and Medicaid Services (CMS) standards and ability to implement policies and procedures needed to secure and maintain accreditation and ensure CMS standards are met
- Knowledge of the Americans with Disabilities Act and its amendments and application to those with SMI/SED
- Ability to lead effectively within complex interprofessional teams and settings
- Knowledge of implementation and dissemination of EBPs for those with SMI/SED and the challenges of this in multiple, complex settings
- Recognition of the importance of conducting program evaluation and/or quality improvement studies and ability to convince management and team members of this
- Ability to develop comprehensive programs across the full continuum of care that incorporates needed interventions such as supported employment and others
- Knowledge of the complexity of systems change issues and ability to implement needed changes
- Ability to assist organizations to understand the importance of providing services within a recovery orientation
- Comprehensive knowledge of all PSR assessments and interventions and ability to impart knowledge about these and ensure cooperation and implementation within teams and overall system

Advocacy

- Ability to create opportunities for people with SMI/SED to meet and interact with others with and without SMI/SED, build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion
- Knowledge of community resources and ability to reach out to these as a means of expanding access to services for people with SMI/SED
- Knowledge of community resources and ability to intervene to help with access to care (e.g., family members trying to get members into care and navigate complex system).
- Knowledge of laws that affect individuals with SMI/SED negatively and may lead to human rights violations (e.g., laws about competency restoration process, not guilty by reason of insanity, etc.).

Please Note: See Appendix III for the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*, a tool that can be used by practitioners and supervisors to evaluate knowledge and skills in the competencies of this specialty. This instrument is a modification of the evaluation tool developed by the Council of Professional Geropsychology Training Programs known as the *Pikes Peak Geropsychology Knowledge and Skill Assessment Tool* (Karel, et al., 2012). Permission was received from the Council of Professional Geropsychology Training Programs to modify and use the Pikes Peak tool; we are grateful for the Geropsychology Council for granting their permission to modify and use this excellent instrument.

Broad, General Descriptive Narrative of the SMI/SED PSR Functional Competencies

Competence in Assessment Skills:

Sophisticated assessment is essential to any recovery service plan. Residents should be able to appropriately assess, evaluate and then develop practical interventions for individuals with severe and persistent mental illnesses, including those with complicated mental, substance use and medical comorbidities, often with histories of trauma. Close monitoring and supervision to ensure the ongoing development and presence of these skills is an essential part of this residency year. All residents present in weekly supervisory meetings, team meetings and case conferences.

Competence in Psychotherapeutic Interventions - Individual, Family, and Group:

By the completion of their training year, residents should demonstrate skill in applying and adapting evidence-based interventions with SMI/SED consumers. Residents are expected to independently assist clients with the development of realistic goals, development of tailored clinical and recovery-oriented interventions that meet the client's identified goals, develop action steps for goal achievement, modify rehabilitation plans to reflect the needs and values of the client and determine satisfaction of services provided. Residents also are expected to manage crisis situations and identify opportunities for transition of services. When working with and on behalf of individual clients, family members and/or groups, residents are expected to demonstrate the ability to effectively work with diverse populations, interprofessional providers, various program specialties, and provide appropriate interventions in response to a range of presenting psychosocial problems and treatment concerns.

Competence in Consultation Skills:

Within the bounds of confidentiality and privacy, residents must be able to listen, understand, communicate, and display excellent rapport with relevant stakeholders including: the person served, family members, relevant community members, other healthcare providers within and outside of the system, and partnering agencies. The resident is expected to exhibit comfort and proficiency in providing effective consultation and feedback to the person served, family members, clinical programs, interprofessional staff and community partners.

Competence in Teaching and Supervision Skills:

By the completion of the training year, residents should demonstrate the ability to give presentations in a formal didactic setting, develop mentoring skills for working with small groups and/or one to one to teach skills, communicate knowledge, and provide feedback to those they serve, their support networks, other professionals, trainees, para-professionals, and/or community partnering agencies. When providing supervision and teaching, residents should demonstrate sensitivity to ethical, legal, and cultural issues and demonstrate ability to teach the principles of PSR.

Competence in Scholarly Inquiry and Application of Theoretical and Scientific Knowledge to Practice:

Residents are expected to participate in scholarly inquiry, and apply theoretical and scientific knowledge to their clinical practices. They are expected to engage in their own scholarly endeavors which may include research, grant proposal writing, as well as program development, implementation, and evaluation.

Competence in Understanding Organizational and Systemic Dynamics:

By the completion of their training, residents should demonstrate an advanced level of knowledge of the various healthcare systems in which they have operated and have a broader understanding of

health and mental healthcare systems both nationally and to some extent globally. They should show awareness of and sensitivity to systemic issues that impact the delivery of services. They should demonstrate a good understanding of organizational dynamics as well as systemic issues within programs, effectively functioning within various institutional contexts and appreciating how such forces impact and influence clinical care.

Competence in Professional Conduct, Ethics, and Legal Matters:

All residents are expected to know and follow strict privacy and confidentiality guidelines. This is taught in a number of settings including: seminars, workshops, supervision sessions, and other trainings. Residents should demonstrate sensitivity to ethical, legal, and cultural issues in all aspects of their work, as well as the nuances of ethics and boundaries in community settings.

Competence in Cultural and Individual Diversity:

Residents should recognize the wide range of diversity that occurs in the SMI/SED population and recognize their own level of acceptability and comfort within each. Residents are expected to learn about and demonstrate understanding of the range of diversity that is critical to understanding the individual. Residents must participate in trainings on diversity and culture. Residents are expected to use individual and group supervision to explore and develop understanding of all different aspects of culture, diversity and identity and to apply this learning to treatment.

Growth in Professional Development:

Residents should demonstrate continued growth in professional development over the post-doctoral year. Residents should assume increasing professional responsibility for clinical care, consultation and program development. They should demonstrate advanced knowledge in ethical, legal and cultural issues related to all of the above competencies, and conduct themselves in accordance with these principles and with current professional standards. Residents should participate in the larger professional community by involvement in professional and scientific organizations. They should demonstrate commitment to continued self-assessment and reflection, to self-education and life-long learning, and contribute to the larger community by making themselves available as an educational resource to other professionals.

Example of Possible Recommended Readings for Post-Doctoral Specialty in SMI Psychology

Please Note: The following list is a sampling only and is not meant to be exhaustive. The references in the APA curriculum (American Psychological Association & Jansen, 2014) along with the references contained in several criteria within this specialty petition may be particularly relevant. Additionally, residents should be required to remain abreast of the literature in relevant journals, for example *Schizophrenia Bulletin*, *Psychiatric Services*, *Psychiatric Rehabilitation Journal*, *World Psychiatry*, among others.

- Addington, D., Birchwood, M., Jones, P., Killackey, E., McDaid, D., Melau, M., ... Nordentoft, M. (2018 Ahead of Print). Fidelity scales and performance measures to support implementation and quality assurance for first episode psychosis services. *Early Intervention in Psychiatry*. <http://dx.doi.org.ezproxy.bu.edu/10.1111/eip.12684>
- Alberta, A. J., & Ploski, R. R. (2014). Cooptation of Peer Support Staff: Quantitative Evidence. *Rehabilitation Process and Outcome*, 3, 25.
- Álvarez-Jiménez, M., Martínez-García, O., Pérez-Iglesias, R., Ramírez, M. L., et al. (2010). Prevention of antipsychotic-induced weight gain with early behavioural intervention in first-episode psychosis: 2-year results of a randomized controlled trial. *Schizophrenia Research*, 116, 1, 16–19.
- Álvarez-Jiménez, M., Parker, A. G., Hetrick, S. E., McGorry, P. D., et al. (2011). Preventing the second episode: A systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis. *Schizophrenia Bulletin*, 11, 37, 619–630.
- American Psychological Association & Jansen, M. (2014). *Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders*. Washington, DC: American Psychological Association.
- Beck, Rector, Stolar & Grant. (2009). *Schizophrenia: Cognitive theory, research and therapy*. New York: Guilford Press.
- Becker, D. R., & Drake, R. E. (2003). *A working life for people with severe mental illness*. New York: Oxford University Press.
- Belcher, J. R., & Deforge, B. R. (2005). The Longitudinal Discharge Planning and Treatment Model (LDPTM) Part 1. *Social Work in Mental Health*, 3(4), 17-31.
- Bellack, Mueser, Gingerich, & Agresta. (2004). *Social skills training for schizophrenia: A step-by-step guide*. New York: Guilford Press.
- Berland, G. (2007). The view from the other side - patients, doctors, and the power of a camera. *The New England Journal of Medicine*, 357, 2533-2536.
- Bromley, E., Gabrielian, S., Brekke, B., Pahwa, R., Daly, K. A., Brekke, J. S., & Braslow, J. T. (2014). Experiencing community: Perspectives of individuals diagnosed as having serious mental illness. *Psychiatric Services*.

- Browne, J., Penn, D. L., Estroff, S. E., Ludwig, K., Merritt, C., Meyer-Kalos, P. S., ... Kane, J. M. (2018). Character strengths of individuals with first episode psychosis in individual resiliency training. *Schizophrenia Research*, 195, 448-54. doi: 10.1016/j.schres.2017.09.036
- Brunette, M. F., Mueser, K. T., Babbin, S., Meyer-Kalos, P., Rosenheck, R., Correll, C. U., ... Kane, J.M. (2018). Demographic and clinical correlates of substance use disorders in first episode psychosis. *Schizophrenia Research*, 194, 4-12. <http://dx.doi.org.ezproxy.bu.edu/10.1016/j.schres.2017.06.039>
- Buckwalter, J. G. (2007). The good patient. *The New England Journal of Medicine*, 357, 2534-2535.
- Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumer-providers: Barriers and alternative solutions. *Community Mental Health Journal*, 37, 199-213.
- Combs, D. R., Mueser, K. T., Morales, S., Smith, C. (2018). Schizophrenia spectrum and other psychotic disorders. In C.C. Beidel and B.C. Frueh (Eds.), *Adult Psychopathology and Diagnosis (Eighth Edition)*, (pp.159-207). New York, NY: Wiley.
- Correll, C. U., Galling, B., Pawar, A., Krivko, A., Bonetto, C., Ruggeri, M., ... Kane, J. M. (2018 Advance Access). Effectiveness of early intervention services versus treatment as usual for patients with early psychosis: Systematic review, meta-analysis, and meta-regression-analysis. *JAMA Psychiatry*. <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2679768>
- Corrigan, P. W., Mueser, K. T., Bond, G. R., Drake, R. E., & Solomon, P. (2008). *Principles and practice of psychiatric rehabilitation*. New York: The Guilford Press.
- Curtis, L. C., & Hodge, M. (1995). Ethics and boundaries in community support services: New challenges. *New Directions for Mental Health Services*, 66, 43-60.
- Davidson, L., Bellamy, C., Chinman, M., Farkas, M., et al. (2018). Revisiting the rationale and evidence for peer support. *Psychiatric Times*, 35(6). <http://www.psychiatrictimes.com/special-reports/revisiting-rationale-and-evidence-peer-support>
- Deegan, P. E. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19, 91-97.
- Deforge, B. R., & Belcher, J. R. (2005). The Longitudinal Discharge Planning and Treatment Model (LDPTM) Part 2. *Social Work in Mental Health*, 3(4), 33-61.
- Department of Veterans Affairs. (2014). *Inpatient Recovery Services Toolkit*. Retrieved from https://vaww.cmopnational.va.gov/CR/MentalHealth/Inpatient_MH_Services/Forms/AllItems.aspx.
- DeTore, N. R., Mueser, K. T., & McGurk, S. R. (2018). What does the managing emotions branch of the MSCEIT add to the MATRICS consensus cognitive battery? *Schizophrenia Research*, 197, 414-420. <https://www.sciencedirect.com/science/article/pii/S0920996418300926?via%3Dihub>
- Disability Rights Washington. (2013). *Lost and Forgotten: Conditions of Confinement While Waiting for Competency Evaluation and Restoration*. Seattle, WA: Author.

- Dixon, L. B., Dickerson, F. B., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., . . . Kreyenbuhl, J. (2009). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36, 48-70.
- Dixon, L. B., Glynn, S. M., Cohen, A. N., Drapalski, A. L., Medoff, D., et al. (2014). Outcomes of a brief program, REORDER, to promote consumer recovery and family involvement in care. *Psychiatric Services*, 65, 1, 16–20.
- Epperson, M. W., Wolff, N., Morgan, R. D., Fisher, W. H., Frueh, B. C., & Huening, J. (2014). Envisioning the Next Generation of Behavioral Health and Criminal Justice Interventions. *International Journal of Law and Psychiatry*, 37, 5, 427–438.
- Farkas, M., & Boevink, W. (2018). Peer delivered services in mental health care in 2018: Infancy or adolescence? *World Psychiatry*, 17(2), 222-4.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5980530/>
- Fulford, D., Piskulic, D., Addington, J., Kane, J. M., Schooler, N. R., & Mueser, K. T. (2018). Prospective relationships between motivation and functioning in the recovery after an initial episode of schizophrenia. *Schizophrenia Bulletin*, 44(2), 369-77.
<https://doi.org/10.1093/schbul/sbx096>
- Gingerich, S., Mueser, K. T., Meyer-Kalos, P.S., Fox-Smith, M., & Freedland, T. (2018). Enhanced Illness Management and Recovery E-IMR. St. Paul, MN: Minnesota Center for Chemical and Mental Health, School of Social Work, College of Education and Human Development, University of Minnesota. <https://mncamh.umn.edu/files/2018/02/Module-0.-EIMR-Manual-Acknowledgements-Table-of-Contents.pdf>
- Granholm, Holden & McQuaid (2016). *Cognitive Behavioral Social Skills Training (CBSST) for Schizophrenia: A Practical Treatment Guide*. New York: Guilford Press.
- Granholm, McQuaid, et al. (2005). A randomized, controlled trial of cognitive behavioral social skills training for middle-aged and older outpatients with chronic schizophrenia. *American Journal of Psychiatry*, 162, 520-529.
- Grubaugh, A. L., Zinzow, H. M., Paul, L., Egede, L. E., & Frueh, B. C. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review*, 31, 6, 883–899.
- Hodges, T. D., & Clifton, D. O. (2004). Strengths-based development in practice. In P. A. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp. 256-268).
- Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care n homelessness services settings. *The Open Health Services and Policy Journal*, 3, 80-100.
- Horne, L., Kent, D., Hutchinson, D., Abelson, S., & Eisenberg, D. (2018). Moving towards a wellness paradigm in higher education. White Paper. University of Michigan, Ann Arbor, MI.
<http://healthymindsnetwork.org/>
- Hunt, M. G., & Resnick, S. G. (in press). Two birds, one stone: unintended consequences and a potential solution for problems with recovery in mental health. *Psychiatric Services*.

- Johnson, H. M. (2003). Unspeakable conversations. *New York Times Magazine*, 16.
- Joy, M., Clement, T., & Sisti, D. (2016). The ethics of behavioral health information technology: Frequent flyer icons and implicit bias. *JAMA*, published online September 08, 2016. doi:10.1001/jama.2016.12534.
- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... Heinssen, R. K. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173, 4, 362-372.
- Ke, K. M., Blazeby, J. M., Strong, S., Carroll, F. E., Ness, A. R., & Hollingworth, W. (2013). Are multidisciplinary teams in secondary care cost-effective? A systematic review of the literature. *Cost Effective Resource Allocation*, 11, 1, 7.
- Korr, W. S., Encandela, J. A., & Brieland, D. (2005). Independence or autonomy: Which is the goal? *International Journal of Law and Psychiatry*, 28, 290-299.
- Kreyenbuhl, J., Buchanan, R.W., Dickerson, F. B. & Dixon, L. B. (2010). The Schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2009. *Schizophrenia Bulletin*, 36, 1, 94-103.
- Lindenmayer, J. P., McGurk, S. R., Khan, A., Kaushik, S., Thanju, A., et al. (2013). Improving social cognition in schizophrenia: A pilot intervention combining computerized social cognition training with cognitive remediation. *Schizophrenia Bulletin*, 39, 3, 507–517.
- Manitoba Trauma Information and Education Centre. (2013). *Trauma Informed: The Trauma Toolkit, Second Edition*. Winnipeg, MB: Clinic Community Health Centre.
- Maru, M., Rogers, E. S., Hutchinson, D., & Shappell, H. (2018). An integrated supported employment and education model: Exploratory study of an innovative approach designed to better meet the needs of young adults with psychiatric conditions. *Journal of Behavioral Health Services and Research*, 1-9. National Council for Behavioral Health. doi: 10.1007/s11414-018-9595-x <https://link.springer.com/article/10.1007%2Fs11414-018-9595-x>
- McGurk, S. R., Drake, R. E., Xie, H., Riley, J., Milfort, R., Hale, T. W., & Frey W. (2018). Cognitive predictors among work in social security disability insurance beneficiaries with psychiatric disorders enrolled in IPS supported employment. *Schizophrenia Bulletin*, 44(1):32-37. doi: 10.1093/schbul/sbx115 <https://academic.oup.com/schizophreniabulletin/article/44/1/32/4098820>
- McQuaid, Granholm, et al. (2000). Development of an integrated cognitive-behavioral and social skills training intervention for older patients with schizophrenia. *American Journal of Psychiatry*, 162, 520-529.
- Metcalfe, J. D., Drake, R. E., & Bond, G. R. (2018). Economic, labor, and regulatory moderators of the effect of Individual Placement and Support among people with severe mental illness: a systematic review and meta-analysis. *Schizophrenia Bulletin*, 44, 22-31. <https://academic.oup.com/schizophreniabulletin/article/44/1/22/4259764>

- Metcalfe, J. D., Drake, R. E., & Bond, G. R. (2018). The use of standardized discharge in IPS supported employment programs. *Psychiatric Services, 69*(4):476-478. doi: 10.1176/appi.ps.201700309. <https://doi.org/10.1176/appi.ps.201700309>
- Metcalfe, J. D., Riley, J., McGurk, S., Hale, T., Drake, R. E., & Bond, G. R. (2018). Comparing predictors of employment in Individual Placement and Support: A longitudinal analysis. *Psychiatry Research, 264*, 85-90. <https://www.sciencedirect.com/science/article/pii/S0165178117322382?via%3Dihub>
- Mitchell, P., Wynia, M., Golden, R., McNellis, B., Okun, S., Webb, C. E., . . . Von Kohorn, I. (2012). Core principles & values of effective team-based health care.
- Mizock, L. & Russinova, Z. (2018). The process of development and analysis of a Photovoice mental health intervention. *SAGE Research Methods Case Studies*. London: SAGE. <http://dx.doi.org/10.4135/9781526427533>
- Monroe-DeVita, M., Morse, G., Mueser, K. T., McHugo, G. J., Xie, H., Hallgren, K. A., . . . Stiles, B. (2018). Implementing Illness Management and Recovery within Assertive Community Treatment: A pilot trial of feasibility and effectiveness. *Psychiatric Services, 69*(5):562-71. doi: 10.1176/appi.ps.201700124 https://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201700124?url_ver=Z39.88-2003&rft_id=ori%3Arid%3Acrossref.org&rft_dat=cr_pub%3Dpubmed&
- Mueser, K. T. (2018). Supported employment for persons with posttraumatic stress disorder. *JAMA Psychiatry, 75*(4):313-4. doi: 10.1001/jamapsychiatry.2017.4471 <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2673376>
- Mueser, K. T. (2018). Interpersonal skills. In S. C. Hayes & S. G. Hoffman (Eds.), *Process-Based CBT: The Science and Core Competencies of Cognitive & Behavioral Therapies* (pp. 309-24). Oakland, CA: Context Press.
- Mueser, K. T., McGurk, S. R., Xie H., Bolton, E. E., Janowsky, M. K., Lu, W., Rosenberg, S. D., & Wolfe, R. (2018). Neuropsychological predictors of response to the cognitive behavioral therapy for posttraumatic stress disorder in persons with severe mental illness. *Psychiatry Research, 259*, 110-116. <http://dx.doi.org.ezproxy.bu.edu/10.1016/j.psychres.2017.10.016>
- Mueser, K. T., McGurk, S. R., Xie H., Bolton, E. E., Janowsky, M. K., Lu, W., Rosenberg, S. D., & Wolfe, R. (2018). Neuropsychological predictors of response to the cognitive behavioral therapy for posttraumatic stress disorder in persons with severe mental illness. *Psychiatry Research, 259*, 110-116. <http://dx.doi.org.ezproxy.bu.edu/10.1016/j.psychres.2017.10.016>
- Mueser, K. T., Deavers, F., Penn, D. L. & Cassisi, J. E. (2013). Psychosocial treatments for schizophrenia. *Annual Review of Clinical Psychology, 9*, 465-497.
- Mueser, K. T., Silverstein, S. M., & Farkas, M. D. (2013). Should the training of clinical psychologists require competence in the treatment and rehabilitation of individuals with a serious mental illness? *Psychiatric Rehabilitation Journal, 36*, 1, 54-59.
- Nagendra, A., Schooler, N. R., Kane, J. M., Robinson, D. G., Mueser, K. T., Estroff, S. E., . . . Penn, D. L. (2018). Demographic, psychosocial, clinical, and neurocognitive baseline characteristics of

Black Americans in the RAISE-ETP study. *Schizophrenia Research*, 193, 64-8.
<https://reader.elsevier.com/reader/sd/BE2AEE96A1534C5AA05E78C9E67E5C83EDAC86FC41DF3AB6B2AADE48896BC5DCC652290E2FD3CF336087DAE3662EE974>

National Collaborating Centre for Mental Health (2014). *Psychosis and Schizophrenia in Adults: The NICE Guideline on Treatment and Management in Adults (update)*. CG 178. London, UK: National Institute for Health and Care Excellence.

Padesky, C. A., & Mooney, K. A. (2012). Strengths- Based Cognitive–Behavioural Therapy: A Four- Step Model to Build Resilience. *Clinical Psychology & Psychotherapy*, 19(4), 283-290.

Patterson, K. (2002, May 5). What doctors don't know (almost everything). *The New York Times*.

Penk, W., Drebing, C. E., Rosenheck, R. A., Krebs, C., Van Ormer, A., & Mueller, L. (2010). Veterans Health Administration Transitional Work Experience vs job placement in Veterans with co-morbid substance use and non-psychotic psychiatric disorders. *Psychiatric Rehabilitation Journal*, 33, 297-307.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (pp. 98). Washington, D.C.

Riger, S. (1993). What's wrong with empowerment. *American Journal of Community Psychology*, 21(3), 279-292.

Rosen, L. (2015). Changing our brains in a good way. Retrieved from <https://www.psychologytoday.com/blog/rewired-the-psychology-technology/201507/changing-our-brains-in-good-way>

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association*, 100(11), 1275.

Said-Foqahaa, N. (2011). Arab women: Duality of deprivation in decision-making under patriarchal authority. *Journal of Women of the Middle East and the Islamic World*, 9, 234–272.

Sakett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, 312, 71-72.

Sanches, S. A., Swildens, W. E., Busschbach, J. T. van, Farkas, M., & Wel, T. van (2018). Fidelity of Rehabilitation (FiRe): Evaluation of a fidelity measure to promote implementation of evidence-based rehabilitation. *Psychiatric Rehabilitation Journal*, 41, 1, 46-54. doi: 10.1037/prj0000276 <http://psycnet.apa.org/fulltext/2017-33351-001.html>

Schaub, A., Goldmann, U., Mueser, K. T., Goerigk, S., Hautzinger, M., Roth, E., ... Möller, H.-J. (2018). Efficacy of extended clinical management, group CBT, and group plus individual CBT for major depression: Results of a two-year follow-up study. *Journal of Affective Disorders*, 238, 570-8. doi: 10.1016/j.jad.2018.05.081 <https://www.sciencedirect.com/sci>

Schiff, G. D. (2013). Crossing Boundaries—Violation or Obligation? *JAMA*, 310(12), 1233-1234.

Shah, P., & Mountain, D. (2007). The medical model is dead—long live the medical model. *The British Journal of Psychiatry*, 191(5), 375-377.

- Sint, K., Rosenheck, R., Robinson, D. G., Schooler, N. R., Marcy, P., Kane, J. M., Mueser, K. T., & Lin, H. (2018). Accounting for group differences in study retention in a randomized trial of specialized treatment for first episode psychosis. *Schizophrenia Research*, 195, 481-7.
<http://dx.doi.org.ezproxy.bu.edu/10.1016/j.schres.2017.08.029>
- Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's working definition of recovery updated. SAMHSA Blog.
- Swift, C., & Levin, G. (1987). Empowerment: An emerging mental health technology. *Journal of Primary Prevention*, 8, 71-93.
- Teixeira, C., Mueser, K. T., Rogers, E. S., & McGurk, S. R. (2018). Job endings and work trajectories in persons receiving supported employment and cognitive remediation. *Psychiatric Services*. Online publication, doi: 10.1176/appi.ps.201700489.
https://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201700489?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed
- Weick, K. E. (1984). Small wins: Redefining the scale of social problems. *American Psychologist*, 39, 40-49.
- Wright, Turkington, Kingdon & Basco. (2009). *Cognitive behavior therapy for severe mental illness: An illustrated guide*. Washington DC: American Psychiatric Publishing.

Criterion VIII. Continuing Professional Development and Continuing Education

A specialty provides its practitioners a broad range of regularly scheduled opportunities for continuing professional development in the specialty practice and assesses the acquisition of knowledge and skills.

***Commentary:** With rapidly developing knowledge and professional applications in psychology, it is increasingly difficult for professionals to deliver high quality services unless they update themselves regularly throughout their professional lives through continuing education mechanisms. A variety of mechanisms may be used to achieve these goals.*

1. Describe the opportunities for continuing professional development and education in the specialty practice. Provide detailed examples, such as CE offerings that are available.

For more than 14 consecutive years (beginning in 2004), the APA Specialty Council (beginning in 2004 and represented initially by the APA Task Force on SMI/SED) has presented symposia at the APA convention that have been offered for CE credit. These symposia have been very well attended, garnering between 100 and 200 attendees each year. Between 2010 – 2018, the Specialty Council also sponsored five full day CE workshops; these were also highly rated, receiving ratings above 4.5 each time the workshops were presented. Beginning in 2012, the SMI/SED Section of Division 18 also began sponsoring symposia; more recently, other divisions have followed suit and as a result, the number of convention offerings on SMI/SED topics has increased considerably. Feedback has consistently indicated that training is needed to help psychologists work more competently with persons with SMI/SED and these symposia and workshops have sought to meet this need. The full day CE workshop offered by the Specialty Council beginning in 2010 are:

- New Interventions and Perspectives for Practitioners Treating Those with Serious Mental Illnesses, August, 2010.
- Treating Adults and Adolescents with Serious Mental Illness: Using EBPs in Clinical Practice, August, 2011.
- New and Emerging Clinical Practices for Treating People with Serious Mental Illness, August, 2012.
- Recent Advances in Evidence Based Practices to Help People Recover from Serious Mental Illnesses, August, 2014.
- Evidence Based Interventions for First Episode Psychosis - RAISE-ETP & Beyond, August, 2018.

In addition to APA convention presentations, members of the Specialty Council have been and continue to be regular presenters (often presenting invited addresses) based on their work at national and international scientific meetings of clinicians, researchers, and educators working in the Specialty. Many of these presentations (symposia, workshops, invited addresses, etc.) are offered for continuing education credit. As noted in this Criterion and elsewhere in this petition, Specialty Council members publish regularly in highly respected journals in the Specialty and are very much respected in this field; sometimes these papers can be read for continuing education credits as well.

In 2010, APA received funding from SAMHSA to develop a curriculum to train psychologists for work with individuals with SMI/SED. The curriculum was completed and published in 2014 (American Psychological Association & Jansen, 2014) and is posted on the APA website <http://www.apa.org/pi/mfp/psychology/recovery-to-practice/training.aspx>. Since publication of the

curriculum, the leaders of the Specialty Council (the APA Task Force, Division 18, the Division 18 Section on SMI/SED, and the SIG on Schizophrenia and Other Serious Mental Disorders of ABCT) have been instrumental in promoting its use at the APA convention, at meetings of the various psychology training councils, and within graduate-level training programs. Specialty Council members have also given presentations at non-APA meetings, sparking interest in the curriculum among other professional groups as well. Most recently, material from the APA curriculum was presented (and very well received) in a year-long series of webinars for mental health professionals from a wide range of disciplines who work in behavioral health settings across the US. These presentations were sponsored by Advocates for Human Potential via a contract from SAMHSA. Through this contract, presentations were given at several national and international meetings and at APA conventions and Division meetings. Another example of the curriculum's reach is its promotion by the Texas based Hogg Foundation which to date, has sponsored two statewide conferences for psychology training directors and their students. Most of these presentations have been offered for CE credit, both for psychologists and for providers in other disciplines. Work is underway for additional presentations at various regional and national psychology meetings and conferences – these would be offered for CE credit as well.

In 2016, the APA Office of Continuing Education partnered with the Office of the APA Task Force on SMI/SED to develop a webinar series on assessment and treatment for persons with SMI/SED. The webinar series is based on the content of the APA curriculum. The webinar was produced and made available on the APA CE website in 2016, and consists of a 4 part series. Each part is one hour in length and each may be taken individually or the full series may be taken. The webinars are available for a nominal fee; the series is available on the APA CE on-line portal and has been highlighted on the CE website. The series may be found under the topical headings of Clinical Psychology or Professional Resources for Practice.

The titles of these are listed below. It is hoped that this series will continue to be available for several years to come so that psychologists could benefit from it. As new findings emerge, updates to the series can also be incorporated. From the APA CE webpage (<http://www.apa.org/education/ce/>):

- SMI/SED Series — New Approaches: Assessment, Engagement and Ethical Considerations (Module 1); Video On-Demand | 1 credit
- SMI/SED Series — New Approaches: Clinical Interventions and Ethical Issues (Module 2); Video On-Demand | 1 credit
- SMI/SED Series — New Approaches: Interventions for Special Populations — Specialized Training for Ethical Practice (Module 3); Video On-Demand | 1 credit
- SMI/SED Series — New Approaches: Interventions for Management & Policy Positions — Ethical Responsibilities and Training the Next Generation of Psychologists (Module 4); Video On-Demand 1 credit.

2. Describe the formal requirements, if any, for continuing professional development and education to maintain competence in the specialty.

The Specialty strongly encourages all who consider themselves Specialists in SMI Psychology to obtain ABPP certification. Once certified, ABPP Specialists will follow the ABPP Maintenance of Certification process as the model for maintaining competency. (See <https://legacy.abpp.org/i4a/pages/index.cfm?pageid=3892>).

For those psychologists who are not ABPP certified, several requirements are noted. One of the important advantages of Specialty recognition is the strength of having formal requirements for continuing professional development and education to maintain competence in the Specialty. In order to develop and

continue to refine these requirements, the Council has, with permission, modified 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)). The revised SMI/SED tool, the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*, includes 4 overarching areas of competence (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). The *Instrument* is intended to serve three main functions for professional development: 1) to allow individuals to target areas identified as needing improvement via continuing professional development and education; 2) to provide aggregate data indicating areas of greatest need for additional training for the development of CE opportunities; and 3) to provide a holistic structure from which to develop and evaluate available training continuing professional development. The *Instrument* is also referenced/described in other areas of this petition and is available on the Specialty Council website (www.psychtrainingsmi.com) and is attached as Appendix III.

For any psychologist who considers him or herself to be an SMI psychologist, at least 8 hours of CE per year are required, 2 of which must be in ethics, and 4 of which must focus on topics related to general knowledge, assessment, intervention, or consultation in SMI/SED. For SMI Psychology Specialists who are not ABPP certified, the Specialty requires completion of the SMI/SED evaluation tool, the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*. All SMI Psychology Specialists are strongly encouraged to seek consultation and supervision from an ABPP certified SMI Psychology Specialty psychologist and to pursue continuing education in additional areas where they may be deficient. The evaluation scheme of the *Instrument* is intended to provide individualized and targeted requirements. More specifically, if the individual rates as below the “proficient” level in any area on the *Instrument*, at least one of the APA approved CE credits should address that area. As directed by the *Instrument’s* instructions, individual evaluation should include the learner's perspective (self-assessment), observation of the learner's work (e.g., direct observation, audiotape, videotape, co-therapy), as well as regular supervision involving case discussion as needed.

3. Describe the minimum expectations, if any, for continuing professional development and education to maintain competence in the specialty.

As discussed above, the Specialty Council strongly recommends ABPP certification for all SMI Psychologists. The Specialty Council recognizes that legally, psychologists cannot be compelled to become ABPP certified or to seek public listing on the Specialty Council website. However, all psychologists must act ethically and refrain from practicing outside their area of competence. Accordingly, the Specialty Council encourages any psychologist who works with the SMI/SED population (including those who are not ABPP certified) to obtain at least 8 hours of APA-approved CE credit each year (at least 2 of those in ethics, and 4 of those directly pertinent be SMI/SED focusing on topics related to general knowledge, assessment, intervention, or consultation) and to engage in supervision and consultation with other psychologists who are SMI Psychology Specialists. The requirement for CE hours is aligned with the requirement for continuing education to remain licensed in most states.

The Specialty Council requires use of the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)* which is available on the Specialty Council website (www.psychtrainingsmi.com) and is attached as Appendix III for all psychologists not having an ABPP in the area but claiming competence. The evaluation scheme of the *Instrument* is intended to provide individualized and targeted requirements. More specifically, if the individual rates as below the “proficient” level in any area on the *Instrument*, at least one of the APA approved CE credits should address that area. As directed by the *Instrument’s* instructions, individual evaluation should include the learner's perspective (self-assessment), observation of the learner's work (e.g., direct observation, audiotape, videotape, co-therapy), as well as regular

supervision involving case discussion as needed. Although it is not possible to implement formal minimal requirements unless a psychologist becomes ABPP certified, the Specialty Council expects that anyone claiming competence for work with individuals with SMI/SED will utilize the *Instrument*, obtain APA approved CE credits targeted to any areas showing a need for improvement, seek consultation and supervision with SMI certified Psychologists, remain current with the research literature, remain current with the Council website, and the listservs of the APA Task Force, Division 18 Section on SMI/SED, and the ABCT SIG where new developments are posted.

References

- American Psychological Association & Jansen, M. A. (2014). Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders. Washington, DC: American Psychological Association.
- Karel, M. J., Holley, C., Whitbourne, S. K., Segal, D. L., Tazeau, Y., Emery, E., ... Zweig, R. (2012). Preliminary validation of a tool to assess knowledge and skills for professional geropsychology practice. *Professional Psychology: Research & Practice*, 43, 2, 110-117.

Criterion IX. Effectiveness

Petitions demonstrate the effectiveness of the services provided by its specialist practitioners with research evidence that is consistent with the APA 2005 Policy on Evidence-based Practice.

Commentary: *A body of evidence is be presented that demonstrates the effectiveness of the specialty in serving specific populations, addressing certain types of psychological, biological and social behaviors, or in the types of settings where the specialty is practiced.*

PLEASE NOTE: *If the same article illustrates more than one of these items, it may be referenced under each applicable category. Evidence should include the most current available published references in each area (e.g., books, chapters, articles in refereed journals, etc.) While reliance on some on classic references is acceptable, the majority of references provided should be from last five years.*

1. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of clients or populations (including groups with a diverse range of characteristics and human endeavors) usually served by this specialty. Summarize and discuss the relevance of the findings of the studies, specify populations, interventions, and outcomes in relation to the specialty practice.

1. Ising, H. K., Kraan, T. C., Rietdijk, J., Dragt, S., Klaassen, R., Boonstra, N., ... & Wunderink, L. (2016). Four-year follow-up of cognitive behavioral therapy in persons at ultra-high risk for developing psychosis: the Dutch early detection intervention evaluation (EDIE-NL) trial. *Schizophrenia Bulletin*, 42, 1243-1252. doi.org/10.1093/schbul/sbw018
2. Bartels, S. J., Pratt, S. I., Mueser, K. T., Forester, B. P., Wolfe, R., Cather, C., ... & Naslund, J. A. (2014). Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness. *The American Journal of Geriatric Psychiatry*, 22, 1251-1261. doi.org/10.1016/j.jagp.2013.04.013
3. Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... & Marcy, P. (2015). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH raise early treatment program. *American Journal of Psychiatry*, 173, 362-372. doi.org/10.1176/appi.ajp.2015.15050632
4. Granholm, E., Holden, J., Link, P. C., McQuaid, J. R., & Jeste, D. V. (2013). Randomized controlled trial of cognitive behavioral social skills training for older consumers with schizophrenia: defeatist performance attitudes and functional outcome. *The American Journal of Geriatric Psychiatry*, 21, 251-262. doi.org/10.1016/j.jagp.2012.10.014
5. Srihari, V. H., Tek, C., Kucukgoncu, S., Phutane, V. H., Breitborde, N. J., Pollard, J., ... & Woods, S. W. (2015). First-episode services for psychotic disorders in the US public sector: a pragmatic randomized controlled trial. *Psychiatric Services*, 66, 705-712. doi.org/10.1176/appi.ps.201400236

Epidemiological studies find that SMI/SED afflicts individuals of every ethnic and socioeconomic group through out the world, although some specific stressors (such as immigration, poverty, and adversity in childhood) seem to increase the risk of the disorders (Tandon, Keshavan, & Nasrallah, 2008; Okkels, Trabjerg, Arendt, & Pedersen, 2017; Isvoranu, van Borkulo, Boyette, Wigman, Vinkers, Borsboom, & Group Investigators, 2017). Studies on psychological treatments evaluated in different SMI/SED ethnic and national groups were quite prevalent in earlier decades, but much of the intervention research in the past five years has focused on ascertaining whether interventions tailored to specific phases of these

illnesses through the lifespan are effective. Of particular interest is the ultimate research objective of determining whether early intervention improves the long-term trajectory of the course of SMI/SED. To this end, three phases of illness have attracted the recent interest of clinical researchers: 1) the prodromal or ultra high risk phase, 2) the initial full symptom onset phase, followed by 3) later phases reflective of more long-term course of the disorder. Exemplars of this research are presented below. These longitudinal research investigations generally involve a test of a comprehensive intervention, including both psychological and pharmacological components, compared to customary care; the psychological components typically involve cognitive-behavioral techniques, often augmented with illness education. The results usually demonstrate a benefit of the comprehensive intervention tailored to the phase of illness over customary care.

Ising, et al., (2016) enrolled 196 young people who were deemed at high risk for psychosis due to poor social functioning and either a family history of psychosis or the documentation of mild prodromal symptoms. Participants were randomized to either 6 months of cognitive behavior therapy for ultra-high risk (called CBTuhr) embedded in treatment-as-usual (TAU) or TAU only. Of the original 196 patients, 113 consented to a 4-year follow-up (57.7%; CBTuhr = 56 vs TAU = 57), and were regularly monitored with symptom and social functioning measures. Over the four year study period, psychosis incidence, remission from UHR status, and the effects of transition to psychosis were evaluated. The number of participants in the CBTuhr group transitioning to psychosis increased from 10 at 18-month follow-up to 12 at 4-year follow-up whereas it did not change in the TAU group ($n = 22$); this represents a clinically important (incidence rate ratio [IRR] = $12/22 = 0.55$) and significant effect favoring CBTuhr. The odds ratio of CBTuhr compared to TAU was 0.44 (95% CI: 0.24–0.82) and the number needed to treat was 8. Moreover, significantly more patients remitted from their UHR status in the CBTuhr group (76.3%) compared with the TAU group (58.7%) [$t(120) = 2.08, P = .04$]. Overall, the CBTuhr group had significantly better outcomes; fewer developed psychosis and more remitted from their prodromal state. These findings support the efficacy of the tailored psychological treatment for individuals at high risk for the development of psychosis.

While efforts to reduce transition to full psychosis in ultra high risk populations are laudable, their impact will be limited unless they are embedded in a health surveillance system that can identify appropriate potential participants. There is now a concomitant international movement to provide intensive comprehensive specialty care (CSC) to young people (typically with ages from 15-35) experiencing a first episode of psychosis (FEP); that is, to individuals who have transitioned from an ultra high risk period to a frank expression of psychotic symptoms. These CSC programs focus primarily on individuals experiencing a non-affective psychosis, which is typically understood to be a likely precursor to the development of a disorder on the schizophrenia spectrum. CSC programs typically include illness education, family support, individual cognitive-behaviorally oriented psychotherapy, supported employment and education, and low-dose medication regimens. While programs tailored to the needs of individuals developing a first episode of psychosis have been available for decades in countries with a national health system (Penn, Waldheter, Perkins, Mueser, & Lieberman, 2005), the US has only recently begun to offer CSC programs on a systematic level. Several papers evaluating CSC programs in the US, have recently been published, two of which we describe here.

The first is a single site study, (Srihari, et al, 2015), comparing a CSC program called *Specialized Treatment Early in Psychosis* (STEP) to customary care. STEP includes comprehensive clinical evaluation and regular outcome assessment, medication management, and individual and group therapy. Treatment targets include school and/or work goals, problem-solving and communication skills, stress management, health and wellness, symptom reduction and personal goals. Symptom status, social functioning, and hospitalization data were collected every six months on 117 randomized participants through the one year follow-up. STEP care resulted in significantly fewer total hospitalizations (20 STEP versus 39 with usual treatment) and a significantly lower likelihood of hospitalization (14 of 60 STEP [23%] patients versus 25 of 57 [44%] of those in usual treatment). These data translate to a number needed to treat (NNT) of five. STEP participants were also more likely to be engaged in productive vocational activity and remain engaged in mental health treatment than those in usual treatment.

In a second CSC publication, Kane et al. (2015) reported on a 34 site cluster randomized controlled trial comparing CSC to customary care throughout the US. Four hundred four individuals were randomized to a minimum of two years of CSC or to customary care. The CSC involved tailored medication, family education and support, individual illness resiliency training, and supported employment and education. Outcome data were collected every 6 months on symptom status, employment/educational status, quality of life, retention in treatment, and rate of hospitalization. The 223 recipients of NAVIGATE remained in treatment longer, experienced greater improvement in quality of life and overall psychopathology (including depression and symptoms of schizophrenia), and participated more in work and school compared with 181 participants in community care; there were no differences in hospitalization rates, which were low for both groups.

These early intervention studies indicate that, at least for the relatively short-term, participation in CSC programs, incorporating illness education, family support, individual cognitive-behaviorally oriented psychotherapy, supported employment and education, and low-dose medication, can significantly improve outcomes. However, there remain a substantial number of individuals diagnosed with SMI/SED who did not have access to such programs when they first became ill and/or still experience symptoms of the disorder years after entering treatment. Recent research has also focused on helping these middle-aged and older individuals improve the quality of their lives. While reducing psychotic symptoms can certainly be a treatment goal in this group of consumers, many consumers have created a life that accommodates the occurrence of these symptoms, which are often not eliminated by medication. For these individuals, improving quality of life - often through improved community functioning or physical health - frequently becomes the primary therapeutic goal. We describe two representative articles from this line of research below.

In the first study, Granholm and colleagues (Granholm, Holden, Link, McQuaid, & Jeste, 2013) compared the benefits of participation in Cognitive Behavioral Social Skills Training (CBSST) to goal-focused supportive contact (GFSC) in improving functioning in 79 older consumers (over age 45) diagnosed with schizophrenia. CBSST was a 36-session, weekly group therapy that combined cognitive behavior therapy with social skills training and problem-solving training to improve functioning. GFSC was supportive group therapy focused on achieving functioning goals. Active treatment was offered for nine months. This was a randomized trial of community outpatients and the primary outcomes were functioning (primary outcome: *Independent Living Skills Survey*; Wallace, Liberman, Tauber, & Wallace, 2000), CBSST skill mastery, schizophrenia symptoms, depression, anxiety, defeatist attitudes, self-esteem, and life satisfaction. Through the 18 month follow-up, functioning trajectories were significantly more positive in CBSST than in GFSC, especially for participants with more severe defeatist performance attitudes. Greater improvement in defeatist attitudes was also associated with better functioning in CBSST, but not GFSC. Both treatments showed comparable significant improvements on amotivation, depression, anxiety, positive self-esteem, and life satisfaction. These results indicate that both psychological interventions had broad effects, but the specific training on social skills, cognitive-behavioral therapy and problems solving had a unique impact on improving functioning, and that this benefit may have been mediated by decreasing defeatist attitudes.

The second trial focused on improving community functioning and physical health in individuals over the age of 50 diagnosed with an SMI (Bartels, et al., 2014). This report describes 1-, 2-, and 3-year outcomes of a combined manualized PSR skills training and preventive healthcare intervention (*Helping Older People Experience Success* [HOPES]) for older persons with SMI. A randomized controlled trial compared HOPES with treatment as usual (TAU) for 183 older adults (mean age: 60.2) diagnosed with SMI. HOPES included 12 months of weekly skills training classes, twice-monthly community practice trips, and monthly nurse preventive healthcare visits, followed by a 1-year maintenance phase of monthly sessions. Blinded evaluations of functioning, symptoms, and service use were conducted at baseline and at 1-year (end of the intensive phase), 2-year (end of the maintenance phase), and 3-year (12 months after the intervention) follow-up. Participation in HOPES, as compared to TAU, was associated with improved community living skills and functioning, greater self-efficacy, lower overall psychiatric and

negative symptoms, greater acquisition of preventive healthcare (more frequent eye exams, visual acuity, hearing tests, mammograms, and Pap smears), and nearly twice the rate of completed advance directives. No differences were found for medical severity, number of medical conditions, subjective health status, or acute service use at the 3-year follow-up.

We summarize the results of these five recent trials as follows: Psychologists working with the SMI/SED population can effectively treat a broad range of consumers, from adolescents through seniors. Effective psychological interventions tend to be intensive and cognitive-behavioral and/or skills based, and outcome domains are typically broader than simple symptom improvement. Most participants are provided concurrent antipsychotic medication. Because SMI/SED diagnoses are associated with declines in functioning as well as the experience of symptoms, clinical researchers have designed interventions with the dual goals of improving community adaptation while addressing psychopathology.

2. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of psychological, biological, and/or social problems usually confronted and addressed by this specialty. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results.

1. Lucksted, A., Drapalski, A. L., Brown, C. H., Wilson, C., Charlotte, M., Mullane, A., & Fang, L. J. (2017). Outcomes of a psychoeducational intervention to reduce internalized stigma among psychosocial rehabilitation clients. *Psychiatric Services*, 68, 360-367. doi.org/10.1176/appi.ps.201600037
2. Modini, M., Tan, L., Brinchmann, B., Wang, M. J., Killackey, E., Glozier, N., ... & Harvey, S. B. (2016). Supported employment for people with severe mental illness: systematic re view and meta-analysis of the international evidence. *The British Journal of Psychiatry*, 209, 14-22. doi.org/10.1192/bjp.bp.115.165092
3. McGinty, E. E., Baller, J., Azrin, S. T., Juliano-Bult, D., & Daumit, G. L. (2016). Interventions to address medical conditions and health-risk behaviors among persons with serious mental illness: a comprehensive review. *Schizophrenia Bulletin*, 42, 96-124. doi.org/10.1093/schbul/sbv101
4. Russolillo, A., Patterson, M., McCandless, L., Moniruzzaman, A., & Somers, J. (2014). Emergency department utilisation among formerly homeless adults with mental disorders after one year of housing first interventions: a randomised controlled trial. *International Journal of Housing Policy*, 14(1), 79-97. doi.org/10.1080/14616718.2014.884881
5. Somers, J. M., Moniruzzaman, A., Patterson, M., Currie, L., Rezansoff, S. N., Palepu, A., & Fryer, K. (2017). A randomized trial examining housing first in congregate and scattered site formats. *Plos one*, 12, e0168745. doi.org/10.1371/journal.pone.0168745

As mentioned in our response to Criterion VI, many individuals diagnosed with SMI/SED encounter significant life challenges. Our society is fearful and rejecting of individuals with thought disorders and unusual behavior, which can then result in the individuals diagnosed with these disorders experiencing psychological problems such as shame and self-stigma. Depression and negative symptoms from schizophrenia often result in difficulties attending to personal health; many psychiatric medications have their own iatrogenic effects on weight and metabolism as well. Coupled with the increased smoking and illicit drug use rates found in this population, it perhaps comes as no surprise that the life spans of individuals diagnosed with SMI are, on average, 20-25 years shorter than their counterparts without diagnosed SMI (Walker, McGee, & Druss, 2015). These differences are largely attributable to cardiovascular disease. Attention to health promotion is a key task for psychologists working with this group of clients. Finally, developmental lags caused by symptom progression in adolescence and early adulthood often impede educational and employment achievement in this population, leading to poverty

and often homelessness. Thus, optimal strategies to address unemployment and homelessness, in the SMI/SED population merit attention. Psychological interventions to address the psychological, biological, and societal challenges associated with a diagnosis of SMI/SED are presented next in turn.

With regard to psychological problems experienced by the SMI/SED population, internalized or self-stigma is a significant one attracting increasing interest. (Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2015). The term refers to the process by which negative stereotypes about mental illness are accepted and incorporated into the identity of people who have been diagnosed with these disorders (Ritsher, Otilingam, & Grajales, 2003; Corrigan, Watson, & Barr, 2006). Self-stigma is considered pervasive in the SMI/SED population, and likely interferes with efforts to achieve desired goals such as employment or finding a life-partner. Lucksted et al., (in press) developed and tested the *Ending Self Stigma* (ESS) cognitive-behavioral and psychoeducational intervention in a community-based randomized controlled trial including 268 adults. Participants were randomly assigned to the nine-week ESS intervention or a minimally enhanced treatment-as-usual (TAU) control condition. Participants were assessed by using symptom, psychosocial functioning, and self-stigma measures at baseline, end of treatment, and six month follow-up. Compared with participants in the control condition, ESS group participants showed significant decreases on the stereotype agreement and self-concurrence subscales of the *Self Stigma of Mental Illness Scale*, significant improvement on the alienation and stigma resistance subscales of the *Internalized Stigma Mental Illness* measure, and a significant increase in recovery orientation from baseline to post-intervention as measured on the *Maryland Assessment of Recovery in People With Serious Mental Illness* (MARS). Unfortunately, these differential benefits were not sustained at follow-up, suggesting the need for a longer or more intensive intervention.

With regard to biological problems experienced by the SMI/SED population, McGinty, Baller, Azrin, Juliano-Bult, and Daumit (2016) published a recent comprehensive review examining the strength of the evidence supporting interventions to address major medical conditions and health-risk behaviors among persons with SMI/SED, and thus lengthen their shorted life span. The review was based on the recommendations of a National Institute of Mental Health stakeholder meeting. Peer-reviewed studies were identified using four research databases. Randomized controlled trials and observational studies testing interventions to address medical conditions and risk behaviors among persons with schizophrenia and bipolar disorder published between January 2000 and June 2014 were included. The quality of the evidence (high, medium, low) and the effectiveness of various interventions were synthesized. One hundred and eight studies were included. The majority of studies examined interventions to address overweight/obesity ($n = 80$), though topics such as diabetes, hyperlipidemia, smoking, cardiovascular disease, hypertension, physical activity, and HIV/AIDs were also included. Both pharmacological and psychological interventions were assessed; the psychological intervention with the strongest evidence base was behavioral interventions for weight loss. Eighteen RCTs and 10 observational studies examined the effects of behavioral weight loss interventions on body mass index (BMI), and 22 RCTs and 15 observational studies examined the effects of behavioral interventions on weight. For BMI, the overall strength of the evidence surrounding behavioral interventions was medium, with the best available studies showing mixed effects. However, for weight, the overall strength of the evidence surrounding behavioral interventions was high, with the best available evidence showing a consistently beneficial effect. The strength of the evidence was low for most other psychological interventions reviewed, suggesting that psychological interventions can play a role in health promotion in SMI/SED, but more work needs to be done.

SMI/SED populations encounter many social challenges, and psychological interventions can play a significant role in overcoming them. For example, un- and underemployment are very common in this population. However, supported employment, and particularly a manualized version known as Individual Placement and Support (IPS), has a strong evidence-base in SMI/SED, typically increasing competitive work rates two or three fold in comparison to treatment as usual in randomized trials (Drake & Bond 2011). Key principles of supported employment include (1) a focus on competitive employment, (2) eligibility based on consumer choice, (3) rapid job search, (4) integration of mental health and employment services, (5) attention to consumer preference in the job search, (6) time unlimited individualized job supports (7)

personalized benefits counseling, and (8) systematic job development. A recent review article by Modini, et al., (2016) examined IPS results in SMI/SED populations internationally. A systematic review and meta-analysis of randomized controlled trials compared IPS (conducted with high fidelity to the model) to traditional vocational services; 17 studies (both US and non-US), as well as 2 follow-up studies, published since 1993 were included. Meta-regressions were carried out to examine whether IPS effectiveness varied according to geographic location, unemployment rates or gross domestic product (GDP) growth. The investigators determined overall pooled risk ratio for competitive employment using IPS compared with traditional vocational rehabilitation was 2.40 (95% CI 1.99–2.90). Meta-regressions indicated that neither geographic area nor unemployment rates affected the overall effectiveness of IPS. These results confirm the utility of a PSR intervention such as IPS in reducing unemployment in individuals diagnosed with an SMI/SED.

As we have indicated in other sections of this petition, poverty and homelessness are common in individuals with SMI/SED, and thus programs to provide a stable residence are important for this population. Housing First (HF) integrates housing and support services in a client-centered model and has been shown to reduce acute health care among homeless populations. In contrast to other forms of supported housing, HF programs typically set a low bar for initial access to housing (few eligibility requirements besides need, typically based on low income and a mental health diagnosis), and then provide extensive supports to socialize previously homeless individuals into behaviors and attitudes necessary to retain the housing or to transition to independent housing. Somers, et al., (2017) recruited two samples of homeless mentally ill participants who differed in the complexity of their needs. Eligibility was based on homeless status and current mental disorder. Participants were classified as either moderate needs (MN) or high needs (HN). Those with HN were randomized to scattered housing with Assertive Community Treatment (SHF), congregate housing with support (CHF), or usual care. Participants were interviewed every 3 months for 2 years. Participants met eligibility for either MN (n = 200) or HN (n = 297) and were randomized accordingly. Both samples were primarily male and white. Compared to participants designated MN, HN participants had higher rates of hospitalization for psychiatric reasons prior to randomization, were younger at the time of recruitment, younger when first homeless, more likely to meet criteria for substance dependence, and less likely to have completed high school. Ninety percent of the HN sample had a “severe” psychiatric diagnosis. Across all study arms, between 92% and 100% of participants were followed over 24 months post-randomization. Of the 297 HN participants, most of whom who had an SMI diagnosis, 107 were randomly assigned to CHF, 90 to SHF (90), and 100 to TAU). The percentage of time in stable housing over 24 months was 26.3% in TAU (reference; 95% confidence interval (CI) = 20.5, 32.0), compared to 74.3% in CHF (95% CI = 69.3, 79.3, $p < 0.001$) and 74.5% in SHF (95% CI = 69.2, 79.7, $p < 0.001$). Secondary outcomes favored CHF but not SHF compared to TAU. These results suggest that HF initiatives can dramatically increase residence stability in at-risk populations.

In a subsequent analysis of the HN data from the Somers, et al. trial (2017), Russolillo, Patterson, McCandless, Moniruzzaman, and Somers (2014) investigated the use of crisis services in the participants. Their analysis was based on HN participants enrolled in the Vancouver At Home Study (n=297) randomized to one of the three intervention arms—congregate housing with support (CF), scattered housing with support (SHF), or ‘treatment as usual’ (TAU) where individuals continue to use existing services available to homeless adults with mental illness. The investigators incorporated linked data from a regional database representing six urban emergency departments. Compared to TAU, significantly lower numbers of emergency visits were observed during the post-randomization period in the SHF group (adjusted rate ratio 0.55 [0.35,0.86]). CHF was associated with marginally lower ED utilization, in comparison to TAU, but was not statistically significant (adjusted RR 0.76 [0.49, 1.17]). The results suggest that HF, particularly the SS model, produced significantly lower hospital emergency department visits among homeless adults with a mental disorder. These findings demonstrate the potential effectiveness of HF to reduce acute health care use among homeless individuals.

Across the psychological, biological, and social domains, these studies indicate that interventions informed by psychological knowledge, and often co-developed by psychologists can have a profoundly positive impact on individuals diagnosed with SMI/SED.

3. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's procedures and techniques when compared with services rendered by other specialties or practice modalities. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results and the comparisons to other specialties or modalities.

1. Bonnin, C. D. M., Torrent, C., Arango, C., Amann, B. L., Solé, B., González-Pinto, A., ... & García-Portilla, M. P. (2016). Functional remediation in bipolar disorder: 1-year follow-up of neurocognitive and functional outcome. *The British Journal of Psychiatry*, 208, 87-93. doi.org/10.1192/bjp.bp.114.162123
2. Goldstein, T. R., Fersch-Podrat, R. K., Rivera, M., Axelson, D. A., Merranko, J., Yu, H., ... & Birmaher, B. (2015). Dialectical behavior therapy for adolescents with bipolar disorder: results from a pilot randomized trial. *Journal of Child and Adolescent Psychopharmacology*, 25, 140-149. doi.org/10.1089/cap.2013.0145
3. Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... & Marcy, P. (2015). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH raise early treatment program. *American Journal of Psychiatry*, 173, 362-372. doi.org/10.1176/appi.ajp.2015.15050632
4. Birchwood, M., Michail, M., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., ... & Peters, E. (2014). Cognitive behaviour therapy to prevent harmful compliance with command hallucinations (COMMAND): a randomised controlled trial. *The Lancet Psychiatry*, 1, 23-33. [doi.org/10.1016/S2215-0366\(14\)70247-0](https://doi.org/10.1016/S2215-0366(14)70247-0)
5. Schaub, A., Mueser, K. T., von Werder, T., Engel, R., Möller, H. J., & Falkai, P. (2016). A randomized controlled trial of group coping-oriented therapy vs supportive therapy in schizophrenia: results of a 2-year follow-up. *Schizophrenia Bulletin*, 42, S71-S80. doi.org/10.1093/schbul/sbw032

Research on psychological interventions in SMI/SED is maturing, and as such there are an increasing number of randomized controlled trials available to inform optimal treatment planning. While early trials often used designs contrasting the benefits of medication to psychotherapy (e.g., the landmark series of studies overseen by Dr. Philip May at Camarillo (CA) State Hospital on schizophrenia in the 1960s), there is now a consensus that most clients diagnosed with SMI/SED benefit from concurrent medication and psychological interventions. Thus, the newer SMI/SED trials typically compare an active psychological intervention to either treatment as usual (TAU), which typically encompasses at least medication and case management and may also include some form of counselling, or an attention placebo.

Turner, van der Gaag, Karyotaki, and Cuijpers (2014) published a recent meta-analysis on psychological interventions with psychosis, with an emphasis on outcomes of randomized trials; they identified the following comparator interventions: befriending, cognitive behavioral therapy for psychosis, cognitive remediation, psychoeducation, social skills training, and supportive therapy. Typical outcomes in these studies assess multiple domains, including symptoms (using measures such as the *Brief Psychiatric Rating Scale* (BPRS) (Lukoff, Nuechterlein, & Ventura, 1986) and *Positive and Negative Syndrome Scale* (PANSS) (Kay, Opler, & Fiszbein, 1987), objective or subjective quality of life measures (such as the *Lehman Quality of Life Scale*, (Lehman, Kernan, & Postrado, 1995) or the *Heinrich Quality of Life Scale*, (Heinrichs, Hanlon, & Carpenter, 1984), and community functioning measured on scales such as the *Social Adjustment Scale* (SAS) (Schooler, Hogarty, & Weissman, 1979), the *Social Functioning Scale*

(SFS) (Birchwood, Smith, Cochrane, Wetton, & Copestake, 1990), or the *VA Mental Illness Research Education and Clinical Center Global Assessment of Functioning* (MIRECC-GAF) (Niv, Cohen, Sullivan, & Young, 2007). The studies typically, though not always, find a benefit for the active psychological intervention in comparison to the control condition.

Prototypic published trials in this area include: Bonnin, et al. (2016) reported on a multicenter, randomized controlled trial comparing outcomes for three adult bipolar patient groups: functional remediation, psychoeducation and treatment as usual (TAU) over 1-year follow-up. The functional remediation program consisted of 21 weekly sessions, each lasting 90 minutes, which addressed neurocognitive issues such as attention, memory and executive functions, but also focused on enhancing functioning in daily routine. The psychoeducation also consisted of 21 weekly sessions of 90 minutes each, aimed at preventing recurrences of bipolar illness by improving four main issues: illness awareness, treatment adherence, early detection of prodromal symptoms of relapse and lifestyle regularity. The primary outcome was change in psychosocial functioning measured by means of the *Functioning Assessment Short Test* (FAST) (Rosa, et al., 2007). In the TAU group, participants received prescribed pharmacological treatment without any PSR therapy. The one year results established a statistically significant group by time interaction for overall psychosocial functioning, favoring patients in the functional remediation group. The investigators concluded that improvements in psychosocial functioning found at 6 months were maintained at 1-year follow-up in patients with bipolar disorder receiving functional remediation.

In another trial on bipolar illness, Goldstein, et al. (2015) conducted a pilot test of dialectical behavior therapy (DBT) in adolescents. Eligible patients were assigned to either DBT or psychosocial TAU. All patients also received medication management. DBT included 36 sessions (18 individual, 18 family skills training) over one year. TAU was an eclectic psychotherapy approach consisting of psychoeducational, supportive, and cognitive behavioral techniques. An independent evaluator, blind to treatment condition, assessed outcomes including affective symptoms, suicidal ideation and behavior, non-suicidal self-injurious behavior, and emotional dysregulation, every three months over 1 year. As compared with adolescents receiving TAU, adolescents receiving DBT demonstrated significantly less severe depressive symptoms during follow-up, and were nearly three times more likely to demonstrate improvement in suicidal ideation; there were no between-group differences in manic symptoms or emotional dysregulation. These results are promising and suggest DBT may be an appropriate treatment for bipolar illness, especially depression and suicidality, in adolescents.

We also present three trials of PSR treatments for psychosis that are relevant here. The RAISE trial described earlier (Kane, et al., 2015), which involved tailored treatment for first episode non-affective psychosis, entailed a 34 site cluster randomized controlled trial comparing comprehensive specialty care (CSC), including pharmacological management, family education, individual therapy, and supported employment and education, to customary care throughout the US. Four hundred four individuals were randomized to a minimum of two years of CSC or to customary care. Outcomes data were collected every 6 months on symptoms status, employment/educational status, quality of life, retention in treatment, and rate of hospitalization. The 223 recipients of NAVIGATE remained in treatment longer, experienced greater improvement in quality of life and overall psychopathology (including depression and symptoms of schizophrenia), and participated more in work and school compared with 181 participants in community care; there were no differences in hospitalization rates, which were low for both groups. These results support the benefits of comprehensive PSR and pharmacological care tailored to the needs of first episode psychosis, compared to customary care.

Birchwood, et al. (2014) reported on a test of a new intervention for command hallucinations. They evaluated a novel cognitive therapy to challenge the perceived power of voices to inflict harm on the voice hearer if commands were not followed, which should thus reduce the hearer's motivation to comply. In a single blind randomized controlled trial, eligible participants who had experienced command hallucinations for at least six months leading to major episodes of harm to themselves or other people were assigned to nine months of cognitive therapy embedded in TAU versus just TAU. The primary outcome was harmful

compliance with the voices. At nine months there was no difference between the two groups, but by eighteen months, 39 (46%) of 85 participants in the TAU group still fully complied with the voices compared with 22 (28%) of 79 in the cognitive therapy for command hallucinations + TAU group ($p=0.021$). Interestingly, however, there was no group related effect on hallucinations overall.

Finally, Schaub, Mueser, von Werder, Engel, Möller, and Falkai (2016) reported on the long-term benefits of participation in a group-based coping-oriented program (COP) that combined the elements of illness management with cognitive behavioral-therapy for psychosis to an equally intensive supportive therapy (SUP) program during inpatient treatment following a symptom exacerbation. One hundred ninety-six inpatients with DSM-IV schizophrenia were randomized to COP or SUP, each lasting 12 sessions provided over 6–8 weeks. Outcome measures were collected in the hospital at baseline and post-assessment, and following discharge into the community one and two years later. Intent-to-treat analyses indicated that patients in COP learned significantly more information about psychosis, and had greater reductions in overall symptoms and depression/anxiety over the treatment and follow-up period than patients in SUP. Patients in both groups improved significantly in other symptoms and psychosocial functioning. There were no differences between the groups in hospitalization rates, which were low. The results were interpreted as indicating that participation in a skills based program, even when administered during a hospitalization stay, can provide lasting benefits.

Taken together, we offer these studies to demonstrate the efficacy of the specialized mental health interventions designed, administered, or overseen by psychologists in the treatment of SMI/SED compared to typical care. These benefits are found across a range of domains, including symptoms, community functioning, and quality of life.

4. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of settings or organizational arrangements where this specialty is practiced. Summarize and discuss the relevance of the findings of these studies in relation to the specialty practice.

1. Malinovsky, I., Lehrer, P., Silverstein, S. M., Shankman, S. A., O'Brien, W., Samuelson, T., & Van Nostrand, G. (2013). An empirical evaluation of recovery transformation at a large community psychiatric rehabilitation organization. *Psychological Services, 10*, 428. doi.org/10.1037/a0032747
2. Zuehlke, J. B., Kotecki, R. M., Kern, S., Sholty, G., & Hauser, P. (2016). Transformation to a recovery-oriented model of care on a veterans administration inpatient unit. *Psychiatric Rehabilitation Journal, 39*, 361-363. doi.org/10.1037/prj000019
3. VanMeerten, N. J., Harris, J. I., Nienow, T. M., Hegeman, B. M., Sherburne, A., Winskowski, A. M., ... & Sponheim, S. R. (2013). Inpatient utilization before and after implementation of psychosocial rehabilitation programs: analysis of cost reductions. *Psychological Services, 10*, 420-427. doi.org/10.1037/a0031159
4. Ben-Zeev, D., Brenner, C. J., Begale, M., Duffecy, J., Mohr, D. C., & Mueser, K. T. (2014). Feasibility, acceptability, and preliminary efficacy of a smartphone intervention for schizophrenia. *Schizophrenia Bulletin, 40*, 1244-1253. doi.org/10.1093/schbul/sbu03
5. Depp, C. A., Ceglowski, J., Wang, V. C., Yaghouti, F., Mausbach, B. T., Thompson, W. K., & Granholm, E. L. (2015). Augmenting psychoeducation with a mobile intervention for bipolar disorder: a randomized controlled trial. *Journal of Affective Disorders, 174*, 23-30. doi.org/10.1016/j.jad.2014.10.053

One of the appealing attributes of the profession of health service psychology is its flexibility in settings and activities. Within the context of SMI/SED, psychologists make a contribution in inpatient

hospital settings, residential settings, and outpatient clinics, as direct care providers, treatment developers, and as managers/supervisors. Furthermore, psychologists have assumed a leadership role in enhancing dissemination of psychological techniques using e-health and mobile technologies, which may greatly expand the capacity of the field to support positive outcomes from SMI/SED research (Furth & Tourus, 2015). Recent developments and research in the role of psychology in these various settings and technologies are discussed here. As we will show, a reverberating theme in this work is bringing recovery-oriented values and practices to these settings and interventions.

With regard to the impact of psychology in more traditional treatment settings, Zuehlke, Kotecki, Kern, Sholty, and Hauser (2016) conducted a quality improvement project to determine whether recovery interventions would yield positive outcomes when delivered on inpatient unit in a VA medical center. Novel recovery interventions on the unit included recovery-focused interdisciplinary team meetings, opportunities for stakeholder feedback, recovery staff education, increased group programming, peer support, and changes to treatment planning to include increased veteran engagement and responsibility. Participants included 352 patients and 27 staff. Outcomes were number of restraints/seclusions used, 30-day readmission rates, and staff satisfaction. The results showed an overall decrease in restraint/seclusion use by over 50% and an increase in staff satisfaction after the transition to the new program.

In their study of community residential settings, Malinovsky, et al. (2013) note that several states and organizations are currently developing plans to transform their mental health systems in accordance with recovery-oriented care, although the data on the specific benefits of these efforts have been limited. The investigators conducted a longitudinal study to evaluate the effectiveness of a recovery-oriented transformation carried out in the housing component of a large, private, not-for-profit psychiatric rehabilitation organization serving individuals with SMI. The outcome variables selected to evaluate the impact of the transformation were grouped into the following categories: (a) objective indicators of recovery, (b) self-report indicators of recovery, (c) indicators of staff competency, and (d) processes that promote recovery. Six-hundred and 27 residents and 490 staff participated in the evaluation. The findings suggest that recovery-oriented services had a positive impact on rates of overnight hospitalization, residents' ability to function in the community, some professional skills of employees, and working alliance between direct care providers and residents from pre to post transition.

VanMeerten, et al. (2013) examined the impact of implementation of several recovery-oriented outpatient PSR interventions on inpatient usage and cost savings in a large mid-western VA. They included veterans (over 75% having a schizophrenia spectrum or bipolar disorder) who had been receiving mental health treatment at the facility before and after a program of PSR interventions (CBSST, family education, supported employment, and illness management and recovery) were implemented. They compared veterans who participated in at least one of the PSR interventions with those who did not; the two groups did not differ in age, gender, GAF functioning scores, and rates of alcohol or substance abuse diagnoses, although there were somewhat higher rates of schizoaffective and bipolar disorders and a lower rate of schizophrenia in individuals who received the PSR interventions compared with those who did not. The investigators report that veterans who utilized at least one of the interventions during the six years between the baseline and second data collection period had less frequent and shorter hospitalizations in the interim, resulting in a greater reduction in overall treatment cost than those who did not utilize the interventions.

The first three studies we presented demonstrate the efficacy of psychology's services for dealing with the types of settings or organizational arrangements where this Specialty is practiced, while the remaining two broaden the discussion to implementation to new settings and organizational arrangements, focusing on advances in technology.

Ben-Zeev, et al. (2014) reported on the development of the FOCUS smartphone intervention, which was designed to provide automated real-time/real-place illness management support to individuals with schizophrenia. The system was specifically designed to be usable by people with psychotic disorders who may have cognitive impairment, psychotic symptoms, negative symptoms, and/or low reading levels.

FOCUS offers users both prescheduled and on-demand resources to facilitate symptom management, mood regulation, medication adherence, social functioning, and improved sleep. In a pilot quasi-experimental study, 33 individuals with schizophrenia or schizoaffective disorder used FOCUS over a one month period in their own environments. Completers ($n=32$) used the system on 86.5% of days they had the device, an average of 5.2 times a day. Approximately 62% of use of the FOCUS intervention was initiated by the participants, and 38% of use was in response to automated prompts. Baseline levels of cognitive functioning, negative symptoms, persecutory ideation, and reading level were not related to participants' use of the intervention. Approximately 90% of participants rated the intervention as highly acceptable and usable. Paired samples *t* tests found significant reductions in psychotic symptoms, depression, and general psychopathology, after 1 month of FOCUS use. This study supports the feasibility, acceptability, and preliminary efficacy of the FOCUS intervention for schizophrenia.

While the Ben-Zeev et al. (2014) intervention discussed above addressed schizophrenia, Depp, et al. (2015) investigated the use of mobile technology in bipolar disorder. They argued that mobile technology may improve access to evidence-based interventions and may increase their efficacy. They evaluated the feasibility, acceptability and efficacy of an augmentative mobile ecological momentary intervention targeting self-management of mood symptoms using a randomized single-blind controlled trial with 82 consumers diagnosed with bipolar disorder. Participants completed a four-session psychoeducational intervention and were assigned to 10 weeks of either: 1) mobile device delivered interactive intervention linking patient-reported mood states with personalized self-management strategies, or 2) paper-and-pencil mood monitoring. Participants were assessed at baseline, 6 weeks (mid-point), 12 weeks (post-treatment), and 24 weeks (follow up) with clinician-rated depression and mania scales and self-reported functioning. Retention at 12 weeks was 93% and both conditions were associated with high satisfaction. Compared to the paper-and-pencil condition, participants in the augmented mobile intervention condition showed significantly greater reductions in depressive symptoms at 6 and 12 weeks (Cohen's *d* for both were $d=0.48$). However, these effects were not maintained at 24-week follow up. Conditions did not differ significantly in the impact on manic symptoms or functional impairment. The results suggest that technology may impact on symptoms during a period of use, but these benefits are not sustained when access to the technology ceases.

Taken together, these five studies indicate that recovery-based transformations of psychological services in physical settings lead to desired improvements in the programs, and that mobile technologies are feasible with individuals diagnosed with SMI/SED, but that further work is needed to fully understand the benefits that can accrue from these interventions.

Criterion X. Quality Improvement

A specialty promotes ongoing investigations and procedures to develop further the quality and utility of its knowledge, skills, and services.

***Commentary:** The public interest requires that a specialty provides the best services possible to consumers. A specialty, therefore, continues to seek ways to improve the quality and usefulness of its practitioners' services beyond its original determination of effectiveness. Such investigations may take many forms. Specialties promote and participate in the process of accreditation in order to enhance the quality of specialty education and training. Petitions describe how research and practice literatures are regularly reviewed for developments which are relevant to the specialty's skills and services, and how this information is publicly disseminated.*

1. Provide a description of the types of investigations that are designed to evaluate and increase the usefulness of the skills and services in this specialty. Estimate the number of researchers conducting these types of studies, the scope of their efforts, and how your organization and/or other organizations associated with the specialty will act to foster and communicate these developments to specialty providers. Provide evidence of current efforts in these areas including examples of needs assessed and change that resulted.

Scholars in the SMI Psychology Specialty conduct high quality, well designed research that has dramatically increased the knowledge base concerning efficacy and effectiveness of services designed to aid individuals with SMI/SED. These scholars contribute extensively to a wide range of academic journals that publish evidence-based literature and empirical and systematic review articles that inform the specialized work of psychologists who treat persons with SMI/SED and increase the skills of providers and enhance services in this Specialty. There is a broad scope of psychological and behavioral interventions ranging from psychotherapies, such as cognitive behavioral therapy for psychosis (CBTp) (Beck, Himelstein, & Grant, in press; Burns, Erickson, & Brenner, 2014; Granholm, Holden, Link, & McQuaid, 2014; Kingdon, & Turkington, in press), cognitive remediation approaches (Cella, et al., 2017; Donohoe, et al., 2018; La Buissonnière-Ariza, Schneider, & Storch, 2017; Lindenmayer, et al., in press; Lystad, et al., 2017; Reeder, et al., 2017; Ullevoldsæter Lystad, et al., 2017) psychological interventions for trauma (Brand, et al., 2018), social cognition training (Granholm & Harvey, 2018), among others, as well as the well known PSR interventions extensively detailed in the NICE practice guideline (National Collaborating Centre for Mental Health (2014), the NIMH Schizophrenia Port review (Kreyenbuhl, Buchanan, Dickerson & Dixon, 2010), the NIMH RAISE trial (Kane, et al., 2016), the SAMHSA evidence based practice toolkits (<https://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs>), and APA's *Recovery Curriculum* (American Psychological Association & Jansen, 2014).

The Specialty Council, along with other organizations that promote evidence-based specialized services for persons with SMI/SED (Association of Cognitive Behavioral Therapy (ABCT), particularly its special interest group (SIG) on Schizophrenia and Other Serious Mental Disorders, which is also a member of the SMI Psychology Specialty Council, and the Psychiatric Rehabilitation Association (PRA), among others, convene scientific programs at conventions, international meetings, and use the many scientific journals that specialize in dissemination of knowledge about the Specialty to foster continued development of the empirical literature and to communicate results to members, other practitioners, and the general public.

As described above, there are many examples of how the skills and services in the treatment of persons with SMI/SED have been shaped by advances in practice. As we indicated, two notable recent widespread changes influenced by the scientific literature (much of which has been contributed by psychologists in this Specialty) include the expansion and uptake of integrated primary care and behavioral healthcare for individuals with SMI/SED, and the validation of effectiveness of comprehensive

services for individuals experiencing first episode psychosis.

The evolution of first episode psychosis (FEP) care in the US is an exemplar of the extensive impact this Specialty is having on general clinical practice. In 2009, the Recovery After an Initial Schizophrenia Episode (RAISE) initiative was launched by the National Institute of Mental Health to research the implementation of early intervention treatment for persons with schizophrenia within the United States. The RAISE initiative included the RAISE Early Treatment Program (RAISE-ETP) study (Kane et al., 2015; Mueser et al., 2015) which was the largest controlled trial in the U.S. to evaluate the effectiveness of a team-based model of treatment of persons with first episode psychosis (Kane et al., 2016). Developed as the primary intervention in the RAISE-ETP study, the NAVIGATE treatment model was designed to promote and facilitate recovery for people with first episode psychosis by building skills to improve resiliency, reinforcing natural supports, support progress to achieve vocational and educational goals, and providing individualized medication treatment (Kane et al., 2015; Mueser et al., 2015). The positive results of RAISE-ETP (now NAVIGATE) contributed to the development of coordinated specialty care (CSC) as the U.S. gold standard of early intervention services (Goldstein & Azrin, 2014). Based on the RAISE results, Congress supported the development of the CSC model by supplementing federal block grants with funds specifically earmarked for the development of early intervention services (Goldman & Karakus, 2014). In 2008, very few states had CSC programs. In 2018, due to the legislation and monies designated for the development and support of these programs, 48 states have CSC programs (Heinssen, Goldstein, & Azrin, 2016; Heinssen, 2018).

Psychologists, including members and consultants to the Specialty Council have had a key role in developing and expanding CSC care throughout the US. Dr. Mueser (Specialty Council consultant) and Dr. Glynn (Specialty Council member) were extensively involved in the RAISE-ETP initiative, as well as providing ongoing training on NAVIGATE, and the Early Psychosis Intervention Center (EPICENTER) at the Ohio State University which is directed by Dr. Nicholas Breitborde (Specialty Council member) is a major CSC clinical and research site. Dr. Breitborde also established the first EPICENTER clinical research center at the University of Arizona in 2010.

Four prominent additional examples of ways the specialty continues to develop knowledge and influence practice include 1) the major US Department of Veterans national initiative on instituting Measurement Based Care (MBC), including for SMI, led by Dr. Resnick, chair of the APA Task Force on SMI/SED, who is also editing a special issue on MBC in mental health services for *Psychological Services*, the journal of Division 18, published by APA and 2) a special issue of *Psychological Services*, on early intervention services in serious mental illness, guest edited by Dr. Shirley Glynn, immediate past president of Division 18 and a member of the APA Task Force. 3) a special issue of *Psychiatric Rehabilitation Journal* (an APA journal edited by Dr. Resnick) on international implementation of individual placement and support, and 4) a special issue of *Psychiatric Rehabilitation Journal*, guest edited by Dr. Richard Goldberg (director of one of the Specialty's four exemplary post-doctoral programs – see Criterion VII) on Feasibility of Implementing a Recovery Education Center in a Veterans Affairs Medical Center. These and other members of the Specialty Council have been leaders in research and practice in the Specialty, as well as implementation and dissemination of these practices as reflected by the five examples above and by recent publications and national presentations at APA Conventions, the Psychiatric Rehabilitation Association National Workforce Summit, presentations at the Association for Behavioral and Cognitive Therapies annual conferences, and national webinars offered through the SAMSHA Recovery to Practice initiative, and other educational sessions for practicing psychologists and those in training. The examples offered in this Criterion and cited in others throughout this petition serve to highlight the ways that the Specialty is changing the direction and implementation of services for person with SMI and SED.

Because specialized research with the SMI/SED population is broad and multidisciplinary, estimating the number of researchers in the field is difficult to calculate. However, a Google Scholar search conducted for articles on the psychological treatment for just schizophrenia alone (psychological treatments in schizophrenia) returned approximately 382,000 articles for this one population in the SMI constellation of specialized diagnosis. Given the heterogeneity of diagnosis and age groups in SMI/SED,

as well as the diversity of keywords that could be used to describe the continuum of interventions, we expect the number of publications on effective skills and services to be many times more than this. This clearly illustrates that there is a specialized research field in SMI/SED that is designed to improve the diagnosis and treatment of this population. As another estimate, the *Psychiatric Rehabilitation Journal*, an interdisciplinary journal published by APA and edited by Dr. Sandra Resnick, a member of this Specialty Council, with a focus on psychological interventions for individuals with SMI/SED, has published slightly over 50 research articles each year since 2014, representing a likely pool of several hundred researchers alone. Given that there are dozens of appropriate journals for such articles, the number of researchers in the field internationally is undoubtedly sufficient to support the increased growth and quality improvement necessary to justify a Specialty in this area.

2. Describe how the specialty seeks ways to improve the quality and usefulness of its practitioners' services beyond its original determinations of effectiveness.

The Specialty Council works to improve the quality and usefulness of practitioners' services by contributing to the literature, leading training for those desiring to practice in the Specialty, and serving as the home within APA for practice in the Specialty. The Specialty has a proven record of commitment to ensuring that the quality and usefulness of practitioners' services are continuously improving. Examples of this commitment and actions taken follow:

The examples cited in question I above are but a small sampling of the ways the Specialty is continually improving the quality and usefulness of its practitioner' services. In addition to the work of Drs. Resnick, Glynn, and Breitborde, there are many others who are contributing to these ongoing efforts. Indeed, much of the literature cited throughout this petition has been contributed by members of the Specialty and has served to enhance the services delivered to persons with SMI/SED. Dr. Mary Jansen, the Executive Officer of the Specialty Council is a past Chair of the APA Task Force on SMI/SED and served as a member of the Task Force for 14 years. She was the founding Chair of the Division 18 Section in SMI/SED, and wrote the APA *Recovery Curriculum*. Dr. Kim Mueser, a member of Division 18, is immediate past Director of the Center for Psychiatric Rehabilitation at Boston University and is known worldwide for his extensive research on evidence based practices for persons with SMI/SED. In addition to the many invited lectures, workshops, and symposia that Dr. Mueser has presented in the US, he has given workshops in over 20 countries outside the US, most often being invited the those countries multiple times. Dr. Anne Klee is the Training Director at the VA/Yale post-doctoral fellowship program, one of the 4 model programs listed in Criterion VII of this petition. Dr. Klee is also a member of APA's Council of Representatives and current President of the Connecticut Psychological Association. Dr. Susan McGurk, also at the Boston University Center for Psychiatric Rehabilitation is widely recognized for her groundbreaking work on the efficacy and effectiveness of cognitive remediation and social cognition training for persons with schizophrenia; her *Thinking Skills for Work* training program has been adopted by many treatment programs in North America and around the globe. These and the others cited in this Criterion and throughout the petition are but a few of the contributions of Specialty members.

In addition to the contributions described above, members of the Specialty conduct investigations and disseminate their work in widely respected journals. Dr. Shirley Glynn serves on the editorial boards of *Psychological Services*, *Psychiatric Rehabilitation Journal* (an APA journal), and *Evaluation and the Health Professions*, Dr. Nadine Kaslow, current President of Division 18 edits the *Journal of Family Psychology* and is well known for her work in the development of competency based education. Dr. Sandra Resnick is the Editor of *Psychiatric Rehabilitation Journal* (an APA journal). Dr. Richard Goldberg (director of one of the Specialty's four exemplary post-doctoral programs – see Criterion VII) is editing a special issue of *Psychiatric Rehabilitation Journal*, on Feasibility of Implementing a Recovery Education Center in a Veterans Affairs Medical Center. Dr. Nicholas Breitborde, a member of the APA Task Force on SMI/SED established the Early Psychosis Intervention Center (EPICENTER) at the Ohio State University and also established the first EPICENTER clinical research center at the University of Arizona in 2010. Dr. Breitborde has published extensively on this work and is one of the investigators changing the way services are conceptualized and delivered to persons with first episode psychosis. Dr. Jansen serves as a

consulting reviewer for *Psychological Services* and the *Psychiatric Rehabilitation Journal*.

In order to ensure that the up to date information reaches members of the Specialty, the literature is continually reviewed by the Research Committee of the Specialty Council with particular attention to the publication of meta-analyses, and other major syntheses of the evidence on effective treatments, skills and services for the target population. The Practice Committee of the Specialty Council is similarly charged with reviewing the literature on the practice of psychology, relevant clinical practice guidelines, and the literature impacting the training of psychologists providing services to individuals from the specialty's target population.

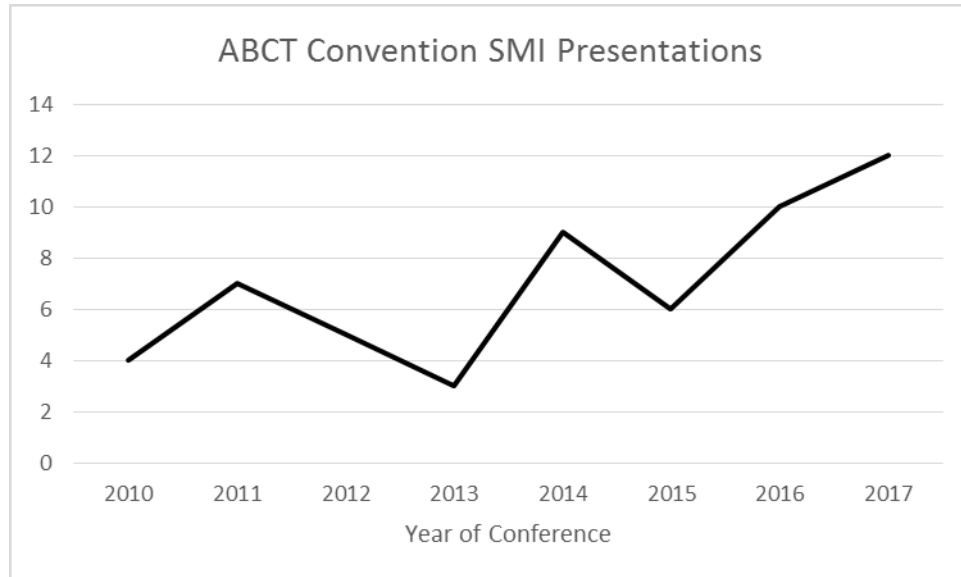
Additionally, those highlighted above and other members of the Specialty are among the leading researchers in the field and publish regularly in journals devoted to the Specialty. Some of these journals include APA's *Psychological Services*, APA's *Psychiatric Rehabilitation Journal* (edited by Specialty Council representative Dr. Resnick), *Schizophrenia Bulletin*, *Early Intervention in Psychiatry*, *Psychiatric Services*, *Schizophrenia Research*, *World Psychiatry*, and many others. These scholarly publications are highly respected and widely read by members of the Specialty and by others who seek to continuously improve the quality and usefulness of practitioners' services. In addition to the special issues and guest editorships noted above, many members of the Specialty publish in and serve as reviewers for multiple journals, both those specifically dedicated to the Specialty and those devoted to health and mental health care more broadly such as the *Journal of Abnormal Psychology*, *American Journal of Psychiatry*, *Journal of Clinical Psychology*, *Journal of Consulting and Clinical Psychology*, *Clinical Psychology Review*, *JAMA Psychiatry*, and others. These consulting editors/reviewers include the current and several past Chairs of the APA Task Force, current and several past Presidents of Division 18, and many members and chairs of the Division's Sections. The scholarly contributions informed by this work serve to update and inform all who are working to improve services for individuals with SMI/SED. The Specialty Council communicates practice trends to members of the Specialty and to the wider scientific audience via the scientific literature in order to continuously improve the quality and usefulness of practitioners' services.

The Specialty has have a long history of providing relevant continuing education opportunities in the assessment and treatment of persons with SMI/SED. Continuing education symposia and workshops on the assessment and treatment of persons with SMI/SED have been offered by representatives of the Specialty Council each year at the APA convention beginning in 2004, coordinated by the member organizations of the Specialty Council. Each year since 2004, several symposia have been offered and very well attended. Beginning in 2010 and continuing through 2018, the Specialty Council has presented five full-day CE workshops. These are:

- New Interventions and Perspectives for Practitioners Treating Those with Serious Mental Illnesses, August, 2010.
- Treating Adults and Adolescents with Serious Mental Illness: Using EBPs in Clinical Practice, August, 2011.
- New and Emerging Clinical Practices for Treating People with Serious Mental Illness, August, 2012.
- Recent Advances in Evidence Based Practices to Help People Recover from Serious Mental Illnesses, August, 2014.
- Evidence Based Interventions for First Episode Psychosis - RAISE-ETP & Beyond, August, 2018.

These symposia and workshops are presented by experts in the field and are designed to highlight the latest developments in this Specialty and offer attendees the opportunity to connect with the presenters. In 2004, APA convention offerings focusing on SMI/SED were sparse to non-existent. Due to the growing interest in SMI/SED and the leadership of the Specialty Council, convention offerings have grown substantially over the years and are now offered by a range of APA divisions.

In addition to APA convention presentations, members of the Specialty have been and continue to be regular presenters (often presenting invited addresses) based on their work at national and international scientific meetings of clinicians, researchers, and educators working in the Specialty. As noted in this Criterion and elsewhere in this petition, members of the Specialty publish regularly in highly respected journals and are very much respected in this field. The growth of the Specialty can be seen in the graph below which highlights growth in the number of presentations at just one of the many conferences organized by those in the Specialty:



Source: Number of presentations on serious mental illness (SMI) at the annual Association for Behavioral and Cognitive Therapies (ABCT) convention. Includes forums, symposia, panels, roundtables, workshops, keynotes/invited addresses, events by the Schizophrenia and Other Serious Mental Disorders Special Interest Group (SIG), and SIG trailblazer awardee presentations. Data collected by Charlie Davidson, Ph.D., SIG representative to the SMI Psychology Specialty Council.

The APA's *Recovery to Practice Curriculum* (American Psychological Association & Jansen, 2014) was written by a member of the Specialty Council. The Recovery to Practice Curriculum is a comprehensive curriculum providing an overview of SMI/SED, the recovery paradigm and the PSR empirically based and officially designated evidence-based and promising practices developed and validated for this population. The Curriculum is designed to be used in the training of psychologists in the Specialty and serves as one of the practice guidelines recommended for use in training and in practice. The Curriculum is free and available to all from the APA website: <http://www.apa.org/pi/mfp/psychology/recovery-to-practice/training.aspx>.

Two members of the Specialty Council (Jansen and Glynn) further developed the information in the *Curriculum* into a series of APA continuing education webinars, co-sponsored by the APA Office of Continuing Education and the APA Task Force on SMI/SED. The series is a 4 part comprehensive CE program; each segment contains an ethics component designed to highlight the importance of ensuring quality service delivery and maintaining the highest level of ethical practice. Each of the segments can be taken for CE credit individually or the full series can be taken for CE credit. As listed on the APA CE website, the four titles are:

- Webinar I: Assessment, Engagement, and Ethical Considerations
- Webinar II: Clinical Interventions and Ethical Issues

- Webinar III: Interventions for Special Populations - Specialized Training for Ethical Practice
- Webinar IV: Interventions for Management & Policy Positions – Ethical Responsibilities, Training the Next Generation of Psychologists

To continue and to enhance the SMI Psychology Specialty's ongoing commitment to quality improvement, we have begun working with the Council of Specialties (CoS) and with the American Board of Professional Psychology (ABPP) and are prepared to join and meet all requirements immediately upon Specialty recognition. ABPP certification itself can be seen as a quality improvement activity at the individual level and requires that those seeking certification document the steps they have taken to remain up to date and abreast of the most current and effective practices in the area. As part of the process, a work sample is required. All information and materials provided are reviewed by a committee of experts in the specialization, ensuring that practitioners are knowledgeable, qualified and able to provide the most efficacious services possible. A recently initiated Maintenance of Certification program requires documentation of specialty-relevant experiences and CE to sustain one's specialty credentialing. The Specialty Council has begun developing certification requirements and these will be implemented once APA recognition of the Specialty is received in order to ensure psychologists remain fully competent in the Specialty.

3. Describe how the research and practice literature are regularly reviewed for developments which are relevant to the specialty's skills and services, and how this information is publicly disseminated. Give examples of recent changes in specialty practice and/or training based upon this literature review.

As part of the evolution and maturation of the SMI Psychology Specialty, the structure of the Specialty Council has been created to support the review and dissemination of new and important advances in the treatment of persons with SMI/SED. As we mentioned above, several members of the Specialty Council are engaged in ongoing research studies and publish frequently – these are but a few of the outstanding scholars of the Specialty. The literature from journals that concentrate on topics the Specialty focuses on is continually reviewed by the Research Committee of the Specialty Council with particular attention to the publication of relevant meta-analyses, and other major syntheses of the evidence on effective treatments, skills and services for the target population. The Practice Committee of the Specialty Council is similarly charged with reviewing the literature on the practice of psychology, and the literature impacting the training of psychologists providing services to individuals from the Specialty's target population with particular attention to clinical practice guidelines. When a committee determines that there has been a significant development in the scientific and/or practice community that warrants communication to members of the Specialty, this information is sent to the Marketing and Communications Committee of the Specialty Council. The Marketing and Communications Committee of the Specialty Council is responsible for dissemination of this material, including but not limited to linking to or summarizing this information on the Council's website and posting it on the listservs of relevant organizations such as the Division 18 Section on SMI/SED and the ABCT SIG. The Marketing and Communications Committee is also charged with recommending other methods of communication with members of the Specialty and with training programs, such as but not limited to email groups (e.g., listservs), newsletters, and periodic conference calls.

As described in question 1 above, there are many examples of how the skills and services in the treatment of persons with SMI/SED have been shaped by advances in practice. As we indicated in question 1, two notable recent widespread changes influenced by the scientific literature (much of which has been contributed by psychologists in this Specialty) include the expansion and uptake of integrated primary care and behavioral healthcare for individuals with SMI/SED, and the validation of effectiveness of comprehensive services for individuals experiencing first-episode psychosis. Five prominent examples include 1) the US Department of Veterans national initiative mentioned above on Measurement Based Care (MBC) led by Dr. Resnick, chair of the APA Task Force on SMI/SED, who is also editing a special issue on MBC in mental health services for *Psychological Services*, the journal of Division 18, published by

APA and 2) a special issue of *Psychological Services*, on early intervention services in serious mental illness, guest edited by Dr. Shirley Glynn, immediate past president of Division 18 and a member of the APA Task Force. Dr. Glynn's work and the special issue she is guest editing are the result of her participation in the NIMH Recovery After an Initial Schizophrenia Episode (RAISE) trial which has led NIMH to begin dissemination of the results of the trial through its Coordinated Specialty Care initiative, 3) a special issue of *Psychiatric Rehabilitation Journal* (an APA journal edited by Dr. Resnick) on international implementation of individual placement and support, 4) a special issue of *Psychiatric Rehabilitation Journal*, guest edited by Dr. Richard Goldberg (director of one of the Specialty's four exemplary post-doctoral programs – see Criterion VII) on Feasibility of Implementing a Recovery Education Center in a Veterans Affairs Medical Center, and 5) the Early Psychosis Intervention Center (EPICENTER) at the Ohio State University which is directed by Dr. Nicholas Breitborde, a member of the Specialty Council. Dr. Breitborde also established the first EPICENTER clinical research center at the University of Arizona in 2010. These and other members of the Specialty Council have been leaders in research and practice in the Specialty, as well as implementation and dissemination of these practices as reflected by the five examples above and by recent publications and national presentations at APA Conventions, the Psychiatric Rehabilitation Association National Workforce Summit, and national webinars offered through the SAMSHA Recovery to Practice initiative, and other educational sessions for practicing psychologists and those in training. The examples offered in this Criterion and cited in others throughout this petition serve to highlight the ways that the Specialty is changing the direction and implementation of services for person with SMI and SED.

4. This criterion includes two components: one focusing on past activities around accreditation (X.4.a), and the other on future activities around accreditation (X.4.b).

For X.4.a, describe how the specialty has promoted and participated in the process of accreditation in order to enhance the quality of specialty education and training. Also, indicate how many programs in this specialty have been accredited at the doctoral and/or postdoctoral level.

Because this petition is requesting formal recognition of SMI Psychology as a new Specialty, those working in the Specialty area have not formally participated in the APA accreditation process *under the rubric of this specialty*. However, there are doctoral and post-doctoral training programs that are accredited under an existing specialty designation (e.g., Clinical, Counseling) and that offer an Exposure, Experience, Emphasis or Major Area of Study in SMI Psychology. For example, our four exemplary programs as well as the other post-doctoral programs listed in Criterion VII are APA accredited. The Specialty has promulgated the APA Curriculum (described above and elsewhere in this petition), competencies, and evaluation materials to help with training in accredited programs. In addition, several members of the Specialty are current or former accreditation site visitors, or have served on the Commission on Accreditation, or on other committees under the direction of APA's Board of Educational Affairs. Several members of the Specialty are current site visitors and within the past year, others have applied to become site visitors.

Since this petition is for designation as a new Specialty, there are currently no accredited doctoral or post-doctoral programs *in this Specialty but there are several with training opportunities in the Specialty*. Please see the partial listing of post-doctoral residencies in Criterion VII for examples of these. The Specialty has evolved over the past several years and there are also several doctoral programs and internship sites that offer training in the Specialty.

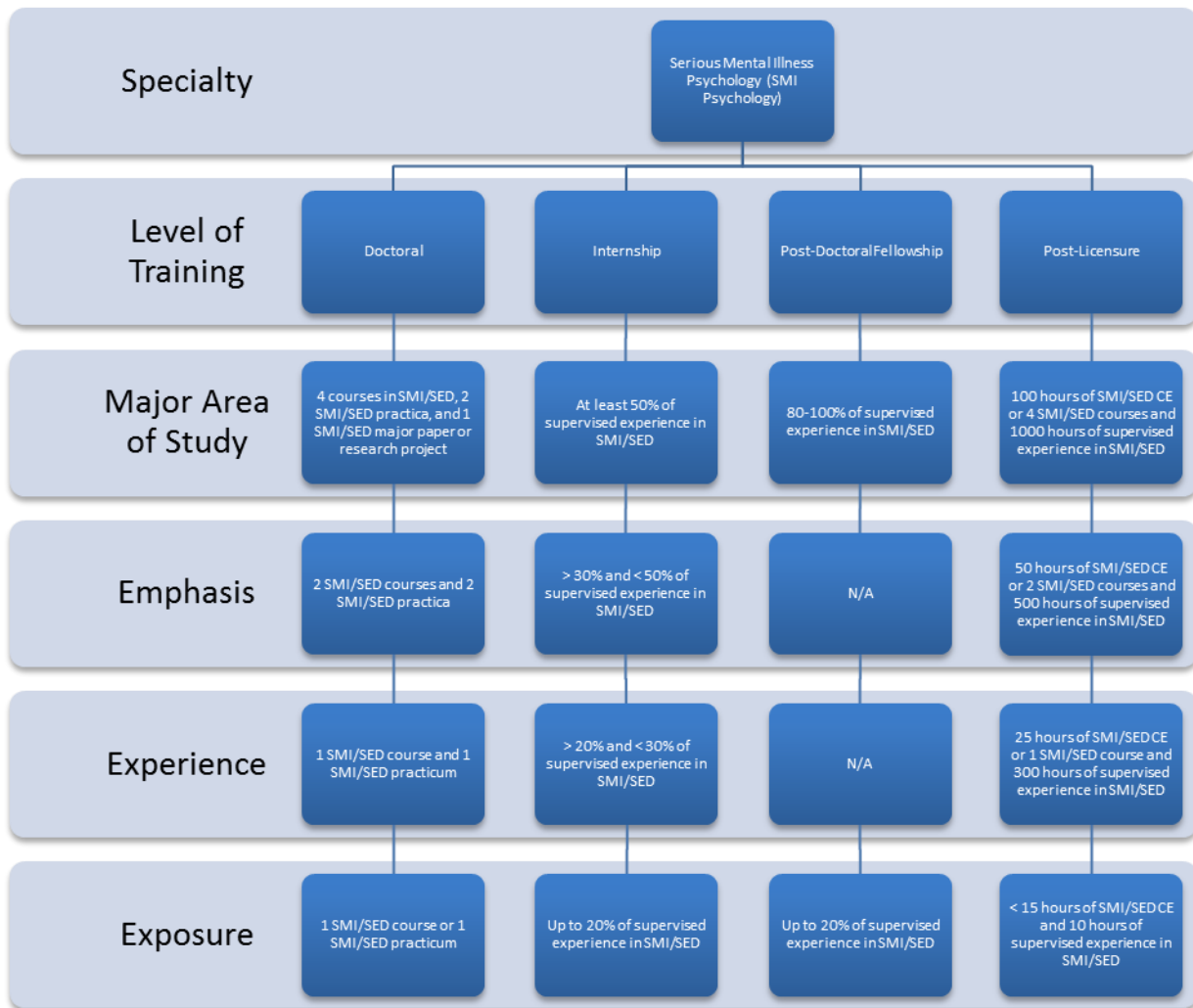
For X.4.b, describe how the specialty will promote and participate in the process of accreditation in the future in order to enhance the quality and sustainability of specialty education and training. Also, explain how the future accreditation support activities will be consistent with the Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties (see: <http://www.apa.org/ed/graduate/specialize/taxonomy.pdf>) and will be sustained (e.g., training CoA site reviewers with specialty expertise, sponsoring CoA self-study

workshops, fostering the development or ongoing operation of a specialty training council, administrative agreements and protections, financial support, etc.). Explain how these activities will result in an increase in the number of specialty programs that are accredited at the doctoral and/or postdoctoral level.

Presently, the Training and Evaluation Committee and the Accreditation Committee of the Specialty Council oversee activities related to training and accreditation. When this Specialty is recognized, the Accreditation Committee of the Specialty Council will immediately begin the process to promote accreditation expertise and involvement by contacting existing accredited programs in health service psychology to inform these programs of the new Specialty and to encourage accreditation in the new Specialty. Several members of the Specialty Council currently serve as accreditation site visitors and several others have served in this capacity in the past. Members of the Specialty Council are actively encouraging and recruiting individuals to apply to become accreditation site visitors and the Council will initiate training for site visitors for Specialty accreditation and will work with CoA to offer self-study workshops. The Specialty Council has encouraged those in the Specialty to apply to become accreditation site visitors if they are not already engaged as site visitors and some have recently applied. The Specialty Council will also work to grow the Specialty by ensuring that post-doctoral residency programs are aware of the area's Specialty status; those with an existing emphasis in SMI/SED will be encouraged to upgrade the residency to one with a Major Area of Study and to seek accreditation in this post-doctoral Specialty. Doctoral programs will also be contacted and encouraged to initiate training in the Specialty area. The Specialty Council is aware of some non-APA accredited doctoral and post-doctoral programs that provide training in the content of the Specialty. These programs will also be contacted and encouraged to pursue APA accreditation.

These future accreditation support activities will be consistent with the *Taxonomy for Education and Training in SMI Psychology* provided below. As such the Exposure, Experience, Emphasis, and Major Area of Study categories of the Taxonomy will be promoted at the doctoral, internship, and post-doctoral levels in order to enhance uptake of the Specialty's topical content.

Taxonomy for Education and Training in Serious Mental Illness Psychology (SMI Psychology)



SMI/SED Course – Each course must have predominant content specific to the recovery paradigm and/or psychosocial rehabilitation for persons with SMI/SED and be taken for at least 3 hours of credit.

SMI/SED Practicum – Minimum experience of 9 months of applied, clinical supervised experience for at least 10 hours per week working with persons with SMI/SED.

Applied, Clinical Supervised Experience – Must include at least 80% clinical contact with persons with SMI/SED and pertain to assessment, treatment, and/or consultation. If offered, seminar attendance, interdisciplinary team participation, readings, and research may count as part of the supervised experience for interns and postdoctoral fellows. Supervision must be provided by a psychologist meeting requirements for Major Area of Study in SMI/SED at the post-licensure stage.

CE coursework – Must be approved by the American Psychological Association and have content specific to SMI/SED.

Post-doctoral specialization in SMI/SED is intended to follow broad and general training in clinical, counseling or school psychology.

References

- American Psychological Association & Jansen, M. A. (2014). *Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment*. Washington DC: American Psychological Association.
- Beck, A. T., Himmelstein, R., & Grant, P. M. (in press). In and out of schizophrenia: Activation and deactivation of the negative and positive schemas. *Schizophrenia Research*, <https://doi.org/10.1016/j.schres.2017.10.046>
- Brand, R., M., McEnery, C., Rossell, S., Bendall, S., & Thomas, N. (2018). Do trauma-focussed psychological interventions have an effect on psychotic symptoms? A systematic review and meta-analysis. *Schizophrenia Research*, 195, 13-22.
- Burns, A. M., Erickson, D. H., & Brenner, C. A. (2014). Cognitive-behavioral therapy for medication-resistant psychosis: A meta-analytic review. *Psychiatric Services*, 65, 7, 874-880.
- Cella, M., Pretib, A., Edwards, C., Dow, T., & Wykes, T. (2017). Cognitive remediation for negative symptoms of schizophrenia: A network meta-analysis. *Clinical Psychology Review*, 52, 43-51.
- Donohoe, G., Dillon, R., Hargreaves, A. Mothersill, O., Castorina, M., Furey, E. ... Robertson, I. H. (2018). Effectiveness of a low support, remotely accessible, cognitive remediation training programme for chronic psychosis: Cognitive, functional and cortical outcomes from a single blind randomised controlled trial. *Psychological Medicine*, 48, 5, 751-764.
- Goldman, H. H., & Karakus, M. C. (2014). Do not turn out the lights on the public mental health system when the ACA is fully implemented. *The Journal of Behavioral Health Services & Research*, 41, 4, 429-433. doi:10.1007/s11414-014-9394-y
- Goldstein, A. B., & Azrin, S. T. (2014). Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. Retrieved from https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf
- Granholm, E. & Harvey, P. D. (2018). Social skills training for negative symptoms of schizophrenia. *Schizophrenia Bulletin*, 44, 3, 472-274.
- Granholm, E., Holden, J., Link, P. C., & McQuaid, J. R. (2014). Randomized clinical trial of cognitive behavioral social skills training for schizophrenia: Improvement in functioning and experiential negative symptoms. *Journal of consulting and clinical psychology*, 82, 6, 1173.
- Heinssen, R. K., Goldstein, A. B., & Azrin, S. T. (2016). Evidence-based treatment for first-episode psychosis: Components of coordinated specialty care. National Institutes of Health website.
- Heinssen, R. K. (2018, August). Implementing coordinated specialty care in the United States: Current status and future directions. Paper presented at the meeting of American Psychological Association, San Francisco, CA.
- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... Heinssen, R. K. (2016). Comprehensive versus usual community care for first-episode

psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173, 4, 362-372.

- Kane, J. M., Schooler, N. R., Patricia Marcy, B. S. N., Correll, C. U., Brunette, M. F., Mueser, K. T., ... & Penn, D. L. (2015). Original research the RAISE early treatment program for first-episode psychosis: Background, rationale, and study design. *Journal of Clinical Psychiatry*, 76, 3, 240-246. doi:10.4088/JCP.14m09289
- Kingdon, D., & Turkington, D. (in press). Cognitive therapy of psychosis: Research and implementation. *Schizophrenia Research*, <https://doi.org/10.1016/j.schres.2017.09.023>.
- Kreyenbuhl, J., Buchanan, R.W., Dickerson, F. B. & Dixon, L. B. (2010). The Schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2009. *Schizophrenia Bulletin*, 36, 1, 94-103.
- La Buissonnière-Ariza, V., Schneider, S. C., & Storch, E. A. (2017). Cognitive remediation of executive functioning in youth with neuropsychiatric conditions: Current knowledge on feasibility, effectiveness, and personalization. *Expert Review of Precision Medicine and Drug Development*, 2, 2, 133-144.
- Lindenmayer, J. P., Khan, A., McGurke, S. R., Kirstie, M., Kulsa, C., Ljuri, I. ... Parker, B. (in press). Does social cognition training augment response to computer-assisted cognitive remediation for schizophrenia? *Schizophrenia Research*, <https://doi.org/10.1016/j.schres.2018.06.012>
- Lystad, J., Falkum, E., Haaland, V. O., Bull, H. C., Evensen, S., McGurk, S. R., & Ueland, T. (2017). Cognitive remediation, cognitive behavioral therapy, and occupational outcome in schizophrenia spectrum disorders: A 2-Year Follow-up Study. *Schizophrenia Bulletin*, 43, Issue suppl 1, S170–S171.
- Mueser, K. T., Penn, D. L., Addington, J., Brunette, M. F., Gingerich, S., Glynn, S. M., ... & Cather, C. (2015). The NAVIGATE program for first-episode psychosis: Rationale, overview, and description of psychosocial components. *Psychiatric Services*, 66, 7, 680-690. <https://doi.org/10.1176/appi.ps.201400413>
- National Collaborating Centre for Mental Health (2014). *Psychosis and Schizophrenia in Adults: The NICE Guideline on Treatment and Management in Adults (update)*. CG 178. London, UK: National Institute for Health and Care Excellence, <https://www.nice.org.uk/guidance/cg178>.
- Reeder, C., Huddy, V., Cella, M., Taylor, R., Greenwood, K., Landau, S., & Wykes, T. (2017). A new generation computerised metacognitive cognitive remediation programme for schizophrenia (CIRCuiTS): A randomised controlled trial. *Psychological Medicine*, 47, 15, 2720-2730.
- Ullevoldsæter Lystad, J., Falkum, E., Øksendal Haaland, V., Bull, H., Evensen, S., McGurke, S. R., & Ueland, T. (2017). Cognitive remediation and occupational outcome in schizophrenia spectrum disorders: A 2 year follow-up study. *Schizophrenia Research*, 185, 122-129.

Criterion XI. Guidelines for Specialty Service Delivery

The specialty has developed and disseminated guidelines for practice in the specialty that expand on the profession's general practice guidelines and ethical principles³.

Commentary: *Such guidelines are readily available to specialty practitioners and to members of the public and describe the characteristic ways in which specialty practitioners make decisions about specialty services and about how such services are delivered to the public.*

1. Describe the specialty-specific practice guidelines for this specialty. Please attach. How do such guidelines differ from general practice guidelines and ethics guidelines? (In this context, professional specialty guidelines refer to modes of conceptualization, identification and assessment of issues, and intervention planning and execution common to those trained and experienced in the practice of the specialty. Such professional guidelines may be found in documents or websites including, but not limited to, those bearing such a title or as described in a variety of published textbooks, chapters, and/or articles focused on such contents.)

With regard to a practice guideline specifically for psychologists practicing in the Specialty, the *APA Recovery to Practice Curriculum* (American Psychological Association & Jansen, 2014) (referenced throughout this petition) was developed specifically by APA for psychologists and is used in psychology training programs across the US. The *Curriculum* was described in an APA Monitor article as laying out the foundations for practice with persons with SMI:

The curriculum's modules include one that introduces recovery-based psychological practice and ... Other modules teach practical skills, such as how to conduct a clinical assessment that focuses on strengths and a person's functional capabilities and how to work with other professionals and patients to develop recovery-oriented treatment plans. Three modules focus on interventions. One lays out the guiding principles of recovery-oriented interventions. Another describes evidence-based practices, while a third describes promising or emerging practices and supportive services. (Clay, 2014, p. 54).

Additionally, the *Clinical Practice Guideline Toolkit for Psychologists Working with Persons with Serious Mental Illness/Severe Emotional Disturbance* is a short clinical practice guideline tool developed for psychologists working in the Specialty. The *Guideline Toolkit* provides an easy to use mechanism for conceptualization, identification and assessment of issues, and intervention planning and execution. The *Guideline Toolkit* consists of a flowchart depicting the stages of psychological practice and is designed as a quick reference guide for use by frontline psychologists and by those serving as program managers or administrators working with the SMI/SED population. The *Guideline 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, but is a handy guide to help psychologists make certain they have covered required steps when working with this specialized population. Following its development for the Specialty, the *Guideline Toolkit* was adapted and published for use by other mental health professionals working with the SMI/SED population (Jansen, 2018). The *Guideline Toolkit* is provided as Appendix II and is also posted on the Specialty Council website (www.psychtrainingsmi.com).

While the SMI Psychology Specialty is devoted to training psychologists to work with persons with SMI and SED, practice in this Specialty requires an interprofessional approach due to the complexity of problems faced by persons with SMI/SED. The most comprehensive practice guideline for the full range of professionals working with the population is 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] which can be accessed at

<https://www.nice.org.uk/guidance/cg178>. The NICE guideline is known globally as the pre-eminent interprofessional guideline for Specialty practice with persons who have SMI. It is one of a series of practice guidelines developed by NICE that are highly respected and considered the gold standard for practice guidelines with specialty populations of all kinds. The NICE guidelines are continuously reviewed and updated and in 2016, NICE introduced a new guideline based on the emerging science around early intervention for those experiencing a first episode of psychosis. Some of this emerging science base has come from the US NIMH RAISE trial as well as from similar studies in other countries. The new guideline is entitled: *Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance*. NICE also updated its *Psychosis and Schizophrenia in Children and Young People: Recognition and Management* guideline, which is the guideline for SED. There are also NICE guidelines for practice with patients diagnosed with bipolar disorder and for co-morbid psychosis and substance use disorders assessment and treatment. The NICE practice guidelines for psychosis are used by post-doctoral residencies in this Specialty, along with the *APA Recovery Curriculum*, the *Clinical Practice Guideline Toolkit* and other similar resources such as the reports of the NIMH PORT study (Kreyenbuhl, Buchanan, Dickerson & Dixon, 2010), the NIMH RAISE trial (Kane, et al., 2016), and the SAMHSA evidence-based toolkits (<https://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs>). These practice guidelines and materials are referenced in our Training Guidelines (Appendix I) and on our website (www.psychtrainingsmi.com).

2. How does the specialty encourage the continued development and review of practice guidelines?

Prior to development of the *APA Curriculum*, the APA Task Force on SMI/SED had encouraged APA to develop a specialized professional practice guideline for psychologists working with persons with SMI/SED. With the development of the *APA Curriculum* and the *Guideline Toolkit*, practice guidelines written specifically for psychologists in the Specialty now exist. The NICE guideline is a comprehensive practice guideline for working with this SMI/SED population used for a wide array of professionals. In order for psychologists to provide the most efficacious services possible, psychologists should be familiar with, and well versed in, all of the above referenced materials, i.e., the *APA Curriculum*, the NICE guideline, the *Guideline Toolkit*, the NIMH PORT and RAISE studies, and the SAMHSA toolkits. Taken together, these documents provide a comprehensive and complete set of practice guideline materials for psychologists. As mentioned in previous sections of this petition, the research and practice literature are continually reviewed for new developments and, as these become available, are posted on the Council website.

Information concerning the practice guideline materials mentioned above (*APA Curriculum*, the *Guideline Toolkit*, NICE guideline, NIMH PORT study, the NIMH RAISE trial, the SAMHSA toolkits, and other practice materials) is posted on the Specialty Council website. Psychologists working with individuals with SMI and SED are encouraged, (and required for maintenance of competence) to use this information and to stay abreast of the literature and new developments in this Specialty.

3. Describe how the specialty's practitioners assure effective and ongoing communication to members of the discipline and the public as to the specialty's practices, practice enhancements, and/or new applications.

The SMI Psychology Specialty always has, and will continue to communicate growth of the field through scientific publications, newsletters, and ongoing work with national organizations focused on the SMI/SED population and on advocacy issues to enhance the health and quality of life of those diagnosed with SMI/SED and their families.

Scientific Outlets: Psychologists who work in this Specialty are actively involved in conducting research and in publishing their results in peer reviewed journals, books, book chapters, newsletter articles, and other outlets. Importantly, there are several specialized journals devoted to SMI/SED populations. These are highly respected outlets for psychological research, translating research into practice, raising important policy issues, and recent developments in the field. Psychologists regularly

publish in these journals and are members of several of their editorial boards. Some examples of these journals include: *Psychiatric Rehabilitation Journal*, (an interprofessional journal published by APA and edited by psychologist and member of the Specialty Council, Dr. Sandra Resnick), *Psychiatric Services*, *Schizophrenia Bulletin*, *Schizophrenia Research*, *Journal of Abnormal Psychology*, and *Early Intervention in Psychiatry*. In addition, there are other more general journals that also publish work by psychologists in this Specialty, including the *American Journal of Psychiatry*, *Archives of General Psychiatry*, *British Journal of Psychiatry*, *BMJ* (British Medical Journal), *Community Mental Health Journal*, *Psychological Services* (Division 18's journal published by APA), and *World Psychiatry*, to name but a few.

Psychology oriented newsletters: Beyond the scientific literature, the SMI Psychology Specialty publishes information of importance to the Specialty in the Division 18 newsletter and informs other organizations that are interested in the Specialty. Specialty Council member organizations update their websites with Specialty information as new information becomes available.

Community Advocacy: Many psychologists who specialize in this work serve as board and committee members of major national organizations and many others contribute their time at state and local levels. These national, state and local organizations work with professionals and the public to:

- Encourage Federal legislative action regarding issues that affect the SMI/SED population. The APA Task Force on SMI/SED works closely with the Practice Directorate's Legislative and Legal Advocacy office on issues that affect services for persons with SMI/SED;
- Advocate for individuals with SMI/SED in a variety of contexts from clinical treatment to criminal justice and forensic settings;
- Promote community inclusion to end stigma experienced by individuals and their families;
- Promote evidence based and promising practices, and
- Work with legislators and policy makers to develop legislation and policies that assure adequate treatment and social justice for people with SMI/SED.

This community based advocacy work helps to inform other psychologists, members of other healthcare, legal, and political organizations, and the public about ongoing work of both the SMI Psychology Specialty and about issues needing greater attention to enhance the quality of life of those diagnosed with SMI/SED.

4. How does the specialty communicate its identity and services to the public?

In addition to the Specialty Council website (www.psychtrainingsmi.com) where we offer information for the public, one organizational member of the Council, the Special Interest Group (SIG) on Schizophrenia and Other Serious Mental Disorders of the Association for Behavioral and Cognitive Therapies (ABCT) posts members who identify as specializing in the area of SMI/SED on its website. In addition to the research, publication, and advocacy work we discussed above and in other sections of this petition, those who identify with the SMI Psychology Specialty routinely present symposia and CE workshops at the annual APA convention, and at regional psychological association conferences, other SMI/SED related venues, and international conferences. Information about these conferences and presentations is often publicized in local media outlets so that those interested can attend or request additional information. Public information about Specialty services is also promoted by psychologists who are frequently invited speakers at non-psychology conferences and who are featured on webinars and other training events sponsored by advocacy organizations. A good example of this is the series of SMI/SED recovery webinars developed by Advocates for Human Potential via a contract from SAMHSA which prominently features psychologists and which over the past three years highlighted the *APA Recovery to Practice Curriculum* (American Psychological Association & Jansen, 2014). As mentioned above, new developments and services are also promoted on the websites of advocacy organizations and

in their newsletters. The Specialty Council website (www.psychtrainingsmi.com) is continuously updated with new research, practice, and training information. The website can be accessed by anyone interested in SMI/SED. The website also has a new section on the home page which offers members of the public information about sources for locating an SMI Psychologist. The primary public advocacy group for SMI/SED is the National Alliance on Mental Illness (NAMI), which is composed primarily of SMI/SED consumers and/or their relatives. Many Specialty Council members speak frequently at local or national NAMI meetings to share information on the state-of-the art practice in this field as a primary venue for educating the public.

When this Specialty is recognized, accredited post-doctoral training programs will provide recognition information on their websites so that prospective trainees and others will know that their training program is an accredited post-doctoral residency program in SMI Psychology. Ads may also be placed in the major national advocacy print outlets to inform the public about the Specialty. Also, as we mentioned previously, we are in contact with the Council of Specialties and with ABPP, and once we are permitted to do so, we will become affiliated with both. As that is accomplished, psychologists will be able to complete the ABPP examination process and use the ABPP notation after their name indicating their expertise and recognition in the Specialty. Members of the public seeking services for themselves, a family member or a friend with SMI/SED will be able to refer to these specially trained and recognized psychologists.

References

- American Psychological Association & Jansen, M. A. (2014). *Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders*. Washington, DC: American Psychological Association.
- Clay, R. A. (2014). From serious mental illness to recovery. *APA Monitor*, 45, 8, printed version p. 54, <http://www.apa.org/monitor/2014/09/recovery.aspx>
- Jansen, M. A. (2018). Psychosocial services for individuals with serious mental illness/severe emotional disturbance: Clinical practice guideline toolkit. *Psychiatry: Interpersonal and Biological Processes* (special issue on Emerging Psychosocial Interventions), 81, 1, 3-21.
- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... Heinssen, R. K. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173, 4, 362-372.
- Kreyenbuhl, J., Buchanan, R.W., Dickerson, F. B. & Dixon, L. B. (2010). The Schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2009. *Schizophrenia Bulletin*, 36, 1, 94-103.
- SAMHSA Evidence-Based Practice Kits. <https://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs>, retrieved July 8, 2018.

Appendix

Appendix II: Clinical Practice Guideline Toolkit for Psychologists Working with Persons with Serious Mental Illness/Severe Emotional Disturbance

Criterion XII. Provider Identification and Evaluation

A specialty recognizes the public benefits of developing sound methods for permitting individual practitioners to secure an evaluation of their knowledge and skill and to be identified as meeting the qualifications for competent practice in the specialty.

***Commentary:** Identifying psychologists who are competent to practice the specialty provides a significant service to the public. Assessing the knowledge and skill levels of these professionals helps increase the ability to improve the quality of the services provided. Initially practitioners competent to practice in the specialty may simply be identified by their successful completion of an organized sequence of education and training. As the specialty matures it is expected that the specialty will develop more formal structures for the recognition of competency in practitioners.*

1. Describe the formal peer review-based examination process of board certification including its use of a review and verification of the individual's training, licensure, ethical conduct status, and a peer assessment of specialty competence.

***If this is a new petition for recognition describe a) current methods by which individual practitioners can secure an evaluation of their knowledge and skill and be identified as meeting the qualifications for competent practice in the specialty and b) efforts to establish a formal peer review-based examination process of board certification including a detailed plan and timeline.**

The American Board of Professional Psychology (ABPP) conducts board certification examinations for most if not all psychological specialties and suggests that specialties be recognized by APA prior to applying for affiliation with ABPP. While this is not required, ABPP has told us (via conference call with ABPP Executive Officer and President, September 14, 2018) that applying for affiliation prior to receiving APA recognition will increase the difficulty of ABPP affiliation; thus APA recognition is strongly recommended prior to seeking ABPP affiliation. We continue to be in contact with ABPP and the Council of Specialties and once recognized by APA we are prepared to move forward with establishing Board Certification in this Specialty.

Prior to affiliation with ABPP, the Specialty of SMI Psychology has diligently worked on assuring the ongoing assessment of quality of services and the preparation of those who wish to specialize in the Specialty. Both individual practitioners and supervisors can evaluate knowledge and skills in the area of this Specialty by using a tool called the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*. This instrument is a modification of the evaluation tool developed by the Council of Professional Geropsychology Training Programs known as the *Pikes Peak Geropsychology Knowledge and Skill Assessment Tool* (Karel, et al., 2012). Permission was received to modify and use the Pikes Peak tool.

This evaluation tool (*Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*) was developed by the Specialty Council to evaluate knowledge and skills in the Specialty and has been pilot tested at post-doctoral programs in this Specialty. An indication of the growth of this Specialty is the fact that this instrument is in use at several post-doctoral residency training programs. The *Instrument* is available on the Specialty Council website (www.psychtrainingsmi.com) and is attached as Appendix III.

In order to be ready to apply for ABPP affiliation, the Specialty Council is developing the SMI Psychology ABPP Manual which outlines the process and steps required for initial certification including the work sample requirements and oral examination procedures. The Manual also contains information for Maintenance of Certification (MoC), and includes the Continuing Professional Development Grid and

Narrative. These processes and documents will constitute the formal peer review examination process for board certification. Following finalization and review of the Manual, we anticipate that it will be ready for submission to ABPP with our Brief Proposal and we expect to submit these documents to ABPP in October, 2019 (following recognition of the Specialty by APA [in April/May, 2019]) for ABPP consideration at its December 2019 meeting. After ABPP acceptance of our Brief Proposal, we will move on to the next phase of ABPP affiliation, the Formal Application phase, and then on to the Implementation phase and finally on to the Monitoring phase. We hope to complete the ABPP affiliation process by mid-2020 or at the latest by the end of December, 2020.

2. Describe how the specialty educates the public and the profession concerning those who are identified as a practitioner of this specialty. How does the public identify practitioners of this specialty?

Members of the public and mental health professionals, including non-Specialty psychologists, are informed about SMI psychologists via the following means:

- The Specialty Council website (www.psychtrainingsmi.com) points members of the public, non-Specialty psychologists and other mental health professionals to publications by Specialty Psychologists, along with organizations and their websites which may list psychologist practitioners who have self-identified as practitioners in this Specialty.
- Licensing board listings of psychologists who specialize in SMI Psychology and are licensed in a given state may list areas of specialization of psychologists in the state.
- The APA Task Force on SMI/SED lists current members on its website. These individuals are sometimes contacted by members of the public.
- The Association for Behavioral and Cognitive Therapies (ABCT) Special Interest Group on Schizophrenia and Other Serious Mental Disorders, is comprised of practitioners in this Specialty and lists those who identify as Specialists by posting a contact point, e mail address, and the website offers the opportunity to find a Specialist in one's geographic area. Similarly to state licensing board listings and the APA Task Force, members of the public can use this resource to identify Specialty Psychologists.
- Members of the public and interested professionals often contact authors of relevant articles in publications such as the APA Monitor, the American Psychologist, other APA journals such as Psychiatric Rehabilitation Journal, Psychological Services, and journals published by other organizations that specialize in this field such as the Psychiatric Services, Schizophrenia Bulletin, Schizophrenia Research, Journal of Abnormal Psychology, Early Intervention in Psychiatry, American Journal of Psychiatry, Archives of General Psychiatry, British Journal of Psychiatry, BMJ (British Medical Journal), Community Mental Health Journal and World Psychiatry, among others.
- As soon as the Specialty is recognized by APA and ABPP affiliation is completed, psychologists with competence in the Specialty will be identified via the ABPP credential and will be listed on the Specialty Council website. Once a psychologist is certified by ABPP in SMI Psychology and listed on the Specialty Council website, they may also be listed on other sites such as their state licensing board website, the ABCT SIG website, and others.

3. Estimate how many practitioners there are in this specialty (e.g., spend 25% or more of their time in services characteristic of this specialty and provide whatever demographic information is available) and how many are board certified through the process decreed in item 1.

In a report prepared for Congress on the Federal government's involvement in mental health care, the author notes: "No consensus exists on which provider types make up the mental health workforce" (Heisler, 2018, p. 1.) Similarly, the authors of an article in a recent special supplement to the *American Journal of Preventive Medicine* noted "Workforce planning efforts are hindered by a variety of factors ...

the field lacks comprehensive data that accurately describe the size, composition, and characteristics of the behavioral health workforce, so estimating current and future supply are difficult” (p. s.193) (Beck, Singer, Buche, Manderscheid & Buerhaus, 2018). In addition to the lack of consensus on such a basic aspect of the workforce as which provider types constitute the mental health workforce, it is difficult, if not impossible to define accurately how many of any provider type are involved in services with a subset of persons with mental health disorders, i.e., those with serious mental illnesses, making accurate workforce data difficult to obtain. However, given the fact that until the Specialty receives recognition from APA, the Specialty is not reasonably able to affiliate with the ABPP, in an effort to be comprehensive yet conservative, we used several sources to estimate the number of psychologists who spend 25% or more of their time in services characteristic of this Specialty:

- 2015 APA Survey of Psychology Health Service Providers
- Published data from the American Hospital Association (AHA)
- Internal data from the US Department of Veterans Affairs (VA)
- IBM Commercial4, MarketScan databases

APA 2015 Survey of Psychology Health Service Providers

APA’s 2015 *Survey of Psychology Health Service Providers* (American Psychological Association, 2016) identified 100,305 unique licensed psychologists with doctoral degrees, of whom slightly less than half had e mail addresses. Of the 36,681 deliverable e mails, only 5,235 psychologists responded to the survey and of those who responded, 3,908 psychologists indicated that they provide services to persons with SMI/SED either very frequently, frequently, or occasionally (we eliminated the rarely and never categories in both patient categories). This figure is derived using only two categories of patients: bi-polar disorder and schizophrenia spectrum disorders. The figure would likely be higher if other serious disorders such as major depressive disorder were included, and if the number of psychologists responding were higher. Using the APA Survey data from a relatively small number of respondents (5% of the 100,305 doctoral level licensed US psychologists), the number of psychologists providing services to persons with SMI/SED can be considered to be **at least 3,908**.

American Hospital Association (AHA) survey

In a survey done by the American Hospital Association (AHA) (American Hospital Association, 2017) drawn from hospital and correction facilities surveys, AHA reports that there are at least 4,451 psychologists in the US (hospital and corrections only), who spend at least 25% or more of their time in specialized services characteristic of the SMI Psychology Specialty. This number was derived, according to the AHA, from looking at 401 AHA registered non-Federal psychiatric hospitals as of 2017. This may not account for all non-Federal psychiatric hospitals in the US because the AHA is a private membership organization, but includes private and public facilities. As with the APA Survey, the number is likely an underestimate, but can be considered to be **at least 4,451 psychologists**.

US Department of Veterans Affairs (VA)

Next, we obtained information from the US Department of Veterans Affairs (VA). VA medical facilities are federal facilities and are therefore not included in the AHA data. In FY17, approximately 13% of veterans with a mental health diagnosis receiving mental health care in VA had a diagnosis of a psychotic disorder (Greenberg and Hoff, 2017a, Greenberg and Hoff, 2017b). As reported in the October, 2018 Monitor on Psychology (Novotney, 2018), there were 5,137 psychologists employed by VA in 2018. Assuming that the proportion of psychologists working with veterans with SMI is roughly equivalent to the proportion of veterans with SMI receiving VA mental health care, there would be approximately **670 psychologists** serving this population in VA in 2018. Given VA’s psychology hiring initiatives (Novotney, 2018), this number is likely to increase in the next year as VA continues to hire additional psychologists.

IBM Commercial MarketScan Database

Next, in order to gain insight into the extent of service provision by psychologists in this Specialty, we ran several queries of the MarketScan databases (IBM Commercial MarketScan Database) which track the number of psychologists who see Medicaid enrollees. Table 1 indicates the number of patients with SMI for whom there was a Medicaid claim in 2015 (n=695,668) and 2016 (n=660,026). In 2015, there were **2,088 psychologists** providing Medicaid-reimbursed services to individuals with SMI. This number decreased slightly in 2016 to **1,930 psychologists**.

Table 1. Use of Psychologist Services by Medicaid Enrollees with Selected Serious Mental Illness, 2006-2016 IBM® MarketScan® Multi-State Medicaid Database

	2015		2016	
	n/mean	%/SD	n/mean	%/SD
Patients with SMI (Total)	695,668		660,026	
Schizophrenia	50,523	7.26	52,488	7.95
Schizoaffective Disorder	36,432	5.24	41,605	6.30
Bipolar Illness	237,781	34.18	176,194	26.70
Delusional and Other Psychotic Disorders	73,633	10.59	92,145	13.96
Major Depressive Disorder	515,529	74.11	493,779	74.81
At least 1 outpatient psychologist visit	22,851	3.29	19,151	2.90
Mean number of outpatient visits	8	13	8	13
Number of unique outpatient psychologists ²	2,088		1,930	

Table 2 shows commercial claims data for the same time period. During 2015 there were over a million (n=1,049,044) patients with SMI seen by psychologists, and slightly fewer (n=972,020) in 2016. The number of psychologists providing commercially-reimbursed services to individuals with SMI was **31,482 psychologists in 2015, and 34,024 psychologists in 2016**.

Table 2. Use of Psychologist Services by Commercially-Insured Enrollees with Selected Serious Mental Illness, 2006-2016 IBM® MarketScan® Commercial Database

	2015		2016	
	n/mean	%/SD	n/mean	%/SD
Patients with SMI (Total)	1,049,044		972,020	
Schizophrenia	9,371	0.9	8,541	0.9
Schizoaffective Disorder	9,024	0.9	8,764	0.9
Bipolar Illness	181,886	17.3	113,720	11.7
Delusional and Other Psychotic Disorders	49,095	4.7	59,553	6.1
Major Depressive Disorder	913,004	87.0	867,122	89.2
At least 1 outpatient psychologist visit	114,282	10.9	101,758	10.5
Mean number of outpatient visits	10	13	10	13
Number of unique outpatient psychologists ¹	31,482		34,024	

Although data for the number of psychologists was not available prior to 2015, the number of claims for psychology services provided to individuals with SMI was available.

In 2006 there were 140,915 patients with SMI served by psychologists. Over the course of the time period studied, the numbers showed a largely stepwise increase by year through 2015, with only one year (2011) showing a decrease from the prior year. This represents a 368% increase in claims. Similarly, in 2006, the number of commercially-insured enrollees with SMI was 406,682. This number has been increasing over time, although with not quite the same linear pattern as seen in the Medicaid

enrollees. However, the rate of increase between 2006 and 2016 was 139%. These data taken together suggest that the number of psychologists providing services to individuals with SMI will continue to increase over time, underscoring the importance of training psychologists to serve this population effectively. These data track service provision by unique psychologists only and do not indicate the number who provide such services at least 25% of the time but the data do serve as an indication of the extent of the need for such services and the number of unique psychologists providing services to the SMI/SED population.

As we indicated at the beginning of our response to this question, accurate workforce data are not available for any profession. It is therefore not possible to estimate with accuracy the number of psychologists who spend 25 percent or more in the Specialty, and it would be inaccurate to provide a summation of the estimates, given unknown overlap.

Data source	Estimate of <i>minimum number</i> of psychologists in service to people with SMI/SED
APA Survey of Psychology Health Service Providers (2015)	3,908
American Hospital Association survey (2017)	4,451
US Department of Veterans Affairs (FY18)	670
IBM Commercial MarketScan – Medicaid (2016)	1930
IBM Commercial MarketScan – Commercially Insured (2016)	34,024

However, based on our investigations using the APA Survey, information from the AHA and from the VA, we can say with reasonable certainty that **at least 3,908 to 5,059** psychologists spend at least 25% of their time practicing in the Specialty. Further, based on the MarketScan data and data from the VA, demand for psychologist services in the Specialty is likely to grow, leading to an increase in the number of psychologists practicing in the Specialty.

The numbers we presented above do not account for psychologists outside the US, such as those in Canada whose settings parallel those in the US and whose psychologists often become ABPP certified; these psychologists would also likely be interested in the Specialty.

The final question in this criterion asks about the number that are board certified in the Specialty. As this will be a new Specialty, there is currently no ABPP board certification process; as we noted in other sections of this petition, we are in contact with ABPP and are developing the materials needed for ABPP affiliation and certification mechanisms in order to be fully prepared once recognition from APA is received.

References

- American Hospital Association. 2017. <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml>
- American Psychological Association. (2016). 2015 survey of psychology health service providers. Washington, DC: Author.
- Beck, A. J., Singer, P. M., Buche, J., Manderscheid, R. W. & Buerhaus, P. (2018). Improving data for behavioral health workforce planning: Development of a minimum data set. *American Journal of Preventive Medicine*, 54, 6, Supplement 3, S192-S198.
- Greenberg, G., Hoff, R (2017a). FY 2017 Veterans with Psychosis Data Sheet: National, VISN, and VAMC Tables. West Haven, CT: Northeast Program Evaluation Center. Annual (FY 2013-Present).

- Greenberg, G., Hoff, R (2017b). FY 2017 Mental Health Data Sheet: National, VISN, and VAMC Tables – All Veterans. West Haven, CT: Northeast Program Evaluation Center. Annual (2010-Present)
- Heisler, E. J. (2018, April 20). The Mental Health Workforce: A Primer. Congressional Research Service 7-5700 www.crs.gov 43255.
- Karel, M. J., Holley, C., Whitbourne, S. K., Segal, D. L., Tazeau, Y., Emery, E., ... Zweig, R. (2012). Preliminary validation of a tool to assess knowledge and skills for professional geropsychology practice. *Professional Psychology: Research & Practice*, 43(2), 110-117.
- Novotney, A. (October, 2018). The VA is Hiring. *Monitor on Psychology*, American Psychological Association.

Appendix

Appendix III: Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)

Public Description

An important component of the recognition process is to develop a public description of the specialty that can be used to inform the public about the specialty area. Please develop a **brief** description of the specialty by responding to the question below (total combined word limit for all five questions must not exceed 400 words). This provides the foundation for what will appear on the APA website upon recognition of the specialty and should be understandable to the general public (wording should not exceed an eighth-grade level). Descriptions will be edited for consistency to conform to the CRSPPP website standards.

1. Provide a brief (2-3 sentences) definition of the specialty.

Psychologists with a specialization in Serious Mental Illness Psychology apply specialized individual, societal, and systems level assessment and intervention methods to assist those who have developed SMI or who are at risk of developing these illnesses (SED) recover and attain their full functional capability.

2. What specialized knowledge is key to the specialty?

Specialized knowledge is key for health service psychologists with this specialty and includes:

- Targeted Individual-level strengths-based, functional and resource assessments developed for people with SMI/SED
- Evidence-based treatments designed and developed specifically for this population
- Methods to implement social and community integration; a key, specialized competency for this population
- Stigma reducing approaches, including those aimed at reducing health disparities
- Most appropriate research techniques including mixed methods approaches
- Systems change processes and procedures.

3. What problems does this specialty specifically address?

Approaches used at individual, societal and systems levels apply to the wide range of special problems individuals in the SMI/SED population face, including:

Individuals:

- Difficulties in thinking, remembering, problem solving, and social skills that depend on cognitive functioning such as relating, communicating well and appropriately, and interpreting social cues;
- Deficits related to when the illness developed, including inability to have appropriate relationships, lack of insight and knowledge about the illness; inability to understand how to manage symptoms, inability to work with mental health professionals to determine basic goals and best treatments; deficits in basic educational and employment skills.

Societal:

- Societal restrictions placed on individuals with these disorders such as exclusion from the rights and privileges enjoyed by others;
- Stigmatization which often makes access to health care and other essential services extremely difficult.

Systems:

- Organizational unwillingness or inability to provide the most efficacious interventions to help individuals recover and attain their full functional capability.

4. What populations does this specialty specifically serve?

The populations served by this specialty are those with SMI/SED including individuals with psychosis manifested by disorders such as schizophrenia, schizo-affective illness, severe depression, serious bi-polar illness, severe post-traumatic stress disorder, and other SMI/SED that result in sustained loss of functional capability.

5. What are the essential skills and procedures associated with the specialty?

For individuals:

- Specialized assessments to assist individuals determine goals based on their life experiences and strengths;
- Evidence-based and promising practice interventions that are efficacious for helping individuals with SMI/SED recover, attain full functional capability and achieve goals including population-specific psychotherapeutic interventions, cognitive remediation and social cognitive interventions, illness management strategies, family interventions, institutional interventions, educational and employment approaches.

Societal:

- Interventions to help individuals live in their chosen community and access the services they need or desire;
- Interventions to help communities recognize the benefits of full participation for people with SMI/SED.

Systems:

- Strategies to effect change in organizations and systems where individuals with SMI/SED are served.

Appendix I: Serious Mental Illness (SMI) Psychology Education and Training Guidelines

Training Guidelines for Post-Doctoral Psychology Residency Programs in Serious Mental Illness (SMI) Psychology

December 2018

Introduction

These Training Guidelines provide guidance for post-doctoral psychology residency programs in Serious Mental Illness (SMI) Psychology. These Guidelines are designed to assist programs as they develop and implement formal post-doctoral residency programs in SMI Psychology and are intended to promote competence in the specialized practices needed to assist persons who have SMI/SED. These Guidelines are just that – guidelines – and are not meant to take precedence over the judgment of program-specific education and training faculty, or of those individuals more generally responsible for education and training at educational institutions. The Guidelines will be updated as new information becomes available.

In accordance with relevant state laws and administrative regulations, the establishment and recognition of specialties in professional psychology does not constrain the general practice of psychology or require specialty credentialing of licensed psychologists practicing within their areas of competence and functioning within the bounds of the APA Ethical Principles of Psychologists and Code of Conduct.

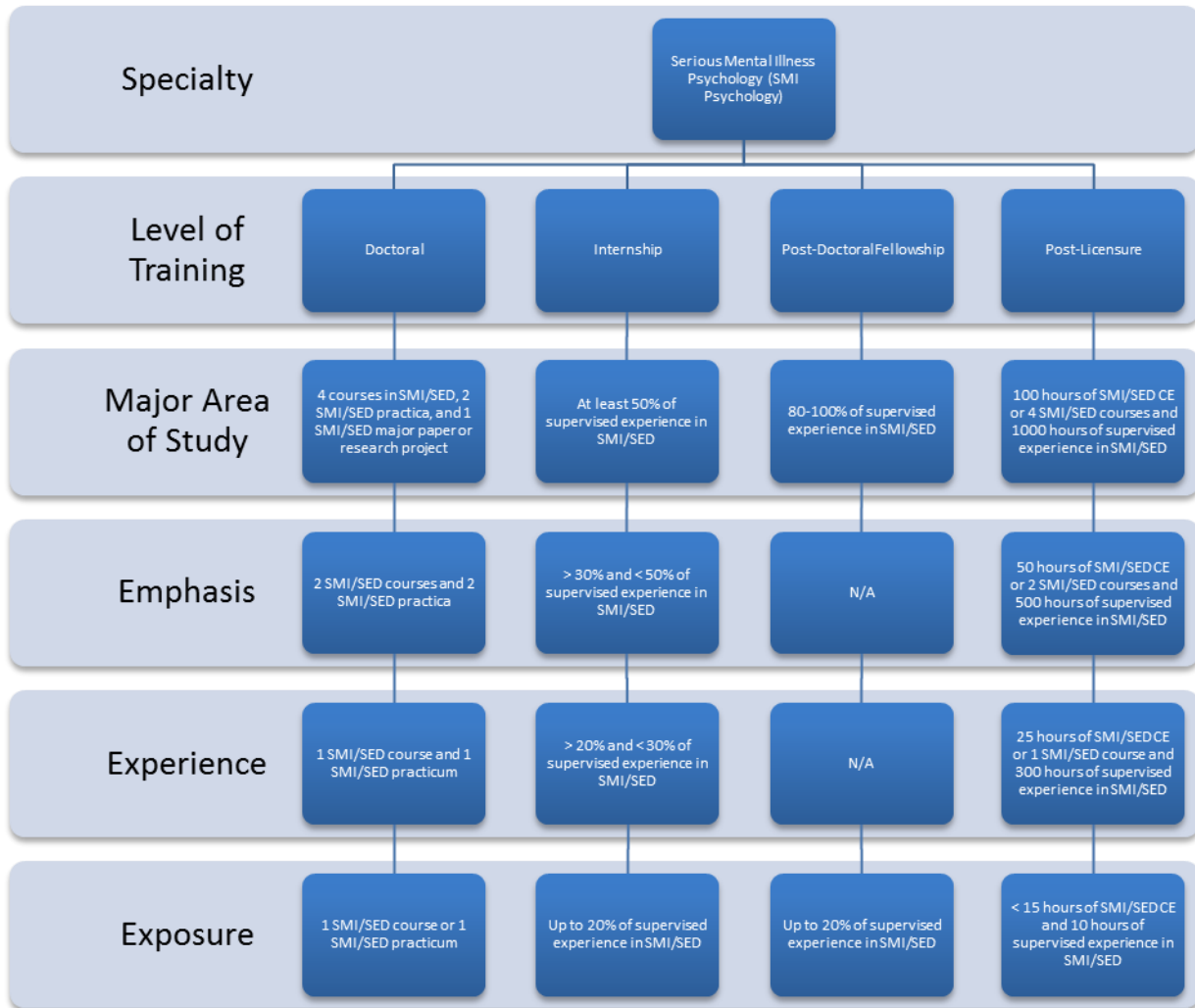
These Guidelines were developed with the participation and input of several groups of interested psychologists. These groups include the APA Task Force on Serious Mental Illness/Severe Emotional Disturbance, APA's Division 18, Psychologists in Public Service, the Division 18 Section on Serious Mental Illness/Severe Emotional Disturbance, the Association for Behavioral and Cognitive Therapies (ABCT) Special Interest Group (SIG) on Schizophrenia and Other Serious Mental Disorders, the Training Directors and Program Leaders of post-doctoral programs offering this Specialized training, and participants at a meeting sponsored by the above groups and convened following the APA 2016 Convention in Denver, CO. This meeting was funded by grants from the APA Board of Educational Affairs and the Division 18 Section on Serious Mental Illness/Severe Emotional Disturbance and included representatives from the groups mentioned above and a representative from the APA Board of Professional Affairs. Following development of a draft of these Guidelines, they were sent for review and comment to members of interested groups, revised based on feedback received, and finalized.

For greater detail regarding all aspects of these Guidelines, please consult the Petition for Recognition of a Post-Doctoral Specialty in 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>.

These Guidelines contain information specific to post-doctoral residency programs in SMI Psychology and also contain information that is more generic and required for all APA accredited post-doctoral residency programs. As with any training program desirous of achieving accreditation, residency programs wishing to become accredited in this Specialty must fully meet the APA Standards of Accreditation (SOA) and must comply with all of the APA Implementing Regulations (IR) that accompany the SOA. It is expected that such post-doctoral programs will clearly delineate that their Major Area of Study corresponds closely to the recommended programmatic requirements as presented in the Taxonomy for SMI Psychology education and training which is presented below, along with 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>, and the information in this Training Guideline. For the APA Standards of Accreditation (SOA) and the APA Implementing Regulations (IR) please consult the APA website at <http://www.apa.org/ed/accreditation/> for information about accreditation.

Taxonomy for Education and Training in Serious Mental Illness Psychology (SMI Psychology)



SMI/SED Course – Each course must have predominant content specific to the recovery paradigm and/or psychosocial rehabilitation for persons with SMI/SED and be taken for at least 3 hours of credit.

SMI/SED Practicum – Minimum experience of 9 months of applied, clinical supervised experience for at least 10 hours per week working with persons with SMI/SED.

Applied, Clinical Supervised Experience – Must include at least 80% clinical contact with persons with SMI/SED and pertain to assessment, treatment, and/or consultation. If offered, seminar attendance, interdisciplinary team participation, readings, and research may count as part of the supervised experience for interns and postdoctoral fellows. Supervision must be provided by a psychologist meeting requirements for Major Area of Study in SMI/SED at the post-licensure stage.

CE coursework – Must be approved by the American Psychological Association and have content specific to SMI/SED.

Post-doctoral specialization in SMI/SED is intended to follow broad and general training in clinical, counseling or school psychology.

Information Regarding the Population, Problems Faced, Procedures and Techniques Used

Psychologists with a Specialization in SMI Psychology serve individuals from youth through older adulthood and work in partnership with the person served to help each individual recover and attain the functional capacity needed to achieve his or her goals in areas such as family and peer group socialization and participation, education, and employment - always based upon the individuals' preferences, needs, goals, and developmental level.

The specialized competencies needed for work in the SMI Psychology Specialization are typically acquired through post-doctoral didactic and experiential education and training. These competencies are necessary for psychologists to appropriately assist persons with SMI/SED because they go beyond the broad and general training expected from those competencies learned by psychologists in most doctoral programs and in other post-doctoral residency training programs that are focused on broad training as a health service psychologist or training in one of the other recognized specialties.

Due to the different and more severe nature of the problems encountered by individuals with these disorders, the Specialized practice of psychology with persons with SMI/SED requires knowledge and skills in assessment and interventions that have been designed and empirically tested for this particular population. This population includes adults and adolescents with primary DSM-5 diagnoses that include the following:

- Schizophrenia
- Schizoaffective Disorder
- Bipolar Illness
- Delusional Disorder
- Other Psychotic Disorders
- Depression with a severe impact on functioning
- May have co-morbid, but not primary, substance use and/or exposure to trauma
- (and does not include individuals with primary personality disorders).

The problems experienced by these individuals are complex, severe, and not singular, i.e., individuals within this population experience multiple problems. While broad and general training in health service psychology may address some of these issues in a general way, it is the complexity of comorbidity and level of disability that requires the specialized competence of the SMI Psychologist. Some of the serious problems experienced by individuals with SMI/SED include:

- Severe symptomatology such as hallucinations, delusions, extreme mood swings, disorganized thinking, bizarre or disorganized behavior, and disordered or flattened affect
- Neuropsychological/cognitive deficits and resultant problems
- Social skill/interpersonal deficits
- Trauma and resultant severe anxiety, depression, co-morbid substance use, and other psychological problems that arise either prior to onset of the SMI/SED or as a result of trauma

associated with the health care system or as a result of incarceration or hospitalization in forensic psychiatric facilities

- Greater morbidity and earlier mortality from natural (cancers, cardiovascular disorders, metabolic syndrome, etc.) and unnatural causes (suicide and violence)
- Stigma and self-stigma often resulting in an inability to access timely and appropriate health care
- Poverty, homelessness, inability to complete educational goals or work competitively
- All of the above problems are frequently magnified for women, people from non-majority cultures, those with co-morbid disabling conditions, members of the LGBTQ population, immigrants and refugees who have SMI/SED, and other disenfranchised or stigmatized groups.

The procedures and techniques used by psychologists who work with persons with SMI/SED build on the basic knowledge and skills acquired by psychologists in doctoral level training but go beyond those basics due to the need for a different and expanded knowledge base, a unique approach to assessment, and specialized interventions that address the complex problems experienced by this population.

Post-Doctoral Residency Training - Specialty Specific Information

Admission Requirements

In accord with APA's Standards of Accreditation for Health Service Psychology (American Psychological Association, Commission on Accreditation, 2015), (downloaded from APA website December 2017):

- i. The program has procedures for resident selection that ensure residents are appropriately prepared for the training offered.
- ii. At the initiation of training, residents will have completed doctoral and internship training in programs accredited by an accrediting body recognized by the U.S. Secretary of Education or by the Canadian Psychological Association. If the program accepts residents who attended unaccredited programs, the residency must describe how the program ensures that selected residents are otherwise qualified and appropriately prepared for advanced training in the residency program. (p. 38).

Accordingly, residency programs are advised to ensure that residents have completed doctoral and internship training that meets these requirements.

Post-doctoral residency programs in SMI Psychology require official transcripts from the doctoral or re-specialization program and from the internship program, a cover letter indicating previous clinical experience with persons with SMI/SED or in settings where persons with SMI/SED are seen, commitment to a career working with those diagnosed with SMI/SED, statement of future goals as they relate to SMI/SED, letters of recommendation, and the applicant's CV. Programs may

also have other requirements such as submission of a work sample, graduation from an APA or CPA accredited program, etc.

Sample SMI/SED specific evaluation admission forms that can be used in addition to more general admission forms required by the institution can be found in the Petition for Recognition of a Post-Doctoral Specialty in SMI Psychology (Criterion VII) which can be found at www.psychtrainingsmi.com. Please note these are samples of forms from several SMI Psychology residency programs and may serve as a guide but programs should ensure their forms comply with current guidance and requirements from APA.

Importantly, post-doctoral residency programs in SMI Psychology ensure a welcoming, supportive, and encouraging learning environment for all residents, including residents from diverse and underrepresented communities. Every effort is made to recruit residents and faculty representing the full range of human diversity.

Qualifications of Faculty and Directors of Training in This Specialty

Core mentors for psychologists must be themselves specialized in the assessment and treatment of the SMI/SED population. Work in the field of SMI/SED requires interprofessional programming and thus extended core faculty who teach 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.), or if in the process of becoming licensed, they must be directly supervised by a licensed practitioner in their discipline. All teaching faculty should have training, experience, or exposure in the area of SMI/SED and have expertise in the specific courses or practice areas in which they are teaching. Faculty who are not yet fully qualified would not qualify as core faculty but they too should have some training and experience, although may be continuing their learning and education.

Faculty who teach in the research component of the program do not need to be licensed but should also have experience in the area of SMI/SED and would typically be affiliated with an active SMI/SED research program. In model programs, research faculty would work with individuals with SMI/SED in a clinic or other setting.

Directors of Training may oversee several training programs at the post-doctoral institution including those in this area of Specialization. Where Training Directors oversee multiple training programs, it is possible they may not have direct experience or expertise in SMI/SED; however, they should be familiar with and have a working knowledge of the principles and practices in the field and be able to provide oversight and general guidance to faculty. If the Director of Training does not personally oversee the Specialty in SMI Psychology, the primary psychologist overseeing the post-doctoral training of those seeking to specialize in SMI Psychology must be a specialist in SMI Psychology. This person should be an experienced psychologist with advanced academic and experiential qualifications such as an ABPP, Fellow status in APA, other recognized status in APA, ABPP, APPIC, certification from the Psychiatric Rehabilitation Association, or similar recognition of

advanced qualifications. Where the program is university affiliated, faculty should have an academic appointment and be active in the university program.

Doctoral Level Foundational and Functional Competencies

For any program that has an exposure, experience, or Major Area of Study in SMI Psychology, at the Doctoral-level broad and general foundational competencies consist of the knowledge, skills, and attitudes/values that form the basis for how and why professional psychologists do what they do. Examples of foundational competencies include, but are not limited to: (a) processes of self-assessment and reflective practice, (b) understanding of scientific knowledge and methods, (c) effective relationship skills, (d) knowledge of ethical and legal standards and policy, (e) understanding and valuing individual and cultural diversity; and (f) ability to function in interdisciplinary systems.

Doctoral-level functional competencies reflect professional psychologists' application of knowledge, skills, and attitudes/values. Functional competencies include, but are not limited to: (a) assessment, diagnosis, and case conceptualization; (b) intervention; (c) consultation; (d) research and evaluation; (e) supervision and teaching; and (f) management and administration.

Specialized Competencies Required for Practice in the Specialization of SMI/SED

Advanced scientific and theoretical knowledge is acquired for the Major Area of Study in SMI Psychology that leads to Specialization via specialized didactic and experiential training that builds on and extends basic preparation in health service psychology. The specialized training needed to develop competence to treat persons with SMI/SED builds on, and expands doctoral level foundational and functional competencies, and includes: additional assessment methods that assess strengths and functional capability rather than solely symptomatology and deficits, evidence-based and promising practices designed specifically for this population, interventions modified and found to be effective with people in this population within the forensic mental health system, research methods adapted for populations such as this, and systems transformation methods specific to large mental health systems that serve this population, to name but a few – these are the major areas of specialized training needed by psychologists to work with individuals with SMI/SED. While post-doctoral Specialty programs could not include detailed training in all of these, post-doctoral residents should receive exposure to all of these domains and more intensive experience and training in as many as possible. The following competencies are those that would ideally be included or available to trainees (a broad, general descriptive narrative follows the listing):

Assessment

Competence and Expected Educational Outcomes in Strengths-Based and Functional Assessment Skills:

Comprehensive assessment is essential to any recovery service plan. Residents should be able to appropriately assess, evaluate and then develop practical interventions for individuals with severe and persistent mental illnesses, including those with complicated mental, substance abuse, and medical

co-morbidities, often with histories of trauma. Residents should achieve competence in conducting a cultural formulation interview; the DSM-5 Cultural Formulation Interview (American Psychiatric Association, 2013) is recommended for use in training programs in this Specialty.

- Residents demonstrate Comprehensive knowledge of strengths based and functional capability assessments, subjective perceptions of recovery and quality of life, and ability to conduct assessments using these measures
- Residents 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 SMI/SED
- Residents demonstrate the ability to competently utilize Specialty assessments as needed and appropriate
- Residents are able to conduct an assessment of an individual's readiness and desire for PSR interventions
- Residents are able to conduct an assessment of resources available to the individual and the person's ability to utilize those resources
- Residents demonstrate ability to assess perceived recovery and life satisfaction/quality of life
- Residents demonstrate ability to assess and address positive and negative symptoms using measures such as the Scale for the Assessment of Positive Symptoms (SAPS) and Scale for the Assessment of Negative Symptoms (SANS)
- Residents are able to recognize psychosis and thought disorder and understand in depth the nuances of each condition considered within the purview of SMI/SED
- Residents demonstrate ability to recognize and screen for potential cognitive deficits that are core areas of dysfunction for people with SMI/SED including processing speed, verbal memory, and attention
- Residents are able to recognize and screen for social deficits that often accompany these disorders
- Residents demonstrate ability to recognize the limitations posed by cognitive impairments and the potential for lessened insight and, as needed, ability to conduct behavioral observational assessments that accurately account for these
- Residents demonstrate ability to assess for the potential risk for suicide and violence to self or others

- ☐ Residents are able to recognize and understand etiology of co-occurring substance use disorders and the importance of trauma in SMI/SED disorders and be competent in differential diagnosis of similarly presenting diagnoses such as PTSD and personality disorders
- ☐ Residents demonstrate knowledge of medication side effects especially those specific to psychotropic medications and ability to assess for medication adherence and barriers to adherence
- ☐ Residents demonstrate ability to integrate the intersection of diversity related to age, gender and gender orientation, race, cultural, spiritual/religious beliefs, etc. specifically related to the presentation of symptoms unique to SMI/SED
- ☐ Residents are able to recognize the level of capacity and competence of an individual with SMI/SED in order to make appropriate recommendations regarding interventions or to refer to appropriate Specialty services including those provided by other disciplines
- ☐ Residents demonstrate the capacity to assess family burden in caregivers of individuals diagnosed with an SMI/SED
- ☐ Residents demonstrate ability to assess recovery attitudes and self-stigma using standardized tools
- ☐ Residents demonstrate ability to assess capacity to provide informed consent for treatment

Goal Setting and Treatment Planning

Competence in Helping Individuals Set Goals and Develop Appropriate Treatment Plans:

- ☐ Residents demonstrate ability to assist clients assess their values as they develop individualized goals using shared decision making and person centered planning approaches
- ☐ Residents demonstrate competence in developing tailored clinical and recovery-oriented interventions that meet the client's identified goals and develop action steps for goal achievement
- ☐ Residents are able to recognize when modifications to treatment plans are needed to reflect the needs and values of the client and determine satisfaction of services provided

Interventions

Competence and Learning Outcomes in Psychosocial Rehabilitation (PSR) Interventions

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. Residents should demonstrate skill in applying and adapting evidence-based PSR interventions with SMI/SED individuals. Residents also are 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

demonstrate the ability to effectively work with diverse populations, interprofessional providers, and various program specialties.

The schizophrenia PORT evidence based and promising practices recommendations (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010) include:

- Residents can utilize *Assertive Community Treatment (ACT)* – and display knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
- Residents are able to implement Supported Employment (SE) – and be able to adhere to fidelity criteria and ability to implement intervention, participate on team, and supervise others
- Residents demonstrate full competence in Cognitive Behavioral Therapy (CBT) and CBT for psychosis (CBTp) – they have thorough knowledge of differences between CBT and CBTp and the ability to competently practice and supervise others in both interventions
- Residents are skilled at providing Skills Training as applied to persons with SMI/SED– knowledge of fidelity criteria and ability to implement intervention and supervise others
- Residents demonstrate knowledge of Family Intervention/Psychoeducation – fidelity criteria and ability to implement intervention and supervise others
- Residents demonstrate knowledge of Social learning programs (Token Economy) interventions and, appropriate use, ability to implement and train and supervise others
- Residents are able to implement Integrated Dual Diagnosis Treatment (IDDT)/Co-occurring disorders treatment – and demonstrate knowledge of fidelity criteria and participate on team, and supervise others
- Residents demonstrate knowledge of Weight management approaches and Smoking cessation approaches – and are able to competently implement appropriate interventions and supervise others
- Residents demonstrate knowledge of Illness Self-Management including Wellness Recovery Action Planning (WRAP) and behavioral tailoring for medication – and how to implement and supervise others
- Residents demonstrate knowledge of Cognitive Remediation and Social Cognition Training interventions, and ability to competently practice and supervise others
- Residents demonstrate knowledge of PSR interventions for first episode psychosis (FEP) – knowledge of recent research indicating the effectiveness of a set of interventions (RAISE) and are able to implement interventions, participate on teams, and supervise others
- Residents are knowledgeable about Peer Support/peer delivered services – including the latest research, and are able to implement and supervise peers

Additional Interventions to Address Critically Important Problems for People with SMI/SED:

- Residents demonstrate Stigma/Self-stigma interventions – knowledge of, and ability to implement interventions to change attitudes and decrease discriminatory behaviors among health providers and the public at large
- Residents demonstrate Trauma interventions (trauma informed and trauma specific care) – ability to competently implement trauma interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care
- Residents demonstrate Suicide prevention – ability to recognize when individuals may be at risk and provide high levels of support, refer for appropriate intervention and provide treatment for depression to mitigate hopelessness and other risk factors
- Residents demonstrate Violence prevention – ability to recognize when individuals may be at risk and refer for appropriate intervention while providing high levels of support
- Residents demonstrate 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
- Residents demonstrate Supported education knowledge of interventions to help individuals achieve their educational goals
- Residents demonstrate Motivational Interviewing (MI) for those with SMI/SED – ability to competently implement motivational interviewing as appropriate and to supervise others in practice

Specialized Interventions for Forensic/Criminal Justice Populations with SMI/SED - including knowledge of the factors that impact on success of interventions for forensic and criminal justice populations with SMI/SED:

- Forensic Assertive Community Treatment (FACT) – Residents demonstrate the ability to implement intervention, participate on team, and supervise others
- CBT and CBTp for those in criminal justice/forensic settings – Residents are able to competently provide specialized CBT and CBTp services for persons with SMI/SED in these 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, ability to provide integrated mental health and substance use services targeted to the population, and supervise others in practice
- Trauma interventions for those in criminal justice/forensic settings (trauma informed and trauma specific care) – Residents demonstrate recognition of trauma as the norm for those with SMI/SED in the forensic and criminal justice systems, ability to competently provide trauma specific

interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care, including services for those at highest risk and to supervise others in provision of services

- Supported housing interventions for those in criminal justice/forensic settings – Residents able to implement comprehensive services to assure supported housing is available for individuals being released into the community
- Transition planning and follow-up for criminal justice/forensic settings – Residents demonstrate understanding of the critical nature of this intervention and ability to implement adequate and appropriate transition planning and follow up for individuals being released into the community

Specialized Intervention for People with Bipolar Disorder - in addition to demonstrating competence with the above interventions for people with SMI/SED (several of which are also recommended specifically for this population), residents should also:

- Residents demonstrate an ability to competently provide Interpersonal and Social Rhythm Therapy (IPSRT) and Family Focused Treatment (FFT) for bipolar disorder and to supervise others in practice
- Residents understand the potential of Dialectical Behavior Therapy (DBT) and Mindfulness Based Cognitive Therapy, which may also be helpful for individuals with bipolar disorder and personality disorders

Consultation

Competence in Consultation Skills When Working with the SMI Population:

Within the bounds of confidentiality and privacy, residents must demonstrate the ability to listen, understand, communicate, and display excellent rapport with relevant stakeholders including: the person served, family members, relevant community members, other healthcare providers within and outside of the system, and partnering agencies. The resident is expected to exhibit comfort and proficiency in providing effective consultation and feedback to the person served, family members, clinical programs, interprofessional staff and community partners.

- Resident must demonstrate the ability to effectively present information and develop treatment recommendations that are understandable to the person, his or her support team, and in accord with his or her goals
- Residents are able to competently work with an interprofessional team and present information about persons with SMI/SED so that team members can understand and learn from the presentation
- Residents are able to apply specialized knowledge and expertise concerning SMI/SED symptomatology and diagnosis to problems that arise in professional settings

- Residents demonstrate comprehensive knowledge of psychosocial functioning and recovery and ability to describe this to team members, other colleagues, and members of the public
- Residents are able to provide education and training for mental health staff on all aspects of the recovery paradigm and PSR assessments and interventions
- Residents demonstrate ability to integrate all information into a case formulation that presents an opportunity for use of PSR interventions designed to promote recovery and attainment of the goals articulated by each person
- Residents are able to assist supervisees and team members in the management of difficult behaviors that may be exhibited by persons with SMI/SED
- Residents are able 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
- Residents demonstrate ability to work with staff in specialized facilities such as supported housing, etc. to help them recognize and respond appropriately to symptoms and problem behaviors to help individuals with SMI/SED thrive in the community
- Residents demonstrate ability to educate, train, and supervise staff at all levels of training, from front-line behavioral health staff through to highly trained staff and managers/administrators, in the best ways to help people with SMI/SED manage symptoms, set and achieve goals for themselves, and access resources available to them. Some examples of potential issues and difficult behaviors include limit setting, stigma, empathy, delusions/hallucinations, and crisis intervention
- Residents demonstrate ability to educate and consult with families about their family member's illness and the role of family in treatment
- Residents 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)
- Residents are able to educate and train staff in facilities and on specialized units for youth, young adults, and older persons where knowledge and expertise is lacking about behavioral health particularly SMI/SED

Research and Evaluation

Competence in Scholarly Inquiry and Application of Theoretical and Scientific Knowledge to Practice with the SMI Population:

Residents participate in scholarly inquiry, and 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, as well as program development, implementation, and evaluation.

- Residents must demonstrate awareness of current literature, and have the ability to search relevant literature that is applicable to the SMI/SED population and evaluate it
- 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 includes formulation of hypotheses, study questions and design, determination of statistical methods, participants to be recruited, etc.
- Residents demonstrate full 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
- Residents demonstrate recognition of importance and ability to incorporate family members and first degree relatives into designs (research provides insight into how the illness manifests in individuals vs. family members looking at the phenotypes in individual and family)
- Residents demonstrate recognition of importance of involvement of caregivers and other stakeholders in research and willingness to incorporate them into designs, and to obtain buy-in from multiple under-resourced clients and stakeholders
- Residents demonstrate understanding of the unique needs of persons with SMI/SED vis a vis study design and ability to apply this knowledge to prevent/minimize drop out as typically this is different for persons with SMI/SED 1) drop outs tend to be doing worse and 2), severe economic disadvantages impact people with SMI/SED disproportionately 3), follow up studies need to include more time (>1 year) due to the nature of the illness
- Residents demonstrate knowledge of and ability to use mixed methods research designs and other methods that are best suited to the environments and situations of persons with SMI/SED
- Residents demonstrate familiarity with and ability to use single case designs (disorders may be persistent over time and multiple baselines provide a clearer picture of the impact of different treatment components and their helpfulness to individuals)
- Residents demonstrate knowledge of and ability to conduct multifactorial designs of programs with SMI/SED populations; understanding of the importance of controls for non-specific factors
- Residents demonstrate ability to collaborate with other disciplines (e.g., psychiatry, rehabilitation services, nursing, occupational therapy, etc.)
- Residents demonstrate up to date knowledge of the latest assessments and interventions for this population and use this to guide evaluation and research efforts.
- Residents are able to utilize research/evaluation knowledge to adapt/modify assessments and interventions that have excluded persons with SMI/SED and to do so appropriately recognizing when fidelity to the original practice is essential

- Residents are able to identify appropriate outcomes for program evaluation efforts due to broad nature of quality of life, psychosocial functioning, and recovery
- Residents are able to undertake program evaluation which is critical so that a developed program can be improved - systems within which SMI/SED persons are seen may be more difficult to work with than structured research settings due to presence of multiple stakeholders
- Residents are able to inform and educate IRBs about the type of intervention research common with SMI/SED populations such as PSR interventions

Supervision/Teaching

Competence in Teaching and Supervision Skills:

By the completion of the training year, residents should demonstrate the ability to give presentations in a formal didactic setting, develop mentoring skills for working with small groups and/or one to one to teach skills, communicate knowledge, and provide feedback to those they serve, their support networks, other professionals, trainees, para-professionals, and/or community partnering agencies. Residents demonstrate capability to competently supervise trainees in the full range of clinical activities, including use of fidelity measures where these exist. When providing supervision and teaching, residents should demonstrate sensitivity to ethical, legal, and cultural issues and demonstrate ability to teach the principles and practices of PSR.

- Demonstrated comprehensive knowledge of psychosocial assessments and interventions and ability to impart knowledge about these and to supervise others in practice. Residents demonstrate capability to competently supervise trainees in the full range of clinical activities, including use of fidelity measures where these exist
- Residents are able to provide education and training for mental health staff on aspects of the recovery paradigm and PSR interventions
- Residents demonstrate ability to impart knowledge and help others develop an understanding of, and ability to convey the importance of hope, respect, positive regard, and acceptance of person's goals, wishes, and preferences in the development of the therapeutic relationship (which is key and sometimes difficult to form) and to supervise others in their development of these factors
- Residents demonstrate ability to impart an understanding of the pace and non-linear process for recovery and ability to develop positive expectations for the person's progress despite the combination of social, functional, and cognitive impairments that are commonly observed
- Residents are able to help trainees and supervisees recognize incremental improvements and utilize the process of shaping in goal setting and recovery

- Residents are able to impart knowledge of the phenomenology of the disorders of SMI (e.g., auditory hallucinations, negative symptoms such as diminutions of basic drives, conceptual disorganization, etc.)
- Residents demonstrate 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
- Residents are able to promote self-reflection and self-examination of fear, stereotypes, pre-conceptualizations of, and biases toward people with SMI/SED including stigma and self-efficacy
- Residents demonstrate ability to teach and supervise trainees about appropriate boundaries and differences in working with this population
- Residents have knowledge of standard tools for fidelity measures and are able to supervise trainees in their use
- Residents demonstrate ability to use live or audiotape feedback to understand the often complex nuances of work with persons with SMI/SED
- Residents are able to supervise a range of other mental health providers (e.g., psychiatrists, peers, nurses, social workers, pharmacists, occupational therapists)

Management/Administration

Competence in Understanding Organizational and Systemic Dynamics:

By the completion of their training, residents should demonstrate an advanced level of knowledge of the various healthcare systems in which they have operated and have a broader understanding of health and mental healthcare systems both nationally and to some extent globally. They should show awareness of and sensitivity to systemic issues that impact the delivery of services to persons with SMI/SED. They should demonstrate a good understanding of organizational dynamics as well as systemic issues within programs, effectively functioning within various institutional contexts and appreciating how such forces impact and influence clinical care, especially for persons with SMI/SED.

- Residents demonstrate knowledge of the complexity of systems change issues, an ability to promote resiliency as resistance is encountered, and to effect change in systems in which they work
- Residents demonstrate knowledge of needed systems of care for persons with SMI/SED and the importance of integration and interprofessional cooperation
- Residents demonstrate familiarity with reimbursement structures and with PSR services that are not funded or are partially funded and ability to secure funding for needed specialized services

- ☐ Residents demonstrate knowledge of Commission on Accreditation of Rehabilitation Facilities (CARF) requirements for accreditation and ability to implement policies and procedures needed to secure and maintain accreditation
- ☐ Residents demonstrate knowledge of Joint Commission and Centers for Medicare and Medicaid Services (CMS) standards and ability to implement policies and procedures needed to secure and maintain accreditation and ensure CMS standards are met
- ☐ Residents demonstrate knowledge of the Americans with Disabilities Act and its amendments and application to those with SMI/SED
- ☐ Residents demonstrate ability to lead effectively within complex interprofessional teams and settings
- ☐ Residents demonstrate knowledge of implementation and dissemination challenges and opportunities of EBPs for those with SMI/SED and the challenges of this in multiple, complex, uncoordinated settings
- ☐ Residents demonstrate recognition of the importance of conducting program evaluation and/or quality improvement studies and ability to convince management and team members of this
- ☐ Residents demonstrate ability to develop comprehensive programs across the full continuum of care that incorporates needed interventions such as supported employment and other interventions specifically developed for this population
- ☐ Residents are able to assist organizations to understand the importance of providing services within a recovery orientation
- ☐ Based on comprehensive knowledge of PSR assessments and interventions residents are able to impart knowledge about these and promote cooperation and implementation within teams and the overall system

Advocacy

Competence in Working for Adequate, Appropriate and Equitable Systems of Care for Persons with SMI/SED:

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 friends to encourage, promote, and assist persons with SMI/SED to develop social networks, access appropriate health/mental health care, access needed social services, and fully participate in their communities.

- Residents are able to create opportunities for people with SMI/SED to meet and interact with others with and without SMI/SED, build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion
- Residents demonstrate knowledge of community resources and ability to reach out to these as a means of expanding access to services for people with SMI/SED
- Residents demonstrate knowledge of laws that affect individuals with SMI/SED negatively and may lead to human rights violations (e.g., laws about competency restoration process, not guilty by reason of insanity, etc.)

Description of Training

The goal of treatment 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. The majority of services provided are PSR interventions, although residents in this Specialty may also provide traditional treatments such as psychotherapy, illness management, and supportive therapy. Embedded in this model is an interprofessional approach based on a recovery model that empowers persons with SMI/SED to develop personalized goals and choose from a menu of PSR treatment program opportunities, including inpatient and outpatient services that are designed to help each person achieve the goals he or she has determined to be personally relevant. The goal of services is to improve community functioning and quality of life for persons with SMI/SED. Ensuring an active partnership with consumers and community linkages is an essential element of this work.

Training for post-doctoral residents in this Specialty consists of a Major Area of Study with at least 80% of time spent within the clinical and scientific areas of the Specialty Training and occurs in several main areas: primary and secondary placements, seminars, didactics, research, supervision, consultation, teaching, and administration. While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training experiences should exist across all programs. These may be called by different names but the content is focused on learning how to use the specialized PSR assessments and interventions to help people with SMI/SED recover and attain their full functional capability – all within a recovery orientation.

Advanced scientific and theoretical knowledge specifically focused on the SMI/SED population is acquired via specialized didactic and experiential training at the post-doctoral level that builds on and extends the broad and general preparation in health service psychology and is based on the empirical literature. The specialized training needed to develop competence to treat persons with SMI/SED builds on, and expands doctoral level foundational and functional competencies, and includes: additional, specialized assessment methods that assess strengths and functional capability rather than solely symptomatology and deficits, evidence-based and promising practices designed specifically for this population, interventions modified and found to be effective with people in this population within the forensic mental health system, research methods adapted for populations such as

this, and systems transformation methods specific to large mental health systems that serve this population, ethical, legal, diversity issues and concerns that impact this population specifically, to name but a few – these are the major areas of Specialized training needed by psychologists to work with individuals with SMI/SED.

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

Training for post-doctoral residents in this Specialty takes place via several principal avenues: primary and secondary placements, seminars, didactics, research, supervision, consultation, teaching, and administration. While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training and scientific experiences should exist with the SMI/SED population (at least 80% of their time) across all programs; all aspects of residency training must be based on the most current scientific literature. The content of residency training should be focused on learning how to apply the scientific literature to develop the competencies necessary to conduct research, evaluation, clinical assessments and interventions with, and on behalf of, those with SMI/SED and to assist them to recover and attain their full functional capability.

Required Education and Training and Other Experiences within Programs with a Major Area of Study in the SMI Psychology Specialty

Each resident's training plan should be individually created to meet the specific training needs of the resident and to develop competence in the range of mental health and PSR skills specifically designed for competent assessment and treatment of individuals with SMI/SED. A Major Area of Study in the SMI Psychology Specialty should include at least 80% of a trainee's time in the SMI/SED setting and working with the SMI/SED population. Training activities include attention to advancing development of core skills such as: specialized assessments, treatment interventions developed and researched specifically for this population, consultation and multi-disciplinary teamwork, research and scientific inquiry, supervision and teaching, ethics, program management and administration, and cross-cultural and diversity sensitivity. Residents should leave their residency well-prepared to function successfully as independent scientist-practitioners and work effectively with persons with SMI/SED. Another goal of the residency is to train residents to function in leadership positions in settings to persons with SMI/SED. As a result, the resident should be prepared to transition to practice with an interprofessional team, promoting client-centered, recovery oriented care and interprofessional collaboration for specialized assessment and treatment of persons with SMI/SED.

A developmental training approach is to be used in which learning objectives are achieved through didactic and experiential clinical placements under observation, supervision and mentoring by one or more supervisors. Each resident's training plan is individually created to meet the specific

training needs of the resident and to develop competence in a full range of community mental health and PSR skills. Competence is evaluated through components of knowledge, skills, and attitudes/values. An evaluation tool adapted specifically for SMI Psychology training and competence evaluation has been piloted and is in use at post-doctoral training sites. 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)*, and is included at Attachment III. 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)

The practice guideline specifically for psychologists practicing in the Specialty is the APA *Recovery to Practice Curriculum* (American Psychological Association & Jansen, 2014) which was developed specifically by APA for psychologists and is used in psychology training programs across the US. The *Curriculum* is a comprehensive guideline for training psychologists to work with persons with SMI/SED and includes readings, exercises, assessments, etc.

Another tool is the *Clinical Practice Guideline Toolkit for Psychologists Working with Persons with Serious Mental Illness/Severe Emotional Disturbance* which is a short clinical practice guideline tool developed for psychologists working in the Specialty. The *Guideline Toolkit* provides an easy to use mechanism for conceptualization, identification and assessment of issues, and intervention planning and execution. The *Guideline Toolkit* consists of a flowchart depicting the stages of psychological practice and is designed as a quick reference guide for use by frontline psychologists and by those serving as program managers or administrators working with the SMI/SED population and can be used together with the *Curriculum*. The *Guideline 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, but is a handy guide to help psychologists make certain they have covered required steps when working with this specialized population. The *Guideline Toolkit* is also posted on the Specialty Council website (www.psychtrainingsmi.com).

While the SMI Psychology Specialty is devoted to training psychologists to work with persons with SMI and SED, practice in this Specialty requires an interprofessional approach due to the complexity of problems faced by persons with SMI/SED. The most comprehensive practice guideline for the full range of professionals working with the population is 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] which can be accessed at <https://www.nice.org.uk/guidance/cg178>. The NICE guideline is known globally as the pre-eminent interprofessional guideline for Specialty practice with persons who have SMI. It is one of a series of practice guidelines developed by NICE that are highly respected and considered the gold standard for

practice guidelines with specialty populations of all kinds. The NICE guidelines are continuously reviewed and updated and in 2016, NICE introduced a new guideline based on the emerging science around early intervention for those experiencing a first episode of psychosis. Some of this emerging science base has come from the US NIMH RAISE trial as well as from similar studies in other countries. The new guideline is entitled: *Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance*. NICE also updated its *Psychosis and Schizophrenia in Children and Young People: Recognition and Management* guideline, which is the guideline for SED. There are also NICE guidelines for practice with patients diagnosed with bipolar disorder and for co-morbid psychosis and substance use disorders assessment and treatment. The NICE practice guidelines for psychosis are used by post-doctoral residencies in this Specialty, along with the APA *Recovery Curriculum*, the *Clinical Practice Guideline Toolkit* and other similar resources such as the reports of the NIMH PORT study (Kreyenbuhl, Buchanan, Dickerson & Dixon, 2010), the NIMH RAISE trial (Kane, et al., 2016), and the SAMHSA evidence-based toolkits (<https://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs>). These practice guidelines and materials are referenced and linked on the Specialty Council website (www.psychtrainingsmi.com).

Required Clinical Placements

Across all placements, the post-doctoral resident should be the primary psychologist responsible for several individual clients. Residents should conduct a range of EBPs and promising practices, with fidelity to the models measured when fidelity criteria exist. Residents should also oversee at least one or more skills training group(s). Post-doctoral residents also conduct several assessments that include cultural, strengths-based, and functional assessments, and use those assessments to develop treatment plans or recommendations from those assessments. Residents should also work provide psychoeducation for several families or support systems of their clients. Given that much of the PSR work focuses on community integration, residents should have at least one ongoing experience outside the clinic (ACT, home-based interventions, etc.).

Required Primary Placement

All psychology post-doctoral residents in this Major Area of Study Specialty should participate as members of an interprofessional team for approximately 20 hours per week for their primary clinical placement for the duration of the training year working with persons who have SMI/SED. This and all placements should operate based on a recovery orientation and utilize PSR practices as primary interventions. As residents increase their skill, confidence, and levels of responsibility, they should receive more complex cases, more independent clinical work, the ability to pursue their own training goals, and take on additional cases if desired. Residents also typically work with pre-doctoral interns and practicum students (where these are present), and are involved with the hierarchical supervision of these interns and students along with their clinical responsibilities on their rotations. The intensity and level of these activities would be determined in a collaborative nature between trainee, supervisors, and the Director of Training.

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

An SMI Psychology post-doctoral residency is fully focused on the SMI/SED population. Though doctorally prepared psychologists may have had some exposure and experience with individuals in this population, post-doctoral training in this Specialty is intense and concentrated; this concentration is required to develop the competencies needed to manage the complexities of the illnesses within the SMI/SED population.

Core components that recovery oriented PSR units/teams include (each residency program would determine which are best suited for their program):

- Specialized individualized assessment/re-assessment including intakes, diagnostic clarifications, cognitive screening, functional assessment, rehabilitation readiness assessment, and recovery/treatment planning – all designated for use with the SMI/SED population
- Evidence-based and promising PSR practices such as family psychoeducation, assertive community treatment, supported education and supported employment (particularly the individual placement and support model), concurrent disorders treatment, social cognition and cognitive remediation training, early intervention and PSR treatments for recent onset psychosis, trauma informed and trauma specific care, illness management, issues and interventions for those in criminal justice and forensic settings, among others. 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 such as CBT for psychosis (CBTp), social skills training, illness management and recovery, anger management skills, relationship skills, family psychoeducation, cognitive behavioral social skills training (CBSST), cognitive enhancement therapy, interpersonal psychotherapy, weight and smoking interventions, and solution-focused approaches including WRAP, etc.

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

Residents' competence 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. This 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. Further, 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 colleagues, behavioral observation, structured observation checklist ratings, and ratings based on record or chart review. 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. Evaluation feedback needs to be given early enough in the program to serve as a basis for correction and should include documentation about intended corrective actions. Subsequent feedback involves the extent to which these corrective actions are, or are not successful in addressing any areas of concern.

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)* which is available on the Specialty Council website (www.psychtrainingsmi.com). 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)). The revised tool, the *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*, includes 4 overarching areas of competence (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). The *Instrument* is intended to serve three main functions for professional development: 1) to allow individuals to target areas identified as needing improvement via continuing professional development and education; 2) to provide aggregate data indicating areas of greatest need for additional training for the development of CE opportunities; and 3) to provide a holistic structure from which to develop and evaluate available training continuing professional development. This evaluation *Instrument* is an excellent means to measure competency over time and is highly recommended for use by programs in this Specialty.

Required Secondary Placements and Other Training Experiences

During the remaining 20 hours of the week, residents participate in an additional rotation as part of their Major Area of Study in SMI Psychology (also one that focusses on recovery and PSR for persons with SMI/SED), attend weekly didactic seminars, have supervisory sessions, and participate in

other experiences designed to round out their understanding and knowledge of SMI/SED service provision. All are focused on SMI/SED and designed to round out their scientific understanding and knowledge of SMI/SED and fully develop their competence in service provision for this population. These are described below.

For their secondary placement, SMI Psychology post-doctoral residents in this Major Area of Study Specialty participate as members of an interprofessional team on one or more units or teams that are different from the primary placement but that also focus on recovery and provision of PSR services to persons with SMI/SED. These should be selected to broaden the resident's training experiences and develop the competencies specific to this Specialty. Examples could include: outpatient clinics, community programs, a short stay unit where treatment services for acute episodes of psychiatric illness are offered and where an individual is helped to stabilize, his or her level of functioning is improved, and connections with outpatient treatments that will help promote community integration are established, e.g., social skills training groups, providing family psychoeducation, etc. A number of distinct clinical programs should be available to residents for secondary placements. Within each of these, residents work closely with a wide range of allied healthcare providers (nurses, social workers, psychiatrists, occupational therapists, vocational specialists, recreational therapists, medical residents, dietitians, art therapists, peer support specialists, etc.), family members, and other partners. Clinical supervision should be provided by a licensed psychologist.

Seminars, Didactics and Teaching/Giving Presentations (see below for examples) as part of a Major Area of Study in SMI Psychology

In addition to completing required primary and secondary placements, residents would also be required to attend seminars, didactic presentations, and supervision sessions which are to be focused on issues related to SMI/SED. Contemporary research literature in each topic is used to facilitate the scientific and theoretical discussion required for the Specialty and how to integrate critical, scientific thinking into the application and clinical work of each resident. Readings exemplifying the most up to date literature along with seminal articles are provided to enhance discussion during seminars and meetings. In order for residents to gain experience in teaching, participants would be encouraged to teach at least one session in an area of interest, and to submit abstracts for talks to be given at relevant conferences such as those of the Psychiatric Rehabilitation Association, Association of Behavioral and Cognitive Therapies, the American Psychological Association convention and/or local, state, or regional conferences with an interest in SMI/SED. If applicable, time is devoted to teaching the mechanics of giving PSR presentations, and providing feedback to participants as they rehearse these talks for presentation for larger audiences.

Topics and Concepts that are Relevant to Training in SMI Psychology – (Note: Described below in seminar format; may be covered in Seminars, Workshops or Other Training Venues)

Principles of Psychosocial Rehabilitation (PSR): This weekly didactic seminar mirrors the training philosophy of the scientist-practitioner model and is designed to provide participants with a broad and thorough understanding of PSR interventions, principles, theories, and current research in

clinical and community psychology. Sessions focus on the specialized assessments and evidence-based and promising PSR practices designed, developed and empirically validated for persons with SMI/SED, stigma, ethics and boundaries (and how they differ from those in clinical settings not focused on persons with SMI/SED), and other topics relevant to the Specialty.

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 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 also may 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. Residents should gain experience in identifying, reviewing, and contributing to the scientific literature and knowledge base in SMI/SED.

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

Systems Change Seminar: A didactic seminar comprised of discussions about leadership, management styles and professional development. Residents should meet with a range of leaders and managers, who lead discussions on topics ranging from mentoring, decision-making, workforce development, career paths, negotiation styles, politics in organizations and leadership in education and community organizations, all with an eye toward effecting systems change to reflect relevant mental health policies for recovery and rehabilitation for persons with SMI/SED. 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: NOTE: 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., Laro, 2014; Luhrmann, 2007; Versola-Russo, 2006). Further, the DSM-5 highlights culture-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.

Training in a Major area of Study in an SMI Psychology Specialty program must integrate both knowledge and practice to be useful. Applications of cultural knowledge acquired in the classroom take place during practice training experiences. Thus, diversity training when working with the SMI/SED population is primarily practical and applied, with cultural competence defined as a foundational competency. Practice training for post-doctoral residents in this Specialty occurs in several main areas: primary and secondary placements, seminars, didactics, research, supervision, consultation, teaching, and administration. While the post-doctoral residency training requirements will vary at individual training programs, a core of required education and training experiences should exist across all programs. With regard to diversity experience, in addition to participation in the diversity seminar described above, fellows should receive clinical training in at least one (and preferably more) clinical setting which 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.

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

While topics and speakers will likely cover a broad range, those that are particularly pertinent to persons with SMI/SED should be highlighted. Among others, important topics include: the poor attention often given by health care providers to physical health complaints of persons with SMI/SED, misattributions of legitimate health concerns to psychotic symptoms, discriminatory practices including failure to follow treatment guidelines when people of color and diverse cultural backgrounds are seen, and need for attention to language barriers, traditional beliefs about mental illness, and religious/cultural issues.

The exploration of power differentials, dynamics, and privilege should be at the core of understanding issues of diversity and impact on social structures and institutionalized forms of discrimination that may influence the person's perception of her/his potential for improved quality of life. In addition to the presence of mental health symptoms, factors such as gender, age, ethnicity, race, sexual orientation, migration history, trauma history, and childhood adversity have all been found to influence patterns of diagnosis and access to treatment among persons diagnosed with SMI/SED, and thus must be considered as psychologists engage in assessment, case conceptualization and formulation, and intervention.

Laws and Ethics Seminar: Mental health recovery for persons with SMI/SED raises important ethical issues regarding competence and safety while balancing with 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 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, both broadly and specific to the jurisdiction of the residency, studying for the EPPP, obtaining employment, managing a research and clinical career, and other timely topics of interest to professional health service psychologists.

Teaching and Supervision

Residents should perform clinical supervision of pre-doctoral practicum students and doctoral interns (where the residency setting also has interns and pre-doctoral students), be supervised themselves by experienced clinical trainers, and take part in workshops or other training opportunities to develop their own supervisory skills. Residents should demonstrate knowledge of methods of teaching specific to PSR and related clinical activities for the SMI/SED population in case conferences, seminars, didactics, journal clubs or other venues and be able to effectively translate knowledge of specialized PSR and related clinical activities for the SMI/SED population to interprofessional audiences.

Residents should also demonstrate knowledge of methods of providing supervision to other psychology trainees that emphasize skill building in providing patient care especially when trainees without Specialty training work with persons with SMI/SED, consulting with other professionals, identifying relevant scientific data and conducting research, and practice management specific to PSR and related clinical activities for the SMI/SED population. Topics could include: models of supervision, clinical competency, goals of supervision, reducing anxiety in supervision, silence, countertransference, supervision and ethics, risk management, self-care for the therapist and supervisor, and awareness and understanding of the full range of human diversity.

Supervision Meetings

Clinical Consultation Meetings: These meetings provide residents opportunities to learn more about how to work with those who have SMI/SED and can include processing past group or individual sessions, reviewing skills, role playing exercises, and learning more about various theories as well as practice tools and techniques. Residents may also participate in interprofessional educational activities such as patient-care rounds, case conferences/team meetings, and/or formal educational opportunities.

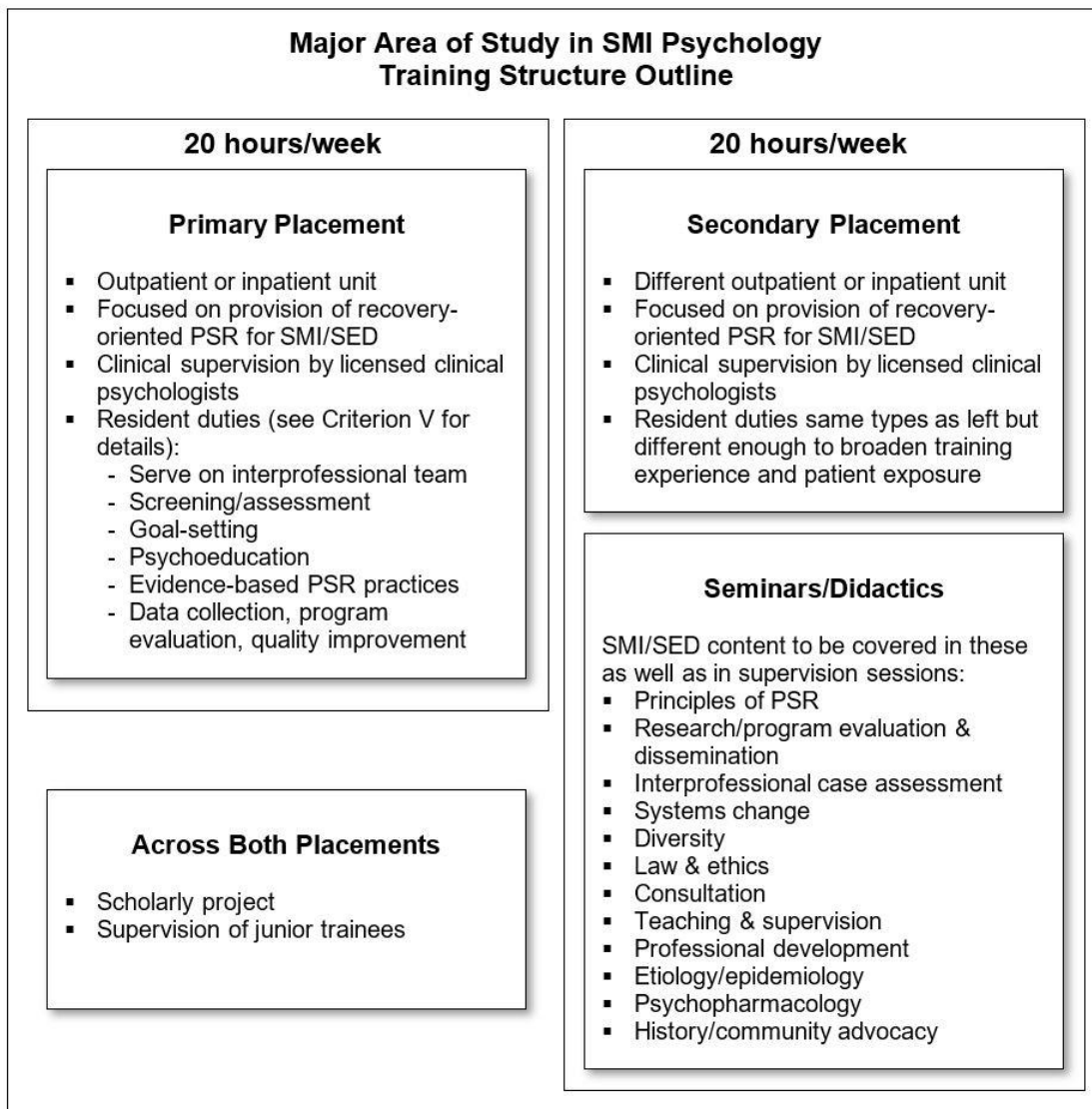
Individual Supervision with Training Faculty: Residents should have the opportunity to meet with a faculty member to discuss program matters including administrative needs, educational plans, professional development, systems issues, and other matters of individual interest.

Didactic Content Covered in Seminar or Lecture Format and in Supervision

NOTE: Didactic content covered in seminars, lectures and supervision is based on up to date empirical literature along with the most important seminal literature focusing on SMI/SED. The information presented below is comprised of examples of current assessments and interventions. These could not all be covered in depth in a one year or even in a two year post-doctoral residency program. However, residents should be made aware of the breath and distinctiveness of assessments and interventions available and provided information about them. Each residency program would decide which of the assessment instruments and interventions would be required and/or emphasized. An overview of the assessments and interventions is provided in the Petition for Recognition of a Post-Doctoral Specialty in SMI Psychology which can be accessed at (www.psychtrainingsmi.com).

For an excellent scholarly review of the many assessments that have been developed, see the chapter by Glynn and Mueser (2018) which presents a comprehensive review along with information about the psychometric properties of each instrument. Additionally, a short presentation is offered in APA's curriculum for training psychologists for work with persons with SMI/SED (American Psychological Association & Jansen, 2014). The curriculum provides information about many relevant recovery-oriented assessments and most of the PSR evidence based and promising practice interventions and is available for free at www.apa.org/pi/rtp.

The figure below is a short table depicting the major elements in the SMI Psychology Specialty. Refer to the descriptions above and the information in Criteria IV, V, VI and VII of the Petition to APA for Recognition of the post-doctoral Specialty.



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

Assessments and Interventions Specific to SMI/SED (See Petition to APA for Recognition of SMI Psychology, Criteria V and VI for full references)

Assessment

- Culturally informed assessment – see Criterion VI of the Petition to APA for comprehensive list and detailed information about the wide array of culturally informed assessment instruments

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).

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).

Self-Stigma of Mental Illness Scale (SSMI) (Corrigan, Watson, & Barr, 2006).

Internalized Stigma of Mental Illness Scale (ISMI) (Ritsher et al., 2003).

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, 2006).

- 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, 2011).

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 – Note: the predictive accuracy of instruments in this category “remains a source of considerable uncertainty” (Fazel, Singh, Doll, & Grann, 2012).

Hare Psychopathy Checklist-Revised (PCL-R) (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).

Interventions and Related Content

- Assertive community treatment
- 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, (e.g., Cognitive Processing Therapy, Prolonged Exposure, CBT for PTSD)

- Interventions for individuals with SMI and SED in the Criminal Justice and Forensic systems

- Interventions for those who are homeless or at risk of homelessness

- Interventions to reduce stigma, social isolation, and community exclusion

- Interventions for suicide prevention

- Implementation and Dissemination Strategies Specific to SMI/SED Interventions

Other Content Specific to SMI/SED

Etiology/Epidemiology

- Stress-vulnerability Model of SMI/SED

- Neurobiologically/neurophysiologically/neurocognitive phenomena

- Biopsychosocial Model

- Premorbid/Prodromal

1st episode
 Untreated psychosis
 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
 - Deinstitutionalization, history of coercion, clubhouse model, empowerment movement
- Advocacy groups/community resources
- Diversity/Individual differences specific to persons with SMI/SED
- Ethical treatment of persons with SMI/SED
- Legal Considerations/civil rights/criminal justice; decision making capacity
- Violence and Aggression – by persons with SMI/SED and against persons with SMI/SED
- Systems of Care/settings for care provision
- Discrimination, stigma, self stigma

Research, Evaluation and Scientific Methods

- The most appropriate methods for conducting research with and for this population, including participatory action research and mixed methods approaches.

Consultation and Systems Change Methods

- Methods for changing mental health systems to incorporate a recovery and PSR perspective.

Sequence of Training

A resident's clinical training follows a progression from didactic learning and observing supervisor modeling (in vivo service delivery with persons with SMI/SED and role plays in supervision), to continued learning and delivering services to persons with SMI/SED with direct observation of resident-delivered services by the supervisor and/or with supervisor and resident as co-therapists, to increasingly autonomous, albeit monitored and supervised, service delivery. All services should be provided within the context of the recovery orientation building on the client's strengths, and focused around the person's goals and PSR services designed to meet those goals.

In the beginning of the training year, caseloads are lower, with increasing intensity as the year progresses. Resident progress is assessed by clinical supervisors during the course of informal and formal supervision, and supervisors and residents are expected to exchange feedback routinely as a part of the supervisory process; the evaluation procedures are meant to formalize this continuous information flow. While it is the responsibility of the training director and supervisors to ensure that evaluation occurs in a timely and constructive fashion, residents are encouraged and expected to take an active role. As trainees progress and increase their confidence and levels of responsibility, they receive more complex cases, more independent clinical work, the ability to pursue own training goals, and take on additional cases if desired. This is all determined in a collaborative nature between trainee, supervisors, and the Director of Training.

While training will build on and enhance the foundation of knowledge, skills, and proficiencies that define the practice of professional health service psychology, post-doctoral training in this Specialty must be of sufficient depth to develop more focused competence and expertise in the specific area of SMI/SED. This is accomplished through involvement in focused didactics and clinical experiences on teams and units devoted to working with persons with SMI/SED. Residents may also take part in more general placements and didactics with post-doctoral psychology residents in other specialty areas where these exist at a given academic training site.

A sample curriculum along with a sample sequence of training can be found in the Petition for Recognition of a Post-Doctoral Specialty in Serious Mental Illness Psychology (SMI Psychology) which can be accessed www.psychtrainingsmi.com.

Supervision

At a minimum, two weekly hours of individual supervision must be conducted by doctoral-level licensed psychologists who are involved in an ongoing supervisory relationship with the resident and have professional clinical responsibility for the cases on which they provide supervision. A postdoctoral resident must have a minimum of two doctoral level licensed psychologist supervisors, at least one of whom serves as the resident's primary supervisor.

Supervisory hours beyond the two hours of individual supervision may be provided either individually or via group supervision and must be provided by professionals who are appropriately credentialed for their role/contribution to the program. The primary licensed psychologist supervisor maintains overall responsibility for all supervision, including oversight and integration of supervision provided by other mental health professionals with psychological research and practice.

Resident and Program Evaluation

During each rotation, there should be a written evaluation of the residents' progress as well as verbal feedback given to the residents by each supervisor and the Director of Training. Feedback should be provided at several times during the rotation with the exact timing dependent on the duration of the rotation. Competency evaluations would typically be behaviorally based and any deficit areas addressed with the resident. Particular attention should be paid to ensuring that residents act ethically

and with understanding of and respect for the full range of diversity issues, particularly as these relate to persons with SMI/SED. Additionally, rotation learning objectives would be reviewed mid and end of rotation to determine appropriateness and status.

Residents would also be evaluated on their knowledge, skills and abilities related to their understanding and ability to use didactic and seminar information, ability to participate in supervision and to supervise others, provide consultation, teach and or provide training, work in interprofessional and discipline specific teams, and conduct research/evaluation activities.

At the end of each rotation, residents would normally complete an evaluation of supervisors and rotations, and at the end of the residency, evaluations of the residency overall, research opportunities, didactics, seminars and other components. This feedback will be used to modify, improve, and/or enhance the quality of residency training.

The *Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*, is suggested for use to evaluate residents and others who are developing competency for work with persons with SMI/SED. This *Instrument* is a modification (modified and used with permission) of the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel, et al., 2012).

The Petition for Recognition of a Post-Doctoral Specialty in SMI Psychology contains additional useful information and sample forms and may be accessed at www.psychtrainingsmi.com.

In Conclusion

These Training Guidelines were developed to provide guidance for post-doctoral psychology residency programs in SMI Psychology but may be used by any level of training program desirous of providing training for those wishing to work with persons with SMI/SED. The Guidelines are supported by additional information and materials previously developed including APA's Curriculum to train psychologists in recovery and rehabilitation practices for persons with SMI/SED (American Psychological Association & Jansen, 2014) and the Petition for Recognition of a Post-Doctoral Specialty in SMI Psychology developed for submission to APA in application for recognition of this Specialty. These and other materials are free and available on line and will be updated as new information and developments become available.

References

- American Psychiatric Association. (2013). Cultural formulation. In: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association, 749-759.
- American Psychological Association, Commission on Accreditation. (2015). *Standards of Accreditation for Health Service Psychology*. Washington, DC: American Psychological Association. Retrieved from <http://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf>.

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010 and January 1, 2017). Retrieved from <http://www.apa.org/ethics/code/index.aspx>

American Psychological Association & Jansen, M. A. (2014). Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders. Washington, DC: American Psychological Association. Downloadable from: www.apa.org/pi/rtp

Certification Commission for Psychiatric Rehabilitation. September 28, 2012. Code of Ethics for Psychiatric Rehabilitation Practitioners. Psychiatric Rehabilitation Association. https://www.psychrehabassociation.org/sites/default/files/images/CPRP-Code_of_Ethics_REV.pdf

Falender, C. A., & Shafranske, E. P. (2004). Clinical supervision: A competency-based approach. Washington, DC: American Psychological Association.

Fazel, S., Singh, J. P., Doll, H., & Grann, M. (2012). Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24 827 people: systematic review and meta-analysis. *BMJ*, 345:e4692 doi: 10.1136/bmj.e4692.

Glynn, S. M. & Mueser, K. T. (2018). Schizophrenia. In Hunsley, J. & Mash, E. J. (Eds.). *A Guide to Assessments that Work* (Second Edition). New York, NY: Oxford University Press.

Jansen, M. A. (2018). Psychosocial services for individuals with serious mental illness/severe emotional disturbance: Clinical practice guideline toolkit. *Psychiatry: Interpersonal and Biological Processes* (special issue on Emerging Psychosocial Interventions), 81, 1, 3-21.

Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... Heinessen, R. K. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173, 4, 362-372.

Karel, M. J., Holley, C., Whitbourne, S. K., Segal, D. L., Tazeau, Y., Emery, E., ... Zweig, R. (2012). Preliminary validation of a tool to assess knowledge and skills for professional geropsychology practice. *Professional Psychology: Research & Practice*, 43, 2, 110-117.

Kreyenbuhl, J., Buchanan, R.W., Dickerson, F. B. & Dixon, L. B. (2010). The Schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2009. *Schizophrenia Bulletin*, 36, 1, 94-103.

National Collaborating Centre for Mental Health (2014). *Psychosis and Schizophrenia in Adults: The NICE Guideline on Treatment and Management in Adults* (update). CG 178. London, UK: National Institute for Health and Care Excellence.

Petition for Recognition of a Post-Doctoral Specialty in Serious Mental Illness Psychology (SMI Psychology) (www.psychtrainingsmi.com)

Stoltenberg, C. & McNeill, B. (2010). *IDM Supervision: An Integrative Developmental Model for Supervising Counselors and Therapists*. Rutledge, Taylor & Francis Group: New York, NY.

Appendix II: Clinical Practice Guideline Toolkit

Clinical Practice Guideline Toolkit for Psychologists Working with Persons with Serious Mental Illness/Severe Emotional Disturbance

Introduction

This document presents a short, easy to use guideline for psychologists working with people with SMI/SED, particularly those with schizophrenia, schizoaffective disorder, delusional disorders, other psychotic disorders, or depression with a significant impact on functioning, and may be of use for those working with individuals with bipolar disorder. Persons with these disorders may have co-morbid, but not primary, substance use, exposure to trauma, or personality disorders. Individuals with severe emotional disturbance (SED) are typically youth/adolescents who have early warning signs of psychosis or early onset psychosis. For youth with early warning signs, this period is often referred to as the prodromal syndrome.

The guideline presented here is comprised of a 6 page flowchart depicting the assessment and treatment steps psychologists should be aware of and be able to use with this population. Each step in the flowchart is accompanied by a short (1 – 3 page) explanation of the components of that step. The explanation is fully referenced for those wishing further information or clarification. This document is a modification of an article in press by the writer (Jansen, in press) which was written for a more general audience.

This guideline is not meant to supplant the more detailed, and excellent clinical practice guidelines that have been developed and published. Rather, the flowchart and explanation are designed as a short, step by step guide or tool that busy psychologists can use to ensure they are following the most appropriate course of action and providing the best PSR services possible for persons with these disorders. Program managers and administrators can also use this tool to evaluate the processes used in their service system to ensure that appropriate services are offered for the individuals in their care.

This guideline is also not meant as a substitute for comprehensive training in the practice of assessment and treatment for individuals with SMI/SED. As such, very little detail about the disorders, appropriate assessments and interventions is provided. Those providing services to people with SMI/SED should have received the specialized training needed to appropriately deliver the services needed by those with these disorders. Well trained psychologists will recognize that the process may appear to be simple and short; in reality providing services to this population is typically a lengthy and complex process requiring specialized training, knowledge, skills, and experience.

This information can be useful either for psychologists in frontline positions or in management and administrative positions. But, it does not include guidance about assessments and approaches that members of every profession might need such as prescription and management of medication, provision of substance abuse treatment, provision of independent living skills training, provision of peer support services, or provision of assistance with placements for specialized housing, to name but a

few. These other treatments and services are often needed by those with SMI/SED due to the many comorbidities and difficulties they frequently encounter and psychologists should help individuals access these services to ensure a comprehensive approach.

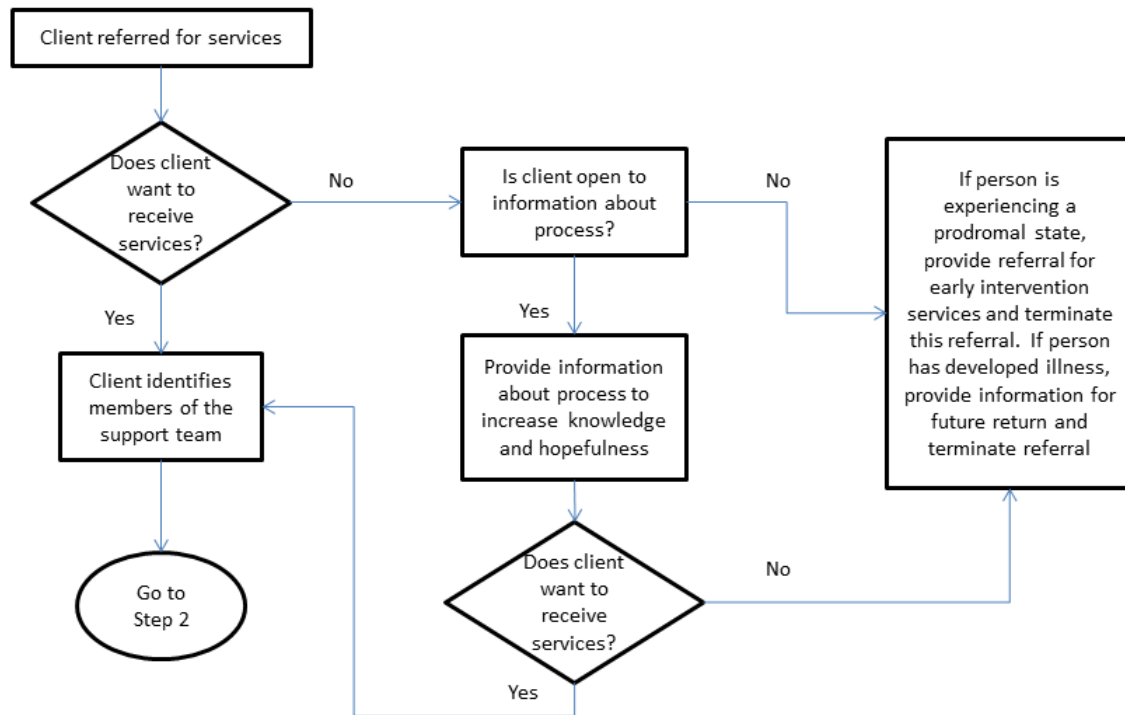
This guideline tool focusses on the process of delivering psychological and PSR services within a recovery framework. At this time, our knowledge about which services, or combination of services will work best for whom, under what specific circumstances, at what stage in a person's illness, and which providers are likely to have the most success is evolving. Presently, there is evidence that a combination of services provided to those in the prodromal period before onset of full psychosis or those experiencing a first episode of psychosis can be useful for preventing, delaying or reducing the severity of future psychotic illness. There is also emerging evidence that for those beyond the first episode, a combination of services that includes a range of cognitive treatments may be the best approach. These examples are provided in more detail in this guideline because the evidence is fairly clear at this time; however, suggestions about particular combinations of services beyond these two circumstances are not provided because to date, the evidence has not coalesced around any particular combination of treatments.

Other, more comprehensive guidelines such as the National Institute for Health and Care Excellence (NICE) (2014) guideline entitled Psychosis and schizophrenia in adults: prevention and management present detailed recommendations for each stage in psychosis from prevention through to first episode intervention, and on to comprehensive assessment and treatment. Psychologists as well as those in leadership positions such as team management and or administration should consult this and other comprehensive documents to ensure that the full range of needed services is provided, either through referral to appropriate agencies and providers, or through appropriate professionals within the team or agency, and to ensure that fidelity to evidence based practices is followed wherever possible. As of the writing of this document, the most comprehensive of these other guideline documents is the NICE guideline which can be accessed at <https://www.nice.org.uk/guidance/cg178>. The NICE guideline also contains a section on SED in youth and young adults, and as such is a comprehensive reference. There is also a NICE guideline for bipolar disorder, a guideline for substance use disorders, and guidelines for trauma and violence among others. These are excellent and comprehensive documents which are available on the website.

Notably, implementing the array of services that persons with SMI/SED find useful and desire can be challenging. This document is not meant to imply that providing this array of services is easy; on the contrary there are often substantial challenges to implementation and sustainability. A short discussion of some of these is presented in the final section along with some suggestions which may be helpful for overcoming these challenges.

Clinical Practice Guideline Flowchart

Step 1: Determination of Client's Desire for Services



Step 1: An Individual is Referred for Services

Individuals with SMI or those with early warning signs who have SED can be referred for clinical services or they may refer themselves for services. In either case, it is important to explain the kinds of services available and determine if the person wishes to receive such services.

In the event the person indicates a desire to not receive services, determining if the person would be open to learning more about the services available, including the potential benefits he or she could expect to receive is the first step. If the person declines to receive such information, it may be that the individual is experiencing the period before onset of full psychosis. This period has been called the “prodromal period”, and those in this state have been said to be at “ultra high-risk”, or to be experiencing an “attenuated psychosis syndrome” (Yung, Woods, Ruhrman, Addington, Schultze-Lutter, et al., 2012); the rate of onset of a psychotic disorder has been shown to be thirty six percent within three years (Fusar-Poli, Bonoldi, Yung, Borgwardt, Kempton, et al., 2012). For those at this stage, early intervention with a combination of interventions can be critical to help individuals avoid the severe developmental delays that often occur when SED is left untreated and progresses to SMI.

If the person is in the prodromal state or is experiencing a first episode of psychosis, a referral for early psychosis intervention services should be made because evidence indicates that reducing the duration of untreated psychosis leads to better long term outcomes (McGlashan, Evensen, Haahr,

Hegelstad, Joa, et al., 2011) and the longer intervention is delayed, the poorer the long term outcome. Although there are many factors that influence functional outcomes, there is growing evidence that early intervention with pharmacologic and PSR interventions during the first episode of psychosis can lead to improved outcomes (Álvarez-Jiménez, Parker, Hetrick, McGorry, et al. 2011; Bertelsen, Jeppesen, Petersen, Thorup, et al., 2008; Bird, Premkumar, Kendall, Whittington, et al., 2010; Kane et al., 2015) and may prevent or delay relapse (Álvarez-Jiménez, et al., 2011). Early intervention programs generally include the provision of multimodal PSR interventions (cognitive behavioral therapy, family based psychoeducation, illness management, educational and vocational interventions), pharmacotherapy, and some form of case management with lower case-loads and an assertive approach to treatment, all provided as early as possible.

If the person has progressed beyond the prodromal or first episode period and has developed an SMI, and declines to receive information about possible services, he or she should be given information about how to re-establish contact if desired at a later time and the referral would be terminated.

In the event the individual is unsure about taking part in services but agrees to receive the information offered, a description of the process, focus on attainment of client determined goals, and expected outcomes should be explained without exerting pressure on the person to continue. Presentation of such information is sometimes referred to as readiness assessment or readiness development (Anthony & Farkas, 2009) and is offered to encourage hope that by taking part in the services, the person's goals have a greater chance of being realized. Employing stages of change models and intensive assertive outreach can help people come to terms with their illness, the prior experiences they've had, the multiple issues they face, and potentially become ready to confront these challenges (Davidson, Roe, Andres-Hyman & Ridgway, 2010).

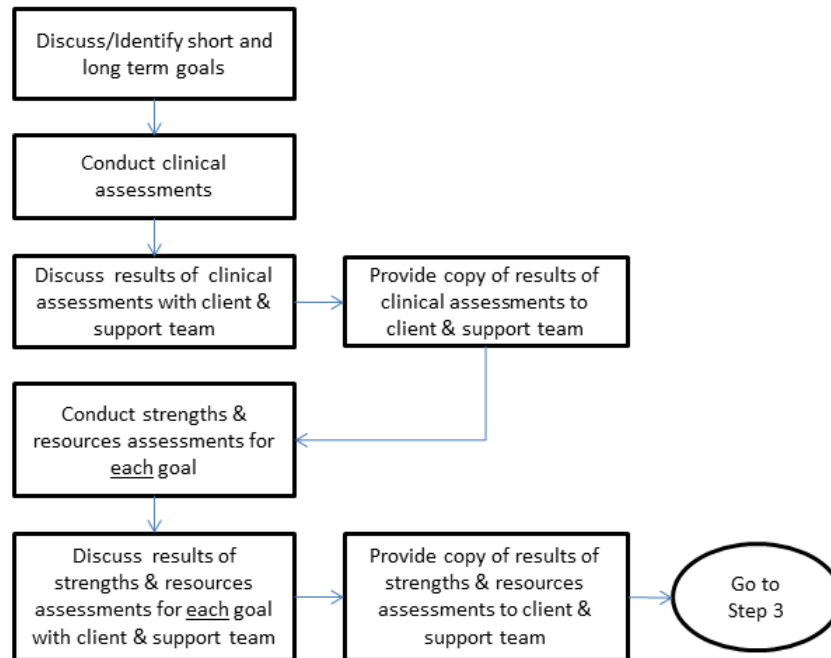
Following presentation of the information, the person should be asked if he or she wishes to participate in services. If the person declines, he or she should be referred for early psychosis intervention services if in the prodromal state or experiencing a first episode of psychosis; in all cases, information about how to re-establish contact if desired at a later time should be provided and the referral would be terminated. For everyone with mental health concerns, peers can be helpful and can enable an individual to feel more comfortable talking about the problems that are occurring and the opportunity to connect with a peer supporter should be offered.

If the person has decided to participate in services, or at least to take the first step toward participation, he or she is asked to identify one or more supporters who will assist as he or she moves through the process. These individuals, referred to in the flowchart as the support team, are full participants with the individual (as he or she wishes) and can assist in many ways. Note that the process is fully participatory, i.e., based on the notion that every person, including those with SMI/SED, has the right to make choices about the services to be received. Thus psychologists will likely offer suggestions and guidance about potential services, but the individual identified as the client should be the one directing his or her own service delivery plan (Green, Estroff, Yarborough, Spofford, Solloway, Kitson & Perrin, 2014).

Clinical Practice Guideline Flowchart

Step 2: Goal Identification and Assessment of Clinical Indicators, Strengths and Resources

NOTE: This and all remaining steps are carried out with the client & the team supports identified by the client unless otherwise directed by the client



Step 2: Goal Identification and Assessment of Clinical Indicators, Strengths and Resources

A true partnership with recipients of services, based on establishment of trust and rapport must be established if clinician suggestions are to be taken seriously and for services to be effective. Such a partnership is at the heart of person centered planning and shared decision making and can only be accomplished when the individual is the one who decides what goals he or she wishes to achieve, what services will best help him or her achieve the goals he or she has, and which providers would be best to facilitate the process (Zisman-Ilani, Barnett, Harik, Pavlo, & O'Connell, 2017).

At the beginning of Step 2, a process is initiated whereby the person identifies his or her short and long term goals. Those goals that can reasonably be expected to be accomplished within one year are chosen as short term goals and constitute those that become the focus of services. Longer term goals can be returned to once short term goals have been accomplished and a progress or monitoring review determines that the person is satisfied and wishes to continue and move on to longer term goals. Typically, the goal identification process would be repeated as the person's original long term goals may have changed after short term goal attainment has been accomplished.

Each person's goals should be written in the language used by the individual and can be written fairly broadly. Examples of broadly written goals include: "I want to be symptom free" or "I need to be able to deal with my symptoms", "I want to be able to think more clearly", "I want to return to school"; "I want to have a job"; "I want to live on my own", etc. All should be discussed fully including those that, to the clinician, may seem unrealistic; importantly the biases of the clinician should not supersede the wishes of the person receiving services. Each goal must be written down so that it is clear to the person and to all involved in the process, i.e., support team members and service providers.

Once the individual has decided on the goals he or she wishes to achieve, the assessment process can begin. In broad terms, two kinds of assessments are conducted: clinical assessments and assessments designed to identify the person's strengths and the resources available to the person.

Clinical assessments that provide information about medical history, diagnosis, distressing symptoms, medication use, alcohol and drug use, physical health/co-morbidities, neuropsychological status and cognitive functioning, etc., can be useful to psychologists as this information may be important when goals, skills, resources, and interventions are considered. It is crucial for psychologists to be aware of the potential for bias that is often introduced upon learning about a person's clinical status, and the potential impact of that bias on service planning and implementation of PSR interventions (Kaplan, 2013; Kopera, et al., 2015; Thornicroft, Rose, & Kassam, 2007).

A strengths based assessment measures skills, competencies and characteristics that contribute to a person's sense of accomplishment and self-worth and contribute to satisfying relationships with family members, peers, and friends, enhance one's ability to deal with adversity and stress, and promote development. A strengths based assessment that includes functional capability and resources available is needed for each goal the individual has identified.

More specifically, this component of the assessment process identifies strengths, skills, talents, accomplishments and challenges, in as much detail as possible; this approach also includes a determination of resources available or desirable in the person's surrounding environment such as his or her natural support network including family strengths, peer and community supports, and social service system network. A strengths based approach recognizes that every individual, no matter how severe the person's illness might be, has the capacity to continue to learn and develop. This capacity means that each person has the potential for future accomplishments that will facilitate continuing to attain the life he or she wishes to achieve (Davidson, Rowe, Tondora, O'Connell, et al., 2008; Pratt & Mueser, 2002).

Information for this assessment should be gathered about several life domains including emotional and psychological aspects, living situation, educational and vocational accomplishments and aspirations, socialization and leisure, financial and legal situation, and everyday circumstances in such realms as independent living, transportation, money management, etc., i.e., all the things considered most important to an individual.

There are many strengths-based assessments that have been developed; most are limited to one or more domains such as independent living and many have little empirical validation information available. Two that are broader in scope and have been empirically tested are the Client's Assessment of Strength, Interests, and Goals (CASIG), a version completed by a clinician (Wallace, Lecomte, Wilde & Liberman, 2001), the CASIG-SR, a self-report version, and the CASIG-I, an informant version (Lecomte, Wallace, Caron, Perreault, et al., 2004), and the Psychiatric Rehabilitation Training Technology: Functional Assessment (Cohen, Farkas & Cohen, 2007). These are by no means the only instruments available; psychologists should investigate the range of available measures and determine which will best meet the needs of the individuals they serve.

An important component of both clinical assessment and assessment of strengths and resources is the impact of the many cultural factors that can influence an individual's responses, experiences, development, health status and functioning. Examples include racial and cultural identity, gender identity and sexual orientation, social and economic factors, to name just a few. Psychologists need to be aware of the literature and be able to monitor their own biases, including their own prejudices and resulting stigma. Be especially cognizant of subtle language differences, beliefs about the etiology and acceptability of mental illness and gender concerns. These factors become critically important for assessment of immigrants, refugees, and children of these groups (Ellis, Lincoln, Charney, Ford-Paz, et al., 2010; Ellis, Miller, Baldwin, & Abdi, 2011; Said-Foqahaa, 2011).

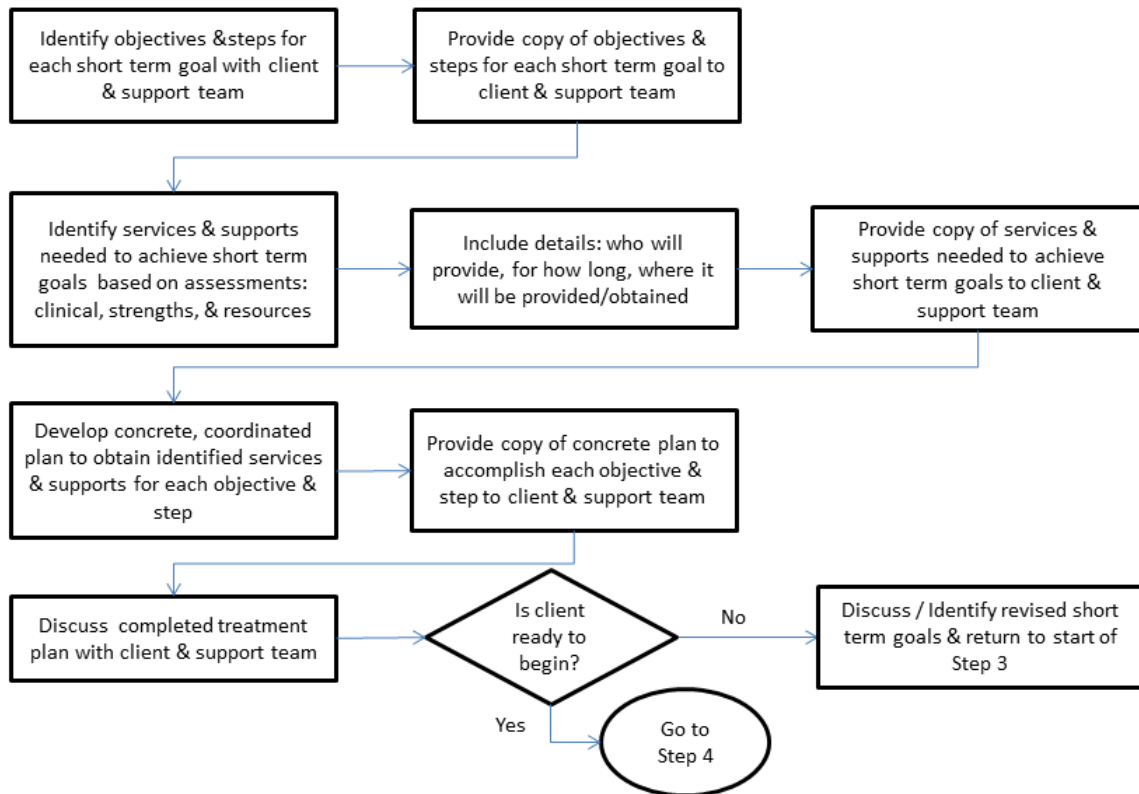
Given the critical nature of trauma and the role that this may play or have played in a person's life, psychologists need to be especially sensitive as they help the person identify the many facets and components of their life situation. Information from all domains should be factored into treatment planning recommendations to ensure a comprehensive plan is developed.

Determining an individual's strengths and capabilities is important for children and young people as well. The Outcomes Roundtable for Children and Families (a consortium of researchers, youth, family members, providers, and policymakers) identified important outcomes that all families want for their children, and noted that families seeking services for children with mental health concerns want services that promote the development of competencies, and functional lifetime outcomes. This focus transcends symptom reduction, and goes beyond reduction of deficits (Bellonci, Jordan, Massey, Lieberman, Zubritsky & Edwall, 2012). Psychologists conducting an assessment with youth should take these factors into account as well.

Once all components of the assessment have been completed a meeting is held with the client and the person's support team where all aspects of the assessment are reviewed and discussed. Following this, a comprehensive summary should be written that pulls together all information into an integrated whole that paints a coherent picture of the person and his or her world. All aspects of the assessment and summary are shared with the person, support team, and others according to the person's wishes.

Clinical Practice Guideline Flowchart

Step 3: Plan Development



Step 3: Plan Development

Following establishment of broadly defined goals and assessment of clinical status, strengths, functional capabilities, and available resources, objectives, i.e., the next steps needed to reach each identified goal must be identified. Objectives should be based on the results of completed assessments and are designed with the strengths and abilities of the person in mind. Objectives usually include the steps needed to overcome a challenge or barrier that was identified during the assessment or that is identified as the process moves forward. Objectives are developed with the person and should be achievable and realistic in that person's eyes.

The SMART (Doran, 1981) mnemonic adapted by Tondora (2011) for identifying objectives and the steps within each objective for every goal can be used in this process. Using this mnemonic means that each objective or step should be specific, measurable, attainable, realistic and have a realistic time frame for each. For each objective, there will likely be several steps and each of these will require an intervention. Specific guidance for accomplishing this step can be found at www.ct.gov/dmhas/lib/dmhas/publications/CSP-GoalsObjInt.pdf

Once all of the objectives and steps have been identified, fully discussed and a copy of all provided to the client and support team, it is time to determine which interventions or services are

needed to accomplish each step in each objective. Like objectives, interventions should be written in detail and should identify what the intervention will consist of, who will provide it, how often it will be provided, where it will occur, and for how long it will be provided. This requires a discussion of the strengths, resources and supports available, based on the assessments already completed. While interventions are often thought of as the purview of professionals, they may also be activities that are carried out by family members, supporting individuals, or by utilizing resources available in the community.

For people with SMI/SED, attainment of life goals often requires substantial assistance in the form of specially designed PSR services. While some people with SMI/SED may recover without assistance, many are unable to recover sufficiently to achieve the quality of life they desire without these specialized services (Moseley, Shen, & Cochran, 2008; Priester, et al., 2016; Silverstein, 2000; Therien, Lavarenne, & Lecomte, 2014; Van Hasselt, Oud, & Loonen, 2013). Several PSR services have been developed to overcome the psychological and behavioral deficits that so many individuals with SMI/SED confront. Those that have been shown in multiple randomized clinical trials to be highly effective are known as evidence based practices (EBPs); there are also several promising practices that are considered highly beneficial interventions (Dixon, Dickerson, Bellack, Bennett, et al., 2010).

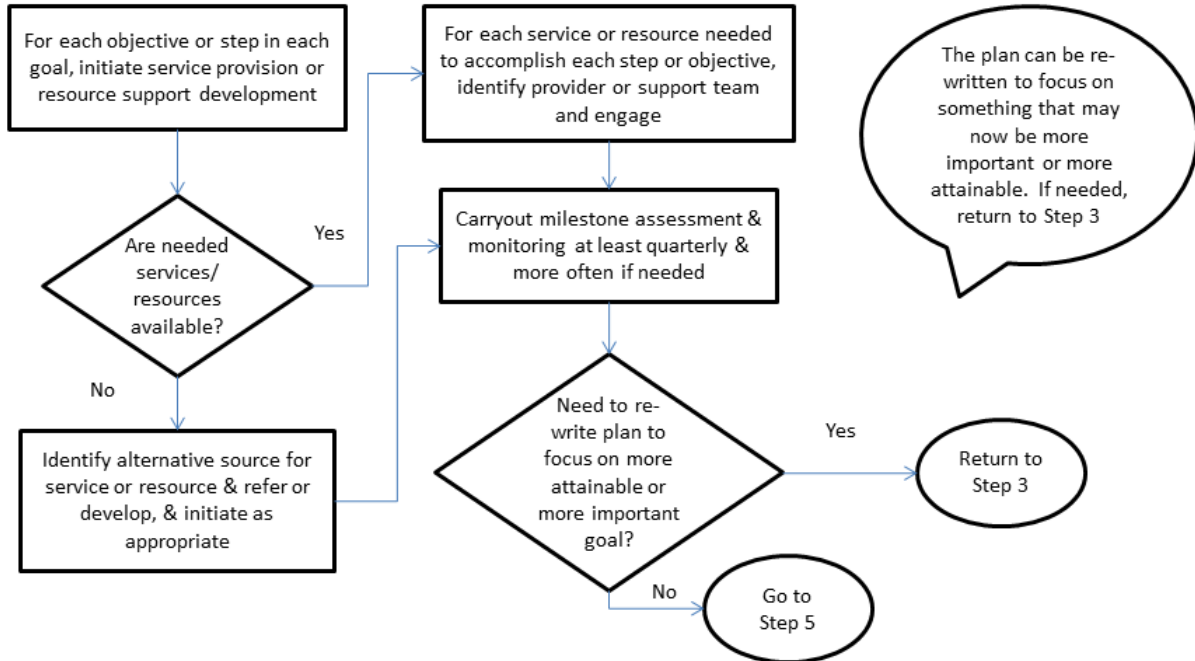
Within the last few years research evidence has accumulated indicating that an integrated approach combining multiple interventions within a recovery oriented context may be the most effective approach (Lyman, Kurtz, Farkas, George, Dougherty, et al., 2014; Spaulding & Deogun, 2011) and scholars are increasingly calling for such an integrated, recovery oriented system (Davidson & Chan, 2014). Such an approach must be targeted to the unique needs of each individual including those in forensic and criminal justice systems (Epperson, Wolff, Morgan, Fisher, Frueh & Huening, 2011; Strauss, 2014). Because cognitive impairment impacts the functional skill deficits so commonly experienced by people with SMI/SED, integrated approaches should include cognitive enhancement approaches as a fundamental component (Ikebuchi, et al., 2017; Mueser, et al., 2013; Pfammatter, Brenner, Junghan & Tschacher, 2011; Roder, Mueller & Schmidt, 2011). Social cognition training and cognitive remediation to improve community functioning and executive processing skills are considered by some to be essential. Indeed, some have stated that including cognitive remediation “may result in a magnitude of change that exceeds that which can be achieved by targeted treatments alone” (Pinkham & Harvey, 2013, p. 499).

Notwithstanding the above, no definitive combination of approaches has been determined to be most effective, although some combination of cognitive therapies (cognitive remediation, social cognition training, cognitive behavioral therapy), supported employment, psychoeducation (client/family approaches, illness management approaches), peer support services, and social and communication skills training, seems to be most promising. At the end of the day however, the range of interventions decided upon must be those that the client determines to be most appropriate for helping him or her to accomplish the goals he or she has chosen.

The totality of this information constitutes the treatment plan and, depending on the skills and resources available to the person, could be quite long with a long list of objectives, steps and interventions needed in order to reach the goal. Ensuring coordination among all involved is crucial. Thus, the person to be served, members of the support team, agency professionals - all involved in helping to accomplish a specific step or objective - need to be on board and working in sync.

Clinical Practice Guideline Flowchart

Step 4: Implementing the Plan - Services and Supports to Accomplish Identified Goals



Step 4: Implementing Services to Accomplish Identified Goals

In order for services to be successful, some conditions must be met. While there are several, three of the most important are mentioned below.

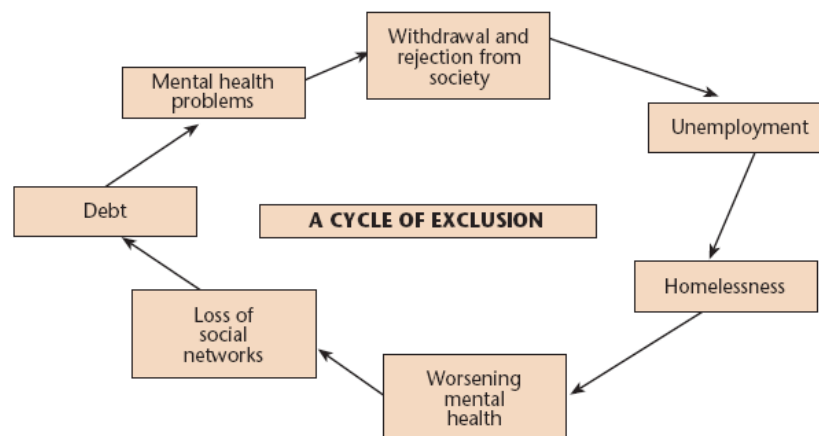
First, interventions must be provided within the context of an empathic, genuine, trusting relationship where the person with SMI/SED is involved in a partnership to agree on and design the components of services he or she will receive. Secondly, services must be provided within a cultural context, i.e., attention must be paid to the nuances of language, values, upbringing and potential implications and limitations that may impact acceptance of services. Thirdly, because of the very high rate of trauma experienced by individuals with SMI/SED, and our increasing knowledge of the importance of services that take this into account (Lu, Yanos, Silverstein, Mueser, Rosenberg, et al., 2013; Thompson, Nelson, Yuen, Lin, Amminger, et al., 2014; Varese, Smeets, Drukker, Lieveise, Lataster, et al., 2012), it is critical that services be provided within a trauma informed system and by providers with specialized training in this area (Manitoba Trauma Information and Education Centre, 2013).

While interventions are often thought of as the purview of professionals, they may also be activities that are carried out by family members, supporting individuals, peer support workers, or from resources available in the community. Many of the evidence based and promising practices require a

team of professionals and supporters in order for the service to be implemented accurately and with fidelity. Further, our definition of professional is changing and most psychologists and administrators now recognize the tremendous value that is added by inclusion of peer support personnel within the treatment team. In fact, peer support services are often cited by clients as one of the most helpful services they have received (Davidson, et al., 2012; Repper & Carter, 2011; Trachtenberg, et al., 2013). With respect to resource development, many interventions can be implemented by members of the client's support team with supervision by the psychologist. Some examples include provision of supported education, behavioral training to ensure success in supported housing, assistance with accessing health services, and advocacy and action to enhance social and community inclusion.

Interventions to enhance and build on a person's strengths are not limited to adults; these are ideal for children, young people, and older adults as well. Interventions that draw on strengths should be implemented across the age span at both individual and community levels (McCammon, 2012).

Helping individuals become accepted and included within their communities is an important but often overlooked component of the recovery model because psychologists and administrators may see this as outside their purview. The graphic below depicts the reality that can be experienced by a person who is stigmatized, marginalized, socially isolated and excluded (either intentionally or because he or she has not been involved before and is inadvertently left out). Exclusion leads to loss of opportunities (for employment, housing, fulfillment of civic duties, etc.) and further marginalization and isolation. A person in such a circular circumstance can find it difficult to become involved, leading to further exclusion and isolation. Anyone who has ever been left out knows that this kind of situation can be hurtful and it is easy to see how it could be traumatic for a person trying to recover from SMI/SED.



Source: Office of the UK Deputy Prime Minister, 2004

Because of the devastating effects of exclusion, all involved in the mental health service delivery system have a responsibility to work to ensure full integration as part of the treatment and rehabilitation services provided rather than assuming that these will be taken care of by someone else after the person leaves the service system (Farkas & Anthony, 2010; Salzer & Baron, 2016; Tondora,

2011). Interventions to help ensure that persons with SMI/SED are integrated into the community in which they live are components of the treatment process and should be built into all aspects of treatment planning.

Cognitive behavioral treatments including behavioral shaping to improve social and communication skills and help individuals feel confident about accessing health and other community services are often needed (Thornicroft, Brohan, Kassam & Lewis-Holmes, 2008); members of the person's support team can be helpful and may need to be trained to carry out this work and assist the person in learning the skills needed to be more integrated into the community.

People with SMI/SED very often internalize the stigma they experience from others; this is referred to as self-stigma (Corrigan, Morris, Michaels, Rafacz & Rüschi, 2012). Creating opportunities for people with and without SMI/SED to meet and interact has been shown to break down stereotypes and reduce stigma (Vaughan & Hansen, 2004). Many believe that peer support programs help to normalize the experience of having SMI/SED while traditional treatment tends to medicalize and stigmatize it (Nemec, Swarbrick, & Legere, 2015). Because of the very real negative impact that stigma and self-stigma can have on an individual's recovery efforts, several interventions have been developed and tested to help combat it (Conner, McKinnon, Ward, Reynolds, & Brown, 2015; Harris, et al., 2015; Mackay, Bradstreet, McArthur, & Dunion, 2015; Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2015).

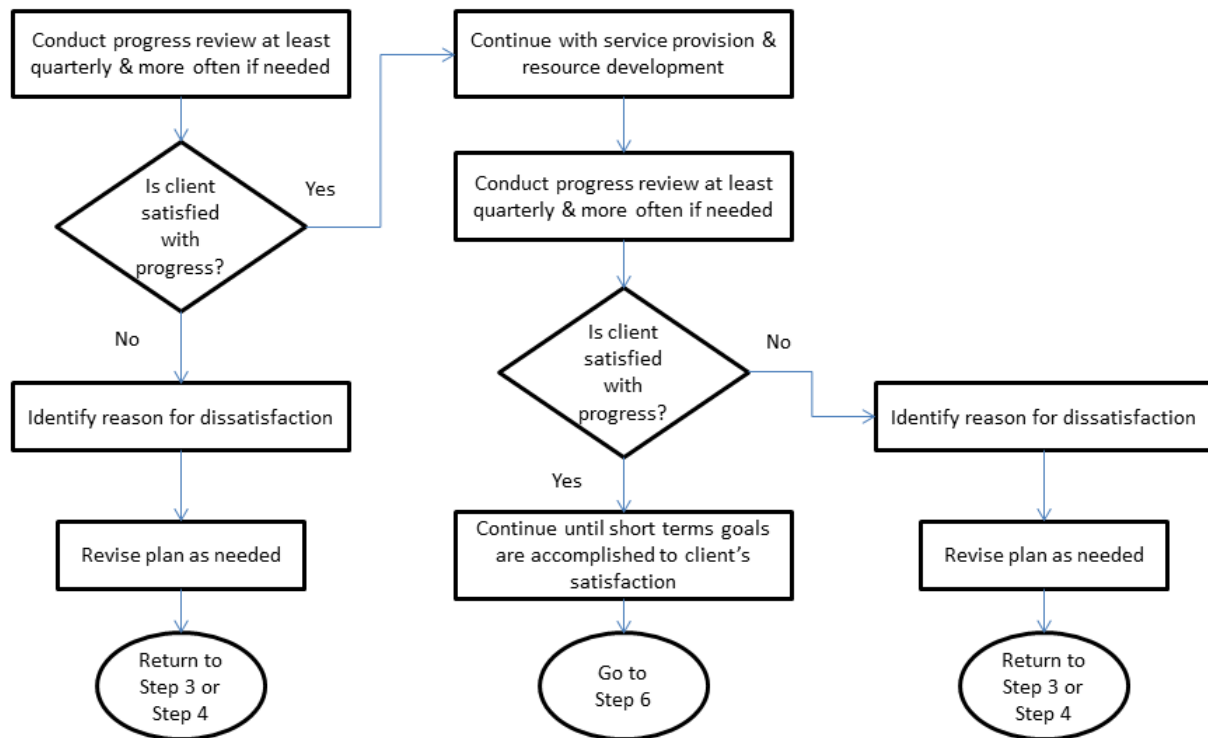
Due to resource limitations and the fact that many evidence based and promising practices require a large team working over several months in order to implement the practice with fidelity, every service needed to help an individual reach his or her goals may not be available within the team or agency. In such cases, it will be necessary to find an alternative source for the service or if there is no other source, attempt to develop it within the agency. Recognizing that developing new services can be resource intensive, it may be necessary to think creatively to find alternative ways to help the individual realize his or her goals.

Additionally, any conditions or problems identified during the assessment process that require services not traditionally found within the mental health system need to be addressed and persons should be referred to appropriate services. Physical health problems can easily be overlooked but are critically important because of the very high rate of serious health conditions such as cancers of all kinds, cardiovascular diseases, diabetes and metabolic syndrome that often lead to the premature morbidity and mortality seen in persons with SMI (Chiu, Chen, Chen, Yu, & Lu, 2010; Manu, 2011; Mitchell, Vancampfort, Sweers, van Winkel, Yu & de Hert, 2013). Due to the little recognized but highly prevalent stigma felt and demonstrated by health care practitioners toward persons with SMI/SED, following up such referrals is especially important (Joy, Clement, & Sisti, 2016; Pearlmutter, et al., 2017).

Assessing client satisfaction is an essential component of service provision and should be done quarterly and whenever milestones are achieved or problems arise.

Clinical Practice Guideline Flowchart

Step 5: Conduct Progress / Monitoring Reviews and Revise Plan as Needed



Step 5: Conduct Progress / Monitoring Reviews and Revise Plan as Needed

Continually monitoring progress and assessing the client's satisfaction are important steps that can be easily overlooked. These are critically important and should be carried out whenever a milestone has been reached or something has happened to impede progress. Setbacks are never seen as failures; rather they are an opportunity to re-direct as necessary. Progress reviews should be conducted as needed and at least quarterly. Planning can occur as often as the person wishes; it does not need to be an annual event or occur only when transitions are on the horizon.

Recently, the importance of formalized routine outcome monitoring (ROM) to assess service effectiveness has been recognized and systems in several countries have been developed to implement these efforts. Consistency of these efforts varies, however (Roe, Drake, & Slade, 2015). Results of outcome monitoring should be translated into treatment plan revisions/updates. This step can easily be overlooked; psychologists and managers should work to ensure that monitoring results are utilized (Tasma, et al., 2016).

There are several points when transitions will occur and planning for these is important. Some of these include times when the person is satisfied that goals have been achieved, requested services have been received, the person indicates a readiness to move on, or other life changes require

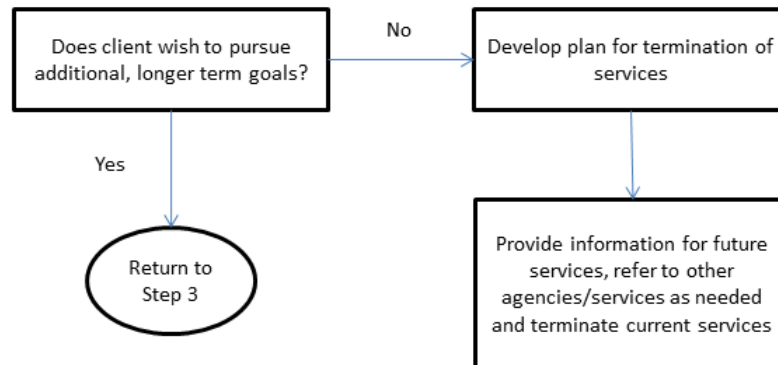
transitioning to a different planning process with the person. If the individual is to remain connected to the service system, a new planning process may be needed for the next phase of services.

At every progress review, the person's satisfaction should be ascertained and as with all clinical and other services, the individual should not feel expected to report satisfaction with progress, the plan for service, those working with him or her, or any other aspect of the process. Since the service plan is a partnership between the individual and his or her team of professionals and supporters, readiness to re-direct the plan as needed and respect for the individual's point of view must always be communicated.

Whenever the plan for services or resource development needs to be changed, it will be necessary to repeat one or more of the steps in the process in order to ensure that the revised plan can be implemented appropriately.

Clinical Practice Guideline Flowchart

Step 6: Transition Planning for Longer Term Goals or for Termination of Services



Step 6: Transition Planning for Longer Term Goals or for Termination of Services

Once the individual has accomplished as many of the short term goals as desired, he or she will need to determine the desirability of working on additional goals, typically those that are longer term. If the person indicates a desire to continue on to additional goals, the process would continue by returning to Step 3, Plan Development.

Often, individuals will have accomplished all that they wish to or will no longer need help from the clinician or mental health agency to tackle future goals. In this case, a transition plan would be developed with the individual and his or her support team. Importantly, information regarding availability of future services should be provided and referrals to other agencies/services would also be made as desired. Services would then be terminated.

Implementation: Challenges and Some Suggestions

There are several challenges faced by psychologists, program managers and administrators who seek to implement comprehensive programs aimed at helping persons with SMI/SED recover and achieve a satisfying and productive life in the community. These challenges are difficult to overcome, not to be taken lightly, and require flexibility and creative thinking. But, challenges should not deter us from working to provide the best possible array of services in an environment that is welcoming, respectful, normalized, and that views those who receive services as partners in the process. A thorough discussion of this topic is beyond the scope of this guideline, however, following is a short listing of some of the more frequently encountered challenges and a few suggestions; admittedly these suggestions seem lofty but may lead to creative solutions and service system improvements.

Some Challenges Frequently Encountered

Practitioner bias and negative attitudes;

Change is very difficult no matter how flexible we might be;

Resource limitations are a reality – comprehensive service provision is expensive and requires well trained staff;

Leadership changes are frequent leading to ever changing priorities;

Sustainability can be difficult even after changes have been implemented.

Some Suggestions

Assess the attitudes and vision of all stakeholders within the service or system;

Form partnerships of all stakeholders including service users, peers, families, advocates, community leaders, etc., and empower members with decision making authority;

Advocate for increased, sustainable funding;

Work toward hiring well trained professionals with a vision for recovery and rehabilitation;

Require and provide on-going training and supervision in recovery principles and PSR practices;

Objectively monitor and evaluate changes; provide accurate feedback to all stakeholders and be willing to modify plans based on feedback and monitoring results.

The challenges and suggestions presented above have been thoughtfully discussed by several authors including Clossey & Rowlett, 2008; Green, et al., 2014; Morris, Day & Schoenwald, 2010, to cite but a few.

Summary and Conclusions

This document presents a short, easy to use guide for those providing psychological and PSR services to persons with SMI/SED. It is designed to be a useful reference tool for psychologists and administrators who want to be sure that they or their service are providing the kind of comprehensive, evidence based care required for this population.

The guideline should be used by trained psychologists; it is not meant as a replacement for the specialized training required to provide the level and kind of assessment and treatment services needed by individuals with SMI/SED. Such training can be obtained by psychologists via their professional association, from accredited training programs, via post graduate training opportunities and through continuing education. In 2010 the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) initiated a program to develop a curriculum designed to train psychologists for work in this area and provided funding for APA to develop the curriculum. APA released free the curriculum in 2014 and it can be accessed via the APA website at <https://apa.org/pi/rtp>.

This guideline should also be used together with the more comprehensive and detailed practice guidelines that are available such as those developed by the UK's National Institute for Health and Care Excellence (NICE) which can be accessed at <https://www.nice.org.uk/guidance/cg178>.

References

- Álvarez-Jiménez, M., Parker, A. G., Hetrick, S. E., McGorry, P. D., et al. (2011). Preventing the second episode: A systematic review and meta-analysis of psychosocial and pharmacological trials in first-episode psychosis. *Schizophrenia Bulletin*, 37, 3, 619–630.
- Anthony, W. A., & Farkas, M. D. (2009). *Primer on the psychiatric rehabilitation process*. Boston, MA: Boston University, Center for Psychiatric Rehabilitation.
- Bellonci, C., Jordan, P. E., Massey, O. T., Zubritsky, C. & Edwall, G. (2012). *Reframing Mental Health Practice for Children, Youth, and Families: In Search of Developmental Competencies to Improve Functioning across Life Domains (Issue Brief)*. Outcomes Roundtable for Children and Families.
- Bertelsen, M., Jeppesen, P., Petersen, L., Thorup, A., et al. (2008). Five-year follow-up of a randomized multicenter trial of intensive early intervention vs standard treatment for patients with a first episode of psychotic illness: The OPUS Trial. *Archives of General Psychiatry*, 65, 7, 762-771.
- Bird, V., Premkumar, P., Kendall, C., Whittington, J., et al. (2010). Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: Systematic review. *The British Journal of Psychiatry*, 197, 350–356.
- Chiu, C. C., Chen, C. H., Chen, B. Y., Yu, S. H., & Lu, M. L. (2010). The time-dependent change of insulin secretion in schizophrenic patients treated with Olanzapine. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, 34, 6, 866-870.
- Clossey, L. & Rowlett, A. (2008). Effective organizational transformation in psychiatric rehabilitation and recovery. *Journal of Social Work in Disability & Rehabilitation*, 7, 3-4, 315-339.
- Cohen, M., Farkas, M. & Cohen, B. (2007). *Psychiatric Rehabilitation Training Technology: Functional Assessment*. Boston, MA: Boston University Center for Psychiatric Rehabilitation.
- Conner, K. O., McKinnon, S. A., Ward, C. J., Reynolds, C. F., III, & Brown, C. (2015). Peer education as a strategy for reducing internalized stigma among depressed older adults. *Psychiatric Rehabilitation Journal*, 38, 2, 186–193.

- Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D. & Rüsçh, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services*, 63, 10, 963–973.
- Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry*, 11, 2, 123-128.
- Davidson, L. & Chan, K. K. S. (2014). Common factors: Evidence-based practice and recovery. *Psychiatric Services*, 65, 5, 675-677.
- Davidson, L., Roe, D., Andres-Hyman, R., & Ridgway, P. (2010). Applying stages of change models to recovery from serious mental illness: Contributions and limitations. *Israel Journal of Psychiatry & Related Sciences*, 47, 3, 213–221.
- Davidson, L., Rowe, M., Tondora, J., O'Connell, M. J., et al. (2008). *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*. New York: Oxford University Press.
- Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., et al. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36, 1, 48-70.
- Doran, G. T. (1981). There's a S.M.A.R.T. way to write management's goals and objectives. *Management Review*, 70, 11 (AMA FORUM).
- Ellis, B. H., Lincoln, A., Charney, M., Ford-Paz, R., et al. (2010). Mental health service utilization of Somali adolescents: Religion, community, and school as gateways to healing. *Journal of Transcultural Psychiatry*, 47, 5, 789–811.
- Ellis, B. H., Miller, A. B., Baldwin, H. & Abdi, S. (2011). New directions in refugee youth mental health services: Overcoming barriers to engagement. *Journal of Child & Adolescent Trauma*, 4, 69–85.
- Epperson, M., Wolff, N., Morgan, R., Fisher, W., Frueh, B. C. & Huening, J. (2011). *The Next Generation of Behavioral Health and Criminal Justice Interventions: Improving Outcomes by*

Improving Interventions. New Brunswick, NJ: Rutgers University, Center for Behavioral Health Services & Criminal Justice Research.

- Farkas, M. & Anthony, W. A. (2010). Psychiatric rehabilitation interventions: A review. *International Review of Psychiatry*, 22, 2, 114–129.
- Fusar-Poli, P., Bonoldi, I., Yung, A. R., Borgwardt, S., Kempton, M. J., et al. (2012). Predicting psychosis: Meta-analysis of transition outcomes in individuals at high clinical risk. *Archives of General Psychiatry*, 69, 3, 220–229.
- Green, C. A., Estroff, S. E., Yarborough, B. J. H., Spofford, M., Solloway, M. R., Kitson, R. S. & Perrin, N. A. (2014). Directions for future patient-centered and comparative effectiveness research for people with serious mental illness in a learning mental health care system. *Schizophrenia Bulletin*, 40, Supplement 1, S1–S76.
- Harris, J. I., Farchmin, L., Stull, L., Boyd, J., Schumacher, M., & Drapalski, A. L. (2015). Prediction of changes in self-stigma among veterans participating in partial psychiatric hospitalization: The role of disability status and military cohort. *Psychiatric Rehabilitation Journal*, 38, 2, 179–185.
- Ikebuchi, E., Sato, S., Yamaguchi, S., Shimodaira, M., Taneda, A., Hatsuse, N., ... & Ito, J. I. (2017). Does improvement of cognitive functioning by cognitive remediation therapy effect work outcomes in severe mental illness? A secondary analysis of a randomized controlled trial. *Psychiatry and Clinical Neurosciences*, 71. DOI: 10.1111/pcn.12486.
- Jansen, M. A. (in press). Psychosocial services for individuals with serious mental illness/severe emotional disturbance: Clinical practice guideline toolkit. *Psychiatry: Interpersonal and Biological Processes* special issue on Emerging Psychosocial Interventions.
- Joy, M., Clement, T., & Sisti, D. (2016). The ethics of behavioral health information technology: Frequent flyer icons and implicit bias. *JAMA*, published online September 08, 2016. doi:10.1001/jama.2016.12534.
- Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... Heinssen, R. K. (2015). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *The American Journal of Psychiatry*, doi.org/10.1176/appi.ajp.2015.15050632.

- Kaplan, A. (June, 2013). Bias against schizophrenic patients seeking medical care. *Psychiatric Times*, 1-3.
- Kopera, M., Suszek, H., Bonar, E., Myszk, J., Gmaj, B., Ilgen, M. & Wojnar, M. (2015). Evaluating explicit and implicit stigma of mental illness in mental health professionals and medical students. *Community Mental Health Journal*, 51, 628-634.
- Lecomte, T., Wallace, C. J., Caron, J., Perreault, M., et al. (2004). Further validation of the Client Assessment of Strengths Interests and Goals. *Schizophrenia Research*, 66, 59–70.
- Lu, W., Yanos, P.T., Silverstein, S. M., Mueser, K. T., Rosenberg, S. D., et al. (2013). Public mental health clients with severe mental illness and probable posttraumatic stress disorder: Trauma exposure and correlates of symptom severity. *Journal of Traumatic Stress*, 26, 266-273.
- Lyman, D. R., Kurtz, M. M., Farkas, M., George, P., Dougherty, R. H., et al. (2014). Skill building: Assessing the evidence. *Psychiatric Services*, 65, 6, 727–738.
- Mackay, R., Bradstreet, S., McArthur, A., & Dunion, L. (2015). Dyad conversations about self-stigma in two Scottish communities. *Psychiatric Rehabilitation Journal*, 38, 2, 194–200.
- Manitoba Trauma Information and Education Centre. (2013). *Trauma Informed: The Trauma Toolkit*, Second Edition. Winnipeg, MB: Klinik Community Health Centre.
- Manu, P. (2011). Medical complications of treatment with antipsychotic drugs. *Romanian Medical Reviews & Research*, 1, 1.
- McCammon, S. (2012). Systems of care as asset-building communities: Implementing strengths-based planning and positive youth development. *American Journal of Community Psychology*, 49, 556–565.
- McGlashan, T. H., Evensen, J., Haahr, J., Hegelstad, W., Joa, I., et al. (2011). Early detection and intervention (EDI) in first episode psychosis: Can it increase the chance for full recovery? TIPS 10 year findings. *Schizophrenia Bulletin*, 37, (Supp 1), 273–274.
- Mitchell, A. J., Vancampfort, D., Sweers, K., van Winkel, R., Yu, W. & de Hert, M. (2013). Prevalence of metabolic syndrome and metabolic abnormalities in schizophrenia and related disorders—A systematic review and meta-analysis. *Schizophrenia Bulletin*, 39, 2, 306-318.

- Morris, J. A., Day, S. & Schoenwald, S. K. (Eds.). (2010). *Turning Knowledge Into Practice*. (2nd edition, revised). Boston, MA: The Technical Assistance Collaborative, Inc.
- Moseley, C., Shen, J., & Cochran, C. (2008). Mental health services availability and admission of the seriously mentally ill from the emergency department. *Journal of Health and Human Services Administration*, 31, 3, 292-308.
- Mueser, K. T., Deavers, F., Penn, D. L. & Cassisi, J. E. (2013). Psychosocial treatments for schizophrenia. *Annual Review of Clinical Psychology*, 9, 465-497.
- National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: Prevention and management*. NICE guidelines [CG178]. London, UK: Author.
- Nemec, P. B., Swarbrick, M., & Legere, L. (2015). Prejudice and discrimination from mental health service providers. *Psychiatric Rehabilitation Journal*, 38, 2, 203–206.
- Office of the UK Deputy Prime Minister. (2004). *Mental Health and Social Exclusion*. London, England: Social Exclusion Unit. Document copyrighted by the Crown and used with permission. Available at <http://www.socialfirmsuk.co.uk/resources/library/mental-health-and-social-exclusion-social-exclusion-unit-report>.
- Pearlmutter, M. D., Dwyer, K. H., Burke, L. G., Rathlev, N., Maranda, L., & Volturo, G. (2017). Analysis of emergency department length of stay for mental health patients at ten Massachusetts emergency departments. *Annals of Emergency Medicine*, DOI: <http://dx.doi.org/10.1016/j.annemergmed.2016.10.005>.
- Pfammatter, M., Brenner, H. D., Junghan, U. M. & Tschacher, W. (2011). The importance of cognitive processes for the integrative treatment of persons with schizophrenia. *Schizophrenia Bulletin*, 37 (suppl 2), 1–4.
- Pinkham, A. & Harvey, P. D. (2013). Future directions for social cognitive interventions in schizophrenia. *Schizophrenia Bulletin*, 39, 3, 499–500.
- Pratt, S. I. & Mueser, K. T. (2002). Schizophrenia. In: M. M. Anthony & D. H. Barlow (Eds.). *Handbook of Assessment and Treatment Planning for Psychological Disorders*. New York: The Guilford Press.

- Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *Journal of Substance Abuse Treatment*, 61, 47-59.
- Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20, 392-411.
- Roder, V., Mueller, D. R. & Schmidt, S. T. (2011). Effectiveness of Integrated Psychological Therapy (IPT) for schizophrenia patients: A research update. *Schizophrenia Bulletin*, 37 (suppl 2), 71–79.
- Roe, D., Drake, R. E., & Slade, M. (2015). Routine outcome monitoring: An international endeavor. *International Review of Psychiatry*, 27, 4, 257-260.
- Said-Foqahaa, N. (2011). Arab women: Duality of deprivation in decision-making under patriarchal authority. *Journal of Women of the Middle East and the Islamic World*, 9, 234–272.
- Salzer, M. S. & Baron, R. C. (2016). *Well Together – A blueprint for community inclusion: Fundamental concepts, theoretical frameworks and evidence*. Melbourne, Australia: Wellways Australia Limited.
- Silverstein, S. M. (2000). Psychiatric rehabilitation of schizophrenia: Unresolved issues, current trends, and future directions. *Applied and Preventive Psychology*, 9, 227–248.
- Spaulding, W. & Deogun, J. (2011). A pathway to personalization of integrated treatment: Informatics and decision science in psychiatric rehabilitation. *Schizophrenia Bulletin*, 37 (suppl 2), 129–137).
- Strauss, J. S. (2014). Psychological interventions for psychosis: Theme and variations. *The American Journal of Psychiatry*, 171, 5, 479-481.
- Substance Abuse and Mental Health Services Administration. (2014). *Recovery to Practice Curricula*. Available at <https://www.samhsa.gov/recovery-to-practice/rtp-curricula>.
- Tasma, M., Swart, M., Wolters, G., Liemburg, E., Bruggeman, R., Knegtering, H., & Castelein, S. (2016). Do routine outcome monitoring results translate to clinical practice? A cross-sectional

study in patients with a psychotic disorder. *BMC psychiatry*, 16, 1, 107, DOI 10.1186/s12888-016-0817-6.

- Therien, P., Lavarenne, S. A., & Lecomte, T. (2014). The treatment of complex dual disorders: Psychologists' and service users' perspectives. *Journal of Addiction Research & Therapy S*, 10, 006.
- Thompson, A. D., Nelson, B., Yuen, H. P., Lin, A., Amminger, G. P., et al. (2014). Sexual trauma increases the risk of developing psychosis in an ultra high-risk “prodromal” population. *Schizophrenia Bulletin*, 40, 3, 697–706.
- Thornicroft, G., Brohan, E., Kassam, A. & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: Candidate interventions. *International Journal of Mental Health Systems*, April, 1–7.
- Thornicroft, G., Rose, D., & Kassam, A. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry*, 19, 2, 113-122.
- Tondora, J. (2011). *Person-centered Care: From Theory to Practice*. [Training curriculum and tools]. Available from: <http://www.ct.gov/dmhas/cwp/view.asp?a=2913&q=456036>.
- Trachtenberg, M., Parsonage, M., Shepherd, G., & Boardman, J. (2013). *Peer support in mental health care: Is it good value for money?* London, UK: Centre for Mental Health.
- Van Hasselt, F. M., Oud, M, J. T., & Loonen, A. J. M. (2013). Improvement of care for the physical health of patients with severe mental illness: A qualitative study assessing the view of patients and families. *BMC Health Services Research*, 13-426.
- Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., et al. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective and cross-sectional cohort studies. *Schizophrenia Bulletin*, 38, 4, 661–671.
- Vaughan, G. & Hansen, C. (2004). Like minds, like mine: A New Zealand project to counter the stigma and discrimination associated with mental illness. *Australian Psychiatry*, 12, 113-117.

- Wallace, C. J., Lecomte, T., Wilde, J. & Liberman, R. P. (2001). Client Assessment of Strengths Interests and Goals (CASIG): A consumer-centered assessment for planning individualized treatment and evaluating program outcomes. *Schizophrenia Research*, 50, 105–119.
- Yanos, P. T., Lucksted, A., Drapalski, A. L., Roe, D., & Lysaker, P. (2015). Interventions targeting mental health self-stigma: A review and comparison. *Psychiatric Rehabilitation Journal*, 38, 2, 171–178.
- Yung, A. R., Woods, S. W., Ruhrman, S., Addington, J., Schultze-Lutter, F., et al. (2012). Whither the attenuated psychosis syndrome? *Schizophrenia Bulletin*, 38, 6, 1130-1134.
- Zisman-Ilani, Y., Barnett, E., Harik, J., Pavlo, A., & O'Connell, M. (2017). Expanding the concept of shared decision making for mental health: Systematic search and scoping review of interventions. *Mental Health Review Journal*, 22, 3, 191-213. doi.org/10.1108/MHRJ-01-2017-0002.

Appendix III: SMI/SED Evaluation Instrument

Instrument to Assess Knowledge and Skills of Psychologists working with Individuals with Serious Mental Illnesses and Severe Emotional Disturbances (SMI/SED)*

Council for Serious Mental Illness (SMI) Psychology*

Purpose

The evolving Specialty of SMI Psychology has developed this instrument to be used to evaluate psychologists who are developing the competencies needed to provide the specialized services to adults with SMI or youth/young adults with SED, their families, those who support them, and their care systems. The SMI Psychology Specialty believes that psychology trainees, their supervisors, and practicing psychologists can use this instrument, in whole or in part, to evaluate progress in developing SMI/SED competencies, and to help define ongoing learning goals and training needs.

Development of SMI/SED Functional Competencies and this Assessment Instrument

Functional Competencies for professional psychology practice with individuals with SMI/SED and their families and supporters were delineated during the 2016 meeting of SMI Psychology experts which was convened for this purpose and supported by a grant from the Board of Educational Affairs, and Division 18 of the APA. Such a training conference is similar to those held by other recognized specialties when they prepared their curricula, competencies and student/trainee evaluation materials. The meeting was convened by the APA Task Force on Serious Mental Illnesses and Severe Emotional Disturbance (TF SMI/SED) and by Division 18 of the APA, both of which are organizing members of the Council for Serious Mental Illness (SMI) Psychology; our base that developed and continues to develop the core materials in support of the SMI Psychology Specialty. The competencies and this Instrument are also presented on the Council's website (www.psychtrainingsmi.com).

To illustrate the breadth of the SMI Psychology Specialty, those in attendance at the meeting included a representative of the Board of Professional Affairs, members of the APA TF on SMI/SED, leaders of Division 18 and the Division's Section on SMI/SED, the ABCT SIG, and a representative from each of four post-doctoral programs with a specialization, Major Area of Study, in SMI/SED. The APA TF, the Division 18 Section, and the ABCT SIG include members who are also psychologists with lived experience of SMI/SED (an important strength of the SMI Psychology Specialty and somewhat different than other specialties).

The meeting focused on two principal themes: 1) ascertaining the distinctiveness of assessment and treatment approaches for persons with SMI/SED and 2) identifying the competencies important for post-doctoral specialized training. Following the meeting, all in attendance reviewed and provided input into the documents produced at the meeting, and agreed with their content. Specifics regarding the distinctiveness of post-doctoral training in SMI/SED were included in the Specialty Council's Petition to APA for recognition of the post-doctoral Specialty in SMI Psychology and a summary of the competencies developed at that meeting is included at the end of this document.

Subsequent to identification of the competencies, the Council decided that it would be prudent to use a format that was part of the successful recognition of another recognized specialty focused on a defined population. Thus, we requested and received permission from the Council of Professional Geropsychology Training Programs to modify the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel, et al., 2012) which was developed to assess the competencies outlined in the Pikes Peak Model of Training (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009) to meet the needs/competencies of the specialized psychologists working with individuals with SMI and SED, their families and supporters. The Council is most grateful to the Council of Professional Geropsychology Training Programs for granting this permission.

* Adapted with permission from the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool developed by the Council of Professional Geropsychology Training Programs

The CoPGTP Task Force on Geropsychology Competency Assessment developed the original version of this tool. Members were: Michele J. Karel, Chair; Jeannette Berman, Jeremy Doughan, Erin E. Emery, Victor Molinari, Sarah Stoner, Yvette N. Tazeau, Susan K. Whitbourne, Janet Yang, Richard Zweig. The original Geropsychology tool was adapted from previous efforts, as summarized by Hatcher and Lassiter (2007) and was developed for learners and supervisors to have a measure by which to gauge competence in serving older adults. Thus the SMI material has a solid foundation on which it built its own specialized tool.

The instrument adapted for SMI/SED use retains the purpose of a measure to gauge competence but in serving those with SMI/SED. Like the original tool, this instrument contains competencies that are specified by behaviorally descriptive items, and can be rated along a continuum from Novice to Expert. Some redundancy is inherent in this measure. The intent is to evaluate both the learner's knowledge base and skill set separately for the same domains, as the awareness of information and ability or experience in applying it may differ. The competencies are aspirational, rather than "required" of any particular psychologist. Even the most accomplished psychologist will have relative strengths and weaknesses across the spectrum of competencies for practice.

Professional Psychological Practice for SMI/SED

Psychologists who work with individuals with SMI/SED, their families and supporters provide assessment, intervention, consultation, and other professional services across a wide range of medical, mental health, residential, community, and other care settings with a population of demographically and socioculturally diverse adults, adolescents, and young adults. The SMI/SED competencies are applicable across varied treatment settings and populations. It is recognized also that each work area or training setting may call for the development of particular competencies, not all of which may be addressed in this document. Rather, core competencies for practice are highlighted. The knowledge and skill competencies reflect core practice attitudes needed to work with this population, including: recognition of scope of competence, self-awareness of attitudes and beliefs about the ability of individuals to recover and gain or re-gain functional capabilities, and achieve a satisfying and productive life.

Using the Competency Evaluation Instrument

This tool is intended to be used both by supervisors to assess trainees, and by psychologists to assess their own knowledge and skills. Supervisors in psychology training programs may choose to evaluate the domains relevant to the goals of their program. Evaluation should include the learner's perspective (self-assessment), observation of the learner's work (e.g., direct observation, audiotape, videotape, co-therapy), as well as regular supervision involving case discussion. Psychologists and trainees conducting self-assessments can use the instrument to evaluate their training and supervision needs in each area. The instrument also can gauge a learner's progress over time.

The learner can be rated on each knowledge domain and skill competency as Novice (N), Intermediate (I), Advanced (A), Proficient (P), or Expert (E), as described below. Each competency (highlighted in light gray in the chart below) is delineated by several specifiers (indicated by letters a., b., c., etc. in the chart). The specifiers are designed to help define the knowledge domain or skill competency and **do not need to be rated separately**. However, the specifiers can be rated individually if that level of assessment is desired. The tool can be modified to suit the needs of individuals or programs.

Rating Scale Anchors

This rating scale assumes that professional competence is developed over time, as learners develop knowledge and skills with ongoing education, training, and supervision. The anchors reflect developmental

N = Novice: Possesses entry-level skills; needs intensive supervision

I = Intermediate: Has a background of some exposure and experience; ongoing supervision is needed

A = Advanced: Has solid experience, handles typical situations well; requires supervision for unusual or complex situations

P = Proficient: Functions autonomously, knows limits of ability; seeks supervision or consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

levels of competence, from Novice through Expert. Because the scale reflects development of competence, the same scale can be used at different levels of training. For example, graduate practica students would be expected to perform at Novice through Advanced levels, while Postdoctoral Fellows would be expected to perform from Intermediate to Proficient levels. Development of knowledge and skills may differ significantly across domains, depending upon previous training experiences.

To illustrate use of the scale, below we provide a brief vignette and how an individual at each level might approach the case.

N = Novice: Possesses entry-level skills; needs intensive supervision

I = Intermediate: Has a background of some exposure and experience; ongoing supervision is needed

A = Advanced: Has solid experience, handles typical situations well; requires supervision for unusual or complex situations

P = Proficient: Functions autonomously, knows limits of ability; seeks supervision or consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

Vignette: *A 24 year-old African-American man is referred to the mental health clinic by his primary care physician because his mother reported that his erratic behavior has become more frequent and disturbing. In recent months, he has become depressed, increasingly disoriented, withdrawn, and is absent from home for several days at a time. His employer has reported him missing from or reporting late for work. He no longer takes care of his personal hygiene and sometimes complains of stomach problems, although the primary care physician has not offered a diagnosis for this. At the insistence of his mother, he very reluctantly has come to the clinic for an initial evaluation.*

Novice (N): Possesses entry-level skills; needs intensive supervision

Novices have limited knowledge and understanding of case conceptualization and intervention skills, and the processes and techniques of implementing them. Novices do not yet recognize consistent patterns of behavior relevant for diagnosis and care planning and do not differentiate well between important and unimportant details.

Example: The learner is able to identify salient symptoms, but does not appreciate possible contributions of potential medical or behavioral co-morbidities, neuropsychological complications, practitioner bias, family system factors, and fear of stigmatization to the individual's presentation, and does not know how to formulate differential diagnosis questions.

Intermediate (I): Has a background of some exposure and experience; ongoing supervision is needed

Experience has been gained through practice, supervision, and instruction. The learner is able to recognize important recurring issues and select appropriate strategies. Generalization of skills is limited and support is needed to guide performance.

Example: The learner recognizes multiple possible contributions to the person's presentation, is able to collect history from the patient (and his mother with his permission), administer clinical, cognitive, and functional screening tools, and consult with supervisor to discuss possible implications and to plan further evaluation. Learner may not appreciate complex family and cultural systems issues, and the possibility of practitioner bias of the family physician.

Advanced (A): Has solid experience, handles typical situations well; requires supervision for unusual or complex situations

Knowledge of the competency domain is more integrated, including application of appropriate research literature. The learner is more fluent in the ability to recognize patterns and select appropriate strategies to guide diagnosis and treatment

Example: The learner is able to integrate multiple sources of information (e.g., behavioral observation, cognitive testing data, medical records, collateral reports [mother, employer, supporters,(with the person's permission),] and complex history (medical, psychiatric, family, occupational, and cultural context) to rule out possibility of co-morbid physical and or behavioral conditions and make recommendations to the individual, his primary care provider and family about further assessment and treatment options. Learner consults with supervisor about local resources for persons with first episode psychosis early intervention programs, and how best to handle issues around the primary care provider's belief that "there is nothing physically wrong" with the patient.

N = Novice: Possesses entry-level skills; needs intensive supervision

I = Intermediate: Has a background of some exposure and experience; ongoing supervision is needed

A = Advanced: Has solid experience, handles typical situations well; requires supervision for unusual or complex situations

P = Proficient: Functions autonomously, knows limits of ability; seeks supervision or consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

Proficient (P): Functions autonomously, knows limits of ability; seeks supervision or consultation as needed

Proficiency is demonstrated in perceiving situations as wholes and not only summations of parts, including an appreciation of longer term implications of current situation. The psychologist has a perspective on which of the many existing attributes and aspects in the present situation are important ones, and has developed a nuanced understanding of the clinical situation.

Example: Learner is able to integrate information, as above, collaborate with family and relevant providers (e.g., family physician, psychiatrist, neuropsychologist, early intervention team, substance abuse team if appropriate, psychosocial rehabilitation (PSR) team, and social service providers for ongoing assessment and intervention for the patient and family, explore community support options). Learner functions as a full member of an interdisciplinary team to address the biopsychosocial needs of the client and his family, and is able to assume a leadership role.

Expert (E): Serves as resource or consultant to others, is recognized as having expertise

With significant background of experience, the psychologist is able to focus in on the essentials of the problem quickly and efficiently. Analytical problem solving is used to consider unfamiliar situations, or when initial impressions do not bear out.

Example: The psychologist is frequently contacted by other psychologists in the community to provide consultation regarding assessment and intervention options for persons with serious mental illness and severe emotional disturbance (SMI/SED). The psychologist is able to use the above case as a teaching example for the need to provide a thorough biopsychosocial assessment in complex cases, to implement an interdisciplinary team plan, and to be knowledgeable about the multiple resources needed to assist individuals with SMI and SED in the community.

N = Novice: Possesses entry-level skills; needs intensive supervision

I = Intermediate: Has a background of some exposure and experience; ongoing supervision is needed

A = Advanced: Has solid experience, handles typical situations well; requires supervision for unusual or complex situations

P = Proficient: Functions autonomously, knows limits of ability; seeks supervision or consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

NOTE: Ratings are only needed where the anchors are provided (highlighted in light gray). Specifiers (indicated by letters a., b., c., etc. in the chart) are designed to help define the knowledge domain or skill competency and do not need to be rated separately, unless that level of assessment is desired.

I. General Knowledge about Serious Mental Illness/Severe Emotional Disturbance (SMI/SED)	
I. A. Knowledge Base - The psychologist/trainee has <u>KNOWLEDGE OF</u>:	
1. Models of Development	N I A P E
a. Development as a life-long process encompassing early to late life, and encompassing both gains and losses over the lifespan, especially those that impact on the development of serious mental illness	
b. Different theories of normal versus pathological development and adaptation	
c. Biopsychosocial perspective for understanding an individual's physical and psychological development within the sociocultural context	
d. Concept of, and variables associated with, development of illness	
e. Relevant research on development and the impact of the various factors that can lead to illness and or functional impairment, including methodological considerations in cross-sectional and longitudinal research	
2. Epidemiology and Demographics	N I A P E
a. Demographic trends related to mental illness, particularly SMI and SED, including gender, racial, ethnic, and socioeconomic heterogeneity	
b. Resources to remain updated on the demographics of the population, including internet sites for: Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, Social Security Administration, Bureau of Labor Statistics, National Institutes of Health particularly National Institute of Mental Health, World Health Organization	
3. Biological, Psychological, Social Aspects	N I A P E
a. Biological and physiological (medical/health) aspects that may impact on development of SMI/SED	
b. Psychological characteristics/factors (behavioral, cognitive including attention, memory, executive functioning, language, and intellectual functions, personality, emotional expression and coping mechanisms) that may impact on development of SMI/SED	
c. Social and environmental factors (socialization, family dynamics, educational and work related) that may impact on development of SMI/SED	
d. Interactions among the three processes above that may impact development of SMI/SED	
4. Functional Capability	N I A P E
a. Relationship between functional abilities and decisions individuals make with regard to life domains including education, employment, healthcare, relationships, lifestyle and leisure activities, and living environment	
b. Relationship between functional ability and psychopathology, including how functional abilities of individuals with SMI and/or SED affect family and significant others	
c. Strategies commonly used to cope with functional limitations	
d. Impact of stereotypes and stigma on an individual's functional status and self-efficacy	
e. Ethical and legal issues which arise in the context of markedly impaired functional status and decision making capacity	
4. Psychopathology	N I A P E
a. Common types of psychopathology in terms of onset, etiology, risk factors, clinical course, associated behavioral features, and medical and psychological management of these disorders	

N = Novice: Possesses entry-level skills; needs intensive supervision

I = Intermediate: Has a background of some exposure and experience; ongoing supervision is needed

A = Advanced: Has solid experience, handles typical situations well; requires supervision for unusual or complex situations

P = Proficient: Functions autonomously, knows limits of ability; seeks supervision or consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

b. Differential presentation, associated features, age of onset, and course of psychological disorders and syndromes	
c. Under-recognized aspects of psychopathology which affect functional impairment and safety (e.g., trauma, suicide risk, substance use)	
d. Interaction of SMI/SED with the more common medical illnesses and medications and implications involved for assessment and treatment	
5. Diversity in the Population	N I A P E
a. The diversity of the population in general and the impact of cultural experiences on illness development and expression	
b. The unique experience of each individual: demographic, sociocultural, and life experiences and the interaction of multiple factors that may interact to influence an individual's patterns of behavior	
c. The varied preferences individuals with SMI/SED have in discussing mental health problems and their effect on functional capability with family, primary care providers, treatment team members, spiritual advisors, etc.	
I. B. Professional Functioning – The psychologist/trainee is <u>ABLE TO</u>:	
1. Apply Ethical and Legal Standards by identifying, analyzing, and proactively addressing complex ethical and legal issues:	N I A P E
a. Tension between sometimes competing goals of promoting autonomy and protecting safety of at-risk clients	
b. Decision making capacity and strategies for optimizing an individual's participation in informed consent regarding a wide range of medical, residential, financial, and other life decisions, and the possible presence of a psychiatric living will	
c. Surrogate decision-making as indicated regarding a wide range of medical, residential, financial, and other life decisions, e.g., changes in capacity depending upon current mental status/acute psychotic episode/in remission	
d. State and organizational laws and policies covering committal, assisted outpatient treatment, advance directives, conservatorship, guardianship, multiple relationships, and confidentiality	
2. Address Cultural and Individual Diversity of those with SMI/SED, their families, communities, & systems/providers by being able to:	N I A P E
a. Recognize gender, age, cohort, ethnic/racial, cultural, linguistic, socioeconomic, religious, disability, sexual orientation, gender identity, and urban/rural variations	
b. Articulate integrative conceptualizations of multiple aspects of diversity influencing those with SMI/SED, psychologists and other providers, and systems of care	
c. Adapt professional behavior in a culturally sensitive manner, as appropriate to the needs of the client	
d. Work effectively with diverse providers, staff, and students in care settings serving those with SMI/SED	
e. Initiate consultation with appropriate sources as needed to address specific diversity issues	
3. Recognize Importance of Teams	N I A P E
a. Understand the importance of diverse team members and their professional expertise	
b. Value the role that other providers play in the assessment and treatment of persons with SMI/SED	
c. Demonstrate awareness, appreciation, and respect for team experiences, values, and discipline-specific conceptual models	
d. Understand the importance of teamwork in settings where individuals with SMI/SED are seen to address the varied bio-psycho-social needs of this population	

N = Novice: Entry-level, beginner, needs intensive supervision

I = Intermediate: Some exposure and experience, ongoing supervision is needed

A = Advanced: Solid experience, handles typical situations well, supervision for unusual or complex situations is needed

P = Proficient: Functions autonomously, knows limits of ability and seeks supervision/consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

4. Practice Self-Reflection	N	I	A	P	E
a. Demonstrate awareness of personal biases, assumptions, stereotypes, and potential discomfort in working with people with SMI/SED, particularly those of backgrounds divergent from the psychologist/trainee					
b. Monitor internal thoughts and feelings that may influence professional behavior, and adjust behavior accordingly in order to focus on needs of the patient, family, significant others, and treatment team					
e. Demonstrate self-awareness and ability to recognize differences between the clinician's and the client's values, attitudes, assumptions, hopes and fears related to the illness, symptoms, functional capabilities, stigma, treatment, social supports					
d. Demonstrate accurate self-evaluation of knowledge and skill competencies related to work with diverse individuals, including those with particular diagnoses, or in particular care settings					
e. Initiate consultation with or referral to appropriate providers when uncertain about one's own competence					
f. Seek continuing education, training, supervision, and consultation to enhance competence related to practice					
5. Relate Effectively and Empathically	N	I	A	P	E
a. Use rapport and empathy in verbal and nonverbal behaviors to facilitate interactions with individuals, families, and treatment teams					
b. Form effective working alliances with wide range of clients, families, colleagues, and other stakeholders					
c. Communicate with individuals and their families, adjusting language and complexity of concepts based on the person's and family's level of sensory and cognitive capabilities, educational background, knowledge, values, and developmental stage					
d. Demonstrate awareness, appreciation, and respect for those with SMI/SED, families, and team perspectives, experiences, values, and conceptual models					
e. Demonstrate appreciation of client, family, and organizational strengths, as well as deficits and challenges, and capitalize on strengths in planning interventions					
f. Tolerate and understand interpersonal conflict and differences within or between clients, families, and team members, and negotiate conflict effectively					
6. Apply Scientific Knowledge	N	I	A	P	E
a. Demonstrate awareness of the scientific knowledge base related to individuals with SMI/SED including areas such as biological, psychological, social, and community influences; physical and mental health care, and incorporate this knowledge into interdisciplinary health and mental health practice					
b. Apply review of available scientific literature to case conceptualization, treatment planning, and intervention					
c. Acknowledge strengths and limitations of knowledge base in relation to individual case					
d. Demonstrate ability to cite scientific evidence to support professional activities in academic, clinical and policy settings					
7. Appropriate Business Practice	N	I	A	P	E
a. Demonstrate awareness of Medicare, Medicaid, and other insurance coverage for diagnostic conditions and health and mental health care services					
b. Demonstrate appropriate diagnostic and procedure coding for psychological services rendered					
c. Demonstrate medical record documentation that is consistent with Medicare, Medicaid, HIPAA, and other federal, state, local or organizational regulations, including appropriate documentation of					

N = Novice: Entry-level, beginner, needs intensive supervision

I = Intermediate: Some exposure and experience, ongoing supervision is needed

A = Advanced: Solid experience, handles typical situations well, supervision for unusual or complex situations is needed

P = Proficient: Functions autonomously, knows limits of ability and seeks supervision/consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

medical necessity for services and insurance companies	
d. Remain updated on policy and regulatory changes that affect practice, such as through professional newsletters and e-mail for a	
e. Demonstrate understanding of quality indicators for the care of individuals with SMI/SED	
8. Advocate for and Provide Care Coordination	N I A P E
a. Demonstrate awareness of possible individual and psychosocial barriers to individuals with SMI/SED accessing and utilizing health, mental health, or community services	
b. Advocate for clients' needs in interdisciplinary and organizational environments when appropriate	
c. Collaborate with clients, families, and organizational and community providers to improve access to needed health care, and residential, transportation, social, or community services	
II. Assessment	
II. A. Knowledge Base -- The psychologist/trainee has <u>KNOWLEDGE OF</u>:	
1. Assessment Methods for Individuals with SMI/SED	N I A P E
a. Current research and literature relevant to understanding theory and current trends in assessment of strengths, functional abilities and limitations, and resource needs	
b. Assessment measures or techniques which have been developed, normed, validated and determined to be psychometrically suitable for use with this population	
c. Importance of a comprehensive interdisciplinary assessment approach (e.g., including other health professionals' evaluations of medical or social issues)	
d. Multi-method approach to assessing those with SMI/SED (including cognitive, psychological, personality, functional and behavioral assessments, drawn from standardized instruments, self-report, interviews, and observational methods)	
e. Importance of integrating collateral information from family, friends, and providers, with appropriate consent, especially when cognitive impairment is suspected	
f. Need for baseline and repeated-measures assessments in order to understand complex diagnostic problems with multiple co-morbidities	
g. Assessment of aspects essential to understanding individuals with SMI/SED (e.g., trauma, potential abuse, suicide, etc.)	
2. Limitations of Assessment Methods	N I A P E
a. Criterion and age requirements, as well as specific standard normative data for testing instruments	
b. Limitations of testing instruments, including those not validated with SMI/SED samples, for assessing diverse individuals	
3. Contextual Issues in Assessment of Individuals with SMI/SED	N I A P E
a. The range of potential individual factors that may affect assessment performance (e.g., medications, substance use, medical conditions, cultural, educational, language background)	
b. The potential impact of the assessment environment on test performance (e.g., noise, lighting, distractions, etc.)	
c. The person's capabilities and resources that impact on recommendations from assessment data, e.g., ability to manage one's affairs vis a vis capabilities and demands	
II. B. Professional Functioning – The psychologist/trainee is <u>ABLE TO</u>:	
1. Utilize Assessment Instruments	N I A P E
a. Utilize assessment tools for mood, cognition, substance use, personality, and other clinical issues to guide and inform comprehensive assessment	

N = Novice: Entry-level, beginner, needs intensive supervision

I = Intermediate: Some exposure and experience, ongoing supervision is needed

A = Advanced: Solid experience, handles typical situations well, supervision for unusual or complex situations is needed

P = Proficient: Functions autonomously, knows limits of ability and seeks supervision/consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

b. Evaluate the person's understanding, appreciation, reasoning, and choice abilities with regard to capacity for decision making	
c. Utilize functional assessment tools to understand basic functional capabilities	
d. Evaluate age, educational, and cultural appropriateness of assessment instruments	
e. Consider reliability and validity data in using standardized instruments with individuals with SMI/SED	
f. Assess a person's ability to provide informed consent for psychological evaluation	
2. Utilize Information from Psychological Assessments	N I A P E
a. Interpret meaning and implications of testing data or reports for case conceptualization	
b. Integrate testing results with information from clinical interview with the person and collateral sources, including behavioral observations and interviews with family members and other supports, to formulate impressions and recommendations	
c. Assess an individual's motivation and readiness for treatment	
d. Make specific and appropriate recommendations, based on testing results, to inform treatment planning	
e. Translate testing results into practical conclusions and recommendations for clients, families, and other care providers	
3. Interpret Assessment Information and Conduct Differential Diagnosis	N I A P E
a. Distinguish between symptoms of lesser versus more severe pathology in making diagnoses	
b. Consider base rates, risk factors, and distinct symptom presentations of psychological disorders when making diagnoses	
c. Conduct differential diagnosis, including consideration of co-morbid medical issues and or substance use, and of medications that may influence an individual's presentation	
d. Utilize biopsychosocial case conceptualization based on clinical evaluation to inform initial recommendations or treatment plan	
4. Assess Risk	N I A P E
a. Identify risk factors for harm to self or others	
b. Screen and comprehensively assesses suicide risk	
c. Screen and assesses capacity for self-care including activities of daily living	
d. Screen and assesses for trauma and for risk of abuse in emotional, physical, sexual, financial, and neglect	
5. Refer for Other Evaluations as Indicated	N I A P E
a. Acknowledge personal level of expertise regarding appropriate and comprehensive assessment of individuals with SMI/SED and know when to refer or consult with other health care professionals	
b. Collaborate with professionals from other disciplines to assess specific functional capacities (e.g., social and communication skills, ability for work, continued education, ability to live independently or with supports)	
c. Utilize assessment data to inform need for more comprehensive, multidisciplinary assessment	
d. Recognize when a medical evaluation is indicated to rule out underlying medical or pharmacological causes of presenting symptoms	
6. Goal Development	N I A P E
a. Work with the person and his/her support team to develop short and long term goals and objectives based on results of clinical, functional, and available resource assessments	
b. Identify interventions and resources needed for each goal and objective	
7. Communicate Assessment Results and Recommendations	N I A P E

N = Novice: Entry-level, beginner, needs intensive supervision

I = Intermediate: Some exposure and experience, ongoing supervision is needed

A = Advanced: Solid experience, handles typical situations well, supervision for unusual or complex situations is needed

P = Proficient: Functions autonomously, knows limits of ability and seeks supervision/consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

a. Communicate results within the confines of federal, state, local, and institutional privacy and confidentiality rules and regulations	
b. Translate assessment results into practical recommendations for the person, family, supporters, and team, providing written recommendations and relevant psychoeducational materials understandable to stakeholders	
c. Appreciate legal and clinical contexts of capacity/competence evaluations (e.g., need for guardianship, loss of right to make decisions, live independently, drive, etc.)	
d. Provide recommendations to other providers and case managers to assure that treatment plans are informed by assessment results and are coordinated	
III. Intervention	
III. A. Knowledge Base – The psychologist/trainee has <u>KNOWLEDGE OF</u>:	
1. Theory, Research, and Practice	N I A P E
a. Basic clinical interventions which target behavioral features and psychological problems in individuals with SMI/SED and their caregivers	
b. Specialized interventions for individuals with SMI/SED (e.g., illness management, assertive community treatment, family psychoeducation, social integration strategies, skills training, cognitive remediation and social cognition strategies, employment and educational interventions, substance use interventions, weight management strategies, peer delivered services, interventions for those with SMI in forensic settings, token economy in residential/institutional settings)	
c. Broad research knowledge regarding the effectiveness of psychological interventions with individuals with SMI/SED (e.g., application of behavioral, cognitive, interpersonal, psychodynamic, family, early intervention, trauma, environmental/social inclusion, psychoeducational, group interventions)	
d. PSR, psychotherapeutic and psychopharmacological approaches to treating psychological disorders, as well as the consequences of not treating and side effects of possible treatments	
2. Health, Illness, and Pharmacology	N I A P E
a. The complexity and interplay of medical problems and health issues of concern for those with SMI/SED (smoking, weight gain, health system failures, stigma and reluctance to seek medical intervention, reluctance to use psychotropic medication)	
b. The possible impact of medications and procedures for medical and psychiatric problems, including detrimental side effects on symptom presentation, mental status, and treatment effectiveness	
c. The frequent comorbidity between chronic medical and psychiatric problems including substance use, and need to address both medical and mental health issues	
3. Specific Settings	N I A P E
a. The salience and presentation of ethical issues when employing interventions across varied care settings (e.g., confidentiality in context of team treatment planning, family and other supporters, privacy constraints in institutional settings)	
b. Adaptations of interventions appropriate to particular settings (e.g., focus on staff education and behavioral, environmental interventions in residential settings)	
4. Recovery and Rehabilitation Services	N I A P E
a. The underlying concepts and necessary components of the recovery paradigm for persons with SMI/SED	
b. Specific referral sources that are knowledgeable about and experienced in delivering appropriate services for persons with SMI/SED	
c. Referral processes and procedures to local community resources	

N = Novice: Entry-level, beginner, needs intensive supervision

I = Intermediate: Some exposure and experience, ongoing supervision is needed

A = Advanced: Solid experience, handles typical situations well, supervision for unusual or complex situations is needed

P = Proficient: Functions autonomously, knows limits of ability and seeks supervision/consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

d. Follow-up mechanism(s) regarding referrals for PSR services	
5. Ethical and Legal Standards	N I A P E
a. Informed consent procedures for services to individuals with SMI/SED and challenges to the capacity of some to provide informed consent	
b. Client's right to confidentiality and to be informed of limits of confidentiality	
c. State and organizational laws and policies covering abuse, advance directives, conservatorship, guardianship, restraints, multiple relationships, and confidentiality	
III. B. Professional Functioning – The psychologist/trainee is <i>ABLE TO</i>:	
1. Provide Effective, Evidence-based Interventions for Those with SMI/SED Including:	N I A P E
a. Adults with SMI (and other co-morbid conditions including substance use disorders) and their family caregivers	
b. Youth and young adults with SED or those with prodromal symptoms	
c. Family, friends, and other supporters of individuals with SMI/SED	
2. Apply Individual, Group, and Family Interventions	N I A P E
a. Together with the person and his or her support team, prioritize treatment goals as appropriate, taking into account multiple problem areas	
b. Integrate relevant treatment modalities	
c. Modify evidence-based and clinically informed intervention strategies to meet the specific needs of individuals with SMI/SED (e.g., cognitive impairments, differing belief systems, cultural practices, etc.)	
d. Provide psychoeducation as needed to help individuals, their support system and families understand the illness, its treatments, the lived experience of SMI/SED, the therapeutic process, and the interventions and strategies used	
e. Choose evidence-based treatment for individuals with SMI/SED based on appropriate assessments, capabilities, available supports and resources, and other factors relevant for the person's recovery	
f. Choose and implement intervention strategies based on available evidence for effectiveness with the client	
g. Provide directly or arrange from other providers, the evidence based PSR interventions developed and tested for this population	
3. Base Interventions on Empirical Research, Theory, and Clinical Judgment	N I A P E
a. Articulate theoretical case conceptualization and empirical support guiding choice of intervention strategies	
b. Describe the integration or adaptation of various strategies to meet the needs of particular clients	
c. Measure the effectiveness of intervention	
d. Make appropriate adjustments to treatment based on client response	
IV. Consultation	
IV. A. Knowledge Base – The psychologist/trainee has <i>KNOWLEDGE OF</i>:	
1. Prevention, Health Promotion and Social Integration	N I A P E
a. Incidence and prevalence rates of mental health problems in the general population and has specialized knowledge of these rates for individuals at risk for or with SMI/SED	
b. How to partner with family and local community resources for health promotion	
c. Strategies for community-based training/education for promoting preventive interventions	

N = Novice: Entry-level, beginner, needs intensive supervision

I = Intermediate: Some exposure and experience, ongoing supervision is needed

A = Advanced: Solid experience, handles typical situations well, supervision for unusual or complex situations is needed

P = Proficient: Functions autonomously, knows limits of ability and seeks supervision/consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

d. Strategies for helping communities be accepting and supportive of people with SMI/SED to help them integrate socially	
2. Diverse Clientele and Contexts	N I A P E
a. Multiple levels of intervention/consultation, including individuals, families, healthcare professionals, organizations, and community leaders	
b. Systems-based consultative and intervention models and their use with appropriate modifications in different settings	
c. Strategies and methods for collaboration to address individual and organizational needs	
3. Interdisciplinary Collaboration	N I A P E
a. The roles, and potential contributions, of a wide range of healthcare professionals in the assessment and treatment of individuals with SMI/SED	
b. How team composition and functioning may differ across settings of care	
c. Appropriate research methodology, including mixed methods in order to capture the best data for use in studying intervention effects	
IV. B. Professional Functioning – The psychologist/trainee is <i>ABLE TO</i>:	
1. Provide Consultation to Improve Assessment and Treatment for People with SMI and SED	N I A P E
a. Recognize situations in which consultation is appropriate	
b. Demonstrate ability to clarify and refine a referral question	
c. Demonstrate ability to gather information necessary to answer referral question(s)	
d. Advocate for quality care for individuals with SMI and SED with their families, professionals, health care services, facilities, programs, legal systems, and other agencies or organizations	
2. Provide Training	N I A P E
a. Assess learning needs of trainees related to varying levels of training and amount of experience within and across disciplines	
b. Define learning goals and objectives as a basis for developing educational sessions	
c. Provide clear, concise education that is appropriate for the level and needs of trainees	
3. Participate in Interprofessional Teams	N I A P E
a. Work with professionals in other disciplines to incorporate information about psychological assessment and treatment of those with SMI/SED into team treatment planning and implementation	
b. Communicate psychological conceptualizations clearly and respectfully to other providers	
c. Appreciate and integrate feedback from interdisciplinary team members into case conceptualizations	
d. Work to build consensus on treatment plans and goals of care, to invite various perspectives, and to negotiate conflict constructively	
e. Demonstrate ability to work with diverse team structures (e.g., hierarchical, lateral, virtual) and team members (e.g., including the ethics board, chaplains, families and support team members)	
4. Communicate Psychological Conceptualizations for SMI/SED	N I A P E
a. Provide clear and concise written communication of psychological conceptualizations and recommendations for assessment and treatment of people with SMI/SED	
b. Provide clear and concise oral communication of psychological conceptualizations and recommendations for assessment and treatment of people with SMI/SED	
c. Use appropriate language and level of detail for the target audience of the communication	
5. Implement Organizational Change	N I A P E
a. Advocate for appropriate services for persons with SMI/SED within and across various settings	
b. Conduct needs assessment for service delivery within the setting or program that serves	

N = Novice: Entry-level, beginner, needs intensive supervision

I = Intermediate: Some exposure and experience, ongoing supervision is needed

A = Advanced: Solid experience, handles typical situations well, supervision for unusual or complex situations is needed

P = Proficient: Functions autonomously, knows limits of ability and seeks supervision/consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

individuals with SMI/SED	
c. Develop policies and procedures for service delivery that involve all appropriate disciplines and staff members	
d. Evaluate effectiveness of service delivery model or program	
6. Participate in a Variety of Models of Service Delivery	N I A P E
a. Differentiate goals and models of care in community, residential, rehabilitation, acute, primary, home, supported housing, and other care settings	
b. Appreciate and be able to work within a variety of models of mental health care for this population, including integrated mental health services in primary care, specialty consultation, and home or community-based services	
c. Demonstrate awareness of strengths and constraints of various care models	
d. Demonstrate flexibility in professional roles to adapt to the realities of work in a variety of healthcare delivery systems	
7. Collaborate and Coordinate with Other Agencies and Professionals	N I A P E
a. Work with team members to create smooth and efficient transitions across health care settings for individuals with SMI/SED and their families	
b. Demonstrate respect for confidentiality and informed consent, as well as continuity of care, in coordinating with family members, other professionals, and agencies regarding treatment for those with SMI/SED	
c. Establish working relationships with local and national agencies and organizations, including advocacy groups, treatment facilities, service providers, legislative bodies that authorize and provide funding, universities that conduct research, etc.	
8. Recognize and Negotiate Multiple Roles	N I A P E
a. Identify the client and explicate the expectations of the relationship at the outset of the consultation	
b. Advocate on behalf of the well-being of clients within each professional role, including when the individual or group of clients is not the direct client (e.g., the actual client may be the organization)	
c. Discuss potential conflicts of interest with colleagues and teams as indicated	
d. Discuss financial arrangements with all stakeholders	

N = Novice: Entry-level, beginner, needs intensive supervision

I = Intermediate: Some exposure and experience, ongoing supervision is needed

A = Advanced: Solid experience, handles typical situations well, supervision for unusual or complex situations is needed

P = Proficient: Functions autonomously, knows limits of ability and seeks supervision/consultation as needed

E = Expert: Serves as resource consultant to others, is recognized as having expertise

Summary

It may help psychologists in training and/or supervisors to summarize knowledge and skill strengths, and areas for growth, based on this assessment. Areas for growth may then be linked to further goals for education and training.

Strengths: Knowledge and skill domains in which the trainee feels most confident and competent for practice with individuals with SMI/SED:

Areas for Growth: Knowledge and skill domains in which the trainee wishes to develop further competency:

Education and Training Goals (within a practicum, internship rotation, fellowship, or post-licensure program of self-study)

*Notes on the Development of the Original and this Instrument

The Council for Serious Mental Illness (SMI) Psychology requested and received permission from the Council of Professional Geropsychology Training Programs to modify the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel et al., 2012) which was developed to assess the competencies outlined in the Pikes Peak Model of Training (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009). The SMI/SED Council is most grateful to the Council of Professional Geropsychology Training Programs for granting this permission.

According to the information provided with the original instrument, development was informed by several important previous efforts. This information is included here in order to acknowledge those efforts. These included the APA policies on multicultural and evidence-based practice, extensive work on the assessment of competencies for professional psychology practice, competencies for geriatric and palliative care, and evaluation tools that have been used by geropsychology internship and fellowship programs. An abbreviated reference list of those efforts follows:

American Psychological Association (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58, 377-402.

American Psychological Association. (2004). Guidelines for psychological practice with older adults. *American Psychologist*, 59, 236-260.

American Psychological Association. (2006). *APA task force on the assessment of competence in professional psychology: Final report*. Washington, DC: American Psychological Association.

APA Board of Educational Affairs and Council of Chairs of Training Councils (CCTC) (2007). Assessment of Competency Benchmarks Workgroup: A developmental model for defining and measuring competence in professional psychology. Accessed at http://www.apa.org/ed/graduate/comp_benchmark.pdf

APA Presidential Task Force on Evidence Based Practice (2006). Evidence based practice in psychology. *American Psychologist*, 61, 271-285.

Hatcher, R. L. & Lassiter, K. D. (2007). Initial training in professional psychology: The Practicum Competencies Outline. *Training and Education in Professional Psychology*, 1, 49-63.

Karel, M. J., Holley, C., Whitbourne, S. K., Segal, D. L., Tazeau, Y., Emery, E., Molinari, V., Yang, J., & Zweig, R. (2012). Preliminary validation of a tool to assess knowledge and skills for professional geropsychology practice. *Professional Psychology: Research & Practice*, 43(2), 110-117.

Kaslow, N. J., Rubin, N. J., Bebeau, M. J., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., et al. (2007). Guiding principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice*, 38(5), 441.

Knight, B.G., Karel, M.J., Hinrichsen, G.A., Qualls, S.H., & Duffy, M. (2009). Pikes Peak Model for Training in Professional Geropsychology. *American Psychologist*, 64, 205-214.

Rodolfa, E., Bent, R., Eisman, E., Nelson, P. D., Rehm, L., & Ritchie, P. (2005). A cube model for competency development: Implications for psychology educators and regulators. *Professional Psychology: Research and Practice*, 36, 347-354.

SMI/SED Functional Competencies**

The specialized training needed includes: very different assessment methods which assess functional capability rather than symptomatology, EBPs and promising practices designed specifically for this population, interventions modified and found to be effective with people in this population within the forensic mental health system, research methods adapted for populations such as this, and systems transformation methods specific to large mental health systems that serve this population, to name but a few – these are the major areas of specialized training needed by psychologists to work with individuals with SMI/SED. With funding from a Board of Educational Affairs grant and from Division 18, a meeting was convened following the 2016 APA convention to identify the specific competencies that are needed to meet the training needs of psychologists. While it is recognized that not every post-doctoral specialty program could include all of these, the following competencies are those that would ideally be included or available to trainees:

Assessment

- Comprehensive knowledge of strengths based and functional capability assessments and ability to use these
- Ability to utilize standardized assessments in ways that may require modification in light of the fact that these assessments were not developed or normed using persons with SMI/SED
- Ability to competently utilize specialty assessments such as the Structured Clinical Interview (SCID for DSM), the Positive and Negative Syndrome Scale (PANSS), the Brief Psychiatric Rating Scale (BPRS), and the Brief Psychiatric Rating Scale for Children (BPRS-C) as needed and appropriate
- Ability to conduct an assessment of an individual's readiness and desire for PSR interventions
- Ability to conduct a strengths based assessment including an assessment of functional capability
- Ability to conduct an assessment of internal and external resource availability and the individual's ability to utilize available resources
- Ability to assess perceived recovery and life satisfaction/quality of life
- Ability to assess and address positive/psychotic and negative symptoms
- Ability to recognize psychosis and thought disorder and understand in depth the nuances of each condition considered within the purview of SMI/SED
- Ability to recognize and screen for potential cognitive deficits that are core areas of dysfunction for people with SMI/SED including processing speed, verbal memory, attention, and social deficits
- Ability to recognize limitations posed by cognitive impairments and potential for lessened insight and, as needed, ability to conduct behavioral observational assessments that accurately account for these
- Ability to assess for the potential risk for suicide and violence to self or others
- Ability to recognize and understand etiology of comorbid trauma and substance use disorders in SMI/SED disorders and be competent in differential diagnosis of similarly presenting diagnoses such as PTSD and personality disorders
- Knowledge of medication side effects especially those specific to psychotropic medications and ability to assess for medication adherence and barriers to adherence
- Ability to integrate the intersection of diversity related to age, cultural, spiritual/religious beliefs, etc. specifically related to the presentation of symptoms unique to SMI/SED
- Ability to recognize the level of capacity and competence of an individual with SMI/SED in order to make appropriate recommendations regarding interventions or to refer to appropriate specialty services including those provided by other disciplines

Interventions: Comprehensive knowledge of PSR interventions designed to foster recovery and meet the needs identified by each person:

Schizophrenia PORT evidence based and promising practices (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010) including:

- Assertive Community Treatment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others

- Supported Employment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
- CBT and CBTp – knowledge of differences between CBT and CBTp and ability to competently practice and supervise others in both interventions
- Family intervention/psychoeducation – knowledge of fidelity criteria and ability to implement intervention and supervise others
- Skills and CBT training – knowledge of how to competently practice and supervise others in practice
- Social learning program (Token Economy) – knowledge of intervention, its appropriate use, ability to implement and train and supervise others
- Integrated dual diagnosis treatment/Concurrent disorders treatment – knowledge of fidelity criteria and ability to implement intervention, participate on team, and supervise others
- Weight management approaches and Smoking cessation approaches – ability to competently implement appropriate interventions and supervise others
- Illness self-management including WRAP, behavioral tailoring for medication – knowledge of interventions, how to implement and supervise others
- Cognitive Remediation and Social Cognition Training – knowledge of interventions, ability to competently practice and supervise others
- PSR interventions for first episode psychosis (RAISE) – knowledge of and ability to implement intervention, participate on team, and supervise others
- Peer support/peer delivered services – knowledge of interventions and ability to implement and supervise peers and other professionals

Additional interventions to address critically important problems for people with SMI/SED including:

- Stigma/Self-stigma interventions – knowledge of, and ability to implement interventions to change attitudes and decrease discriminatory behaviors among health providers and the public at large
- Trauma interventions (trauma informed and trauma specific care) – ability to competently implement trauma interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care
- Suicide prevention – ability to recognize when individuals may be at risk and provide high levels of support, refer for medical intervention and provide treatment for depression in order to reduce hopelessness
- Violence prevention – ability to recognize when individuals may be at risk and refer for medical intervention while providing high levels of support
- Interventions to decrease homelessness – ability to provide a comprehensive array of services designed to facilitate supported housing, trauma informed care, relapse prevention for substance abuse, and support to maintain housing
- Motivational interviewing for those with SMI/SED – ability to competently implement motivational interviewing as appropriate and to supervise others in practice

Specialized interventions for forensic/criminal justice populations with SMI/SED including:

- Knowledge of the factors that impact on success for forensic and criminal justice populations with SMI/SED
- Forensic Assertive Community Treatment (FACT) – ability to ability to implement intervention, participate on team, and supervise others
- CBT for those in criminal justice/forensic settings – ability to competently provide specialized CBT services and to supervise others in practice
- IDDT/Concurrent disorders treatment for those in criminal justice/forensic settings – knowledge of the specialized needs of people with SMI/SED in these settings, ability to provide integrated mental health and substance use services targeted to the population, and supervise others in practice
- Trauma interventions for those in criminal justice/forensic settings (trauma informed and trauma specific care) – recognition of trauma as the norm for those with SMI/SED in the forensic and criminal justice system,

ability to competently provide trauma specific interventions including CBT for trauma, relapse prevention for alcohol and drug use, stress inoculation training for PTSD and other components of trauma specific care, including services for those at highest risk and to supervise others in provision of services

- Supported housing interventions for those in criminal justice/forensic settings – ability to implement comprehensive services to assure supported housing is available for individuals being released into the community
- Transition planning and follow-up for criminal justice/forensic settings – ability to implement adequate and appropriate transition planning and follow up for individuals being released into the community

Specialized interventions for people with bipolar disorder:

- In addition to demonstrating competence with the above interventions for people with SMI/SED (several of which are also recommended specifically for this population), an ability to competently provide interpersonal and social rhythm therapy (IPSRT) and Family Focused Treatment (FFT) for bipolar disorder and to supervise others in practice
- Understanding the potential of Dialectical Behavior Therapy (DBT) which may also be helpful for individuals with bipolar disorder and personality disorders dialectical behavior therapy (DBT) and to supervise others in practice

Consultation

- Ability to effectively present information and develop treatment recommendations that are understandable to the person, his or her support team, and in accord with his or her goals
- Ability to competently work with an interdisciplinary team and present information about persons with SMI/SED so that team members can understand and learn from the presentation
- Ability to apply specialty knowledge and expertise concerning SMI/SED symptomatology and diagnosis to problems that arise in professional settings
- Comprehensive knowledge of psychosocial functioning and recovery and ability to describe this to team members, other colleagues, and members of the public
- Ability to provide education and training for mental health staff on all aspects of the recovery paradigm and PSR assessments and interventions
- Ability to integrate all information into a case formulation using PSR interventions designed to promote recovery and attainment of the goals articulated by each person
- Ability to assist supervisees and team members in the management of difficult behaviors
- Ability to integrate the knowledge, values, and attitudes critical for successful work with people with SMI/SED into interdisciplinary team settings to facilitate shared decision making
- Ability to work with staff in specialized facilities such as supported housing, etc. to help them recognize and deal appropriately with symptoms and problem behaviors to help individuals with SMI/SED thrive in the community
- Ability to educate, train and supervise staff in the best ways to help people with SMI/SED manage symptoms, set and achieve goals for themselves, and use resources available to them. Some examples of potential issues include limit setting, stigma, empathy, delusions/hallucinations, reflective listening, crisis intervention - at all levels of training from front-line behavioral health staff through to highly trained staff and managers/administrators
- Ability to consult with families about their member's illness and the role of family in treatment
- Knowledge of resources to help with access to care (e.g., family members trying to get members into care and navigate complex system)
- Ability to educate and train staff in facilities and on specialized units for youth, young adults, and older persons where knowledge and expertise is lacking about behavior health particularly SMI/SED

Research and Evaluation

- Recognition of the importance of incorporating persons with lived experience of SMI into all aspects of research and evaluation from conception to completion and publication. This includes formulation of hypotheses, study questions and design, determination of statistical methods, participants to be recruited, etc.
- Knowledge of and ability to use mixed methods research designs
- Familiarity with and ability to use single case designs (disorders may be persistent over time and multiple baselines provides a more clear picture of the impact of different treatment components and their helpfulness with individuals)
- Recognition of ability to incorporate family members and first degree relatives into designs (research provides insight into how the illness manifests in individuals vs. family members looking at the phenotypes in individual and family)
- Recognition of importance of involvement of caregivers and other stakeholders in research and willingness to incorporate into designs
- Up to date knowledge of the latest assessments and interventions for this population
- Ability to utilize research/evaluation knowledge to adapt/modify assessments and interventions that have excluded persons with SMI and to do so appropriately recognizing when fidelity to the original practice is essential
- Recognition and understanding the needs of vulnerable populations vis a vis their participation in research efforts
- Recognition and understanding of the ability of persons with SMI/SED to provide informed consent
- Ability to inform and educate IRBs about the type of intervention research common with SMI populations such as PSR interventions
- Understanding of the unique needs of persons with SMI/SED vis a vis research/evaluation and ability to apply this knowledge to prevent/minimize drop out as typically this is different for SMI 1) drop outs tend to be doing worse and 2), severe economic disadvantages impact people with SMI disproportionately 3), follow up studies need to include more time (>1 year) due to the nature of the illness
- Knowledge of and ability to conduct multifactorial designs of programs as these are the norm with SMI populations; understanding of the importance of controls for non-specific factors
- Ability to identify appropriate outcomes for program evaluation work due to broad nature of quality of life, psychosocial functioning, recovery
- Ability to undertake program evaluation which is critical so that a developed program can be improved - systems within which SMI/SED persons are seen often more difficult to work with in structured research settings due to multiple stakeholders
- Ability to obtain buy-in from multiple under-resourced clients and stakeholders

Supervision/Teaching

- Comprehensive knowledge of all PSR assessments and interventions and ability to impart knowledge about these and to supervise others in practice
- Ability to provide education and training for mental health staff on all aspects of the recovery paradigm and PSR interventions
- Ability to impart knowledge about the importance of hope, respect, positive regard, and acceptance of person's goals and wishes with development of the therapeutic relationship which is key and sometimes difficult to form and to supervise others in their development of these
- Ability to impart an understanding of the pace and common non-linear process for recovery and ability to develop reasonably positive expectations for the person's progress despite the combination of social, functional, and cognitive impairments that are common
- Ability to help trainees and supervisees recognize incremental improvements and utilize the process of shaping in goal setting and recovery
- Ability to impart knowledge of the phenomenology of the disorders of SMI (e.g., auditory hallucinations, negative symptoms such as diminutions of basic drives, etc.)
- Ability to supervise effective goal setting that is often different in quality (i.e., level of difficulty) and outcome (i.e., type of goals set)

- Ability to promote self-examination of fear and pre-conceptualization of people with SMI including stigma and self-efficacy
- Ability to teach and supervise trainees about appropriate boundaries and differences in work this population
- Knowledge of standard tools for fidelity measures and ability to supervise trainees in their use
- Ability to use live or audiotape feedback to understand the often complex nuances of work with persons with SMI
- Ability to supervise a range of other mental health providers (e.g., psychiatrists, peers, nurses, social workers, occupational therapists)
- Knowledge of the complexity of systems change issues and ability to promote resiliency as resistance is encountered

Management/Administration

- Knowledge of needed systems of care and the importance of integration and interdisciplinary cooperation
- Familiarity with reimbursement structures and with PSR services that are not funded or are partially funded and ability to secure funding for needed specialized services
- Knowledge of Commission on Accreditation of Rehabilitation Facilities (CARF) requirements for accreditation and ability to implement changes needed to secure accreditation
- Knowledge of Joint Commission and Centers for Medicare and Medicaid Services standards and ability to implement changes needed to secure accreditation and ensure CMS standards are met
- Knowledge of the Americans with Disabilities Act and its amendments and application to those with SMI/SED
- Ability to lead effectively within complex multi-disciplinary teams and settings
- Knowledge of implementation and dissemination of EBPs for those with SMI/SED and the challenges of this in multiple, complex settings
- Recognition of the importance of conducting program evaluation and/or quality improvement studies and ability to convince team members of this and to implement?
- Comprehensive program development, i. e., full continuum of care that incorporates interventions and general understanding of aspects of the continuum of care
- Knowledge of the complexity of systems change issues and ability to implement needed changes
- Comprehensive knowledge of all PSR assessments and interventions and ability to impart knowledge about these and ensure cooperation and implementation within teams and overall system

Advocacy

- Ability to create opportunities for people to meet and interact with others, build social capital, promote community wellbeing, overcome social isolation, increase social connectedness and address social exclusion
- Knowledge of community resources and ability to reach out to these as a means of expanding access to services for people with SMI/SED
- Knowledge of community resources and ability to intervene to help with access to care (e.g., family members trying to get members into care and navigate complex system)
- Knowledge of laws that affect individuals with SMI/SED negatively and may lead to human rights violations (e.g., laws about competency restoration process, not guilty by reason of insanity, etc.).

**Developed by representatives of the APA Task Force on SMI/SED, Division 18 of the APA, the Division 18 Section on SMI/SED, the ABCT SIG, and representatives of post-doctoral programs with a specialization in SMI/SED.

Appendix IV: Minneapolis VA Post-Doctoral Residency in SMI Brochure

Psychology Postdoctoral Residency Training Program Minneapolis VA Healthcare System Serious Mental Illness Emphasis*

The Minneapolis VA Healthcare System (MVAHCS) offers psychology postdoctoral training with an emphasis in Serious Mental Illness (SMI) where residents spend at least 80% of their time devoted to training in psychosocial rehabilitation approaches for persons with SMI. Team Z is an interprofessional team that provides specialized mental health care to approximately 800 veterans with serious mental illness, such as Schizophrenia, Schizoaffective Disorder, and Bipolar Affective Disorder, although veterans with other diagnoses are also treated. The team consults throughout the medical facility and offers services to veterans from other mental health teams. The team's approach is client-centered with an emphasis on recovery-based, empirically-supported interventions. Our primary aim is to promote the individual's recovery, measured not only as a reduction in symptoms but also as improved functioning and life satisfaction, and participation in environments of one's choice. The majority of services are psychosocial rehabilitation interventions, although the team also provides traditional treatments such as medication management and supportive therapy. Treatment is coordinated to provide a full range of mental health services for veterans and their family members.

* Please note that the SMI residency is accredited as part of a clinical psychology program with an emphasis/focus in SMI. However, the SMI residency provides training that includes more than 80% of the resident's time devoted to psychosocial and psychiatric rehabilitation approaches for persons with SMI, which is consistent with a major area of study.

THE RESIDENCY PROGRAM: This residency program builds upon many aspects of the resident's previous training, providing a specialized set of skills and knowledge that has been demonstrated to be effective with the SMI population. In addition, the residency training model also emphasizes balancing breadth with depth. We expect that the postdoctoral resident will demonstrate a high degree of initiative and independence in working toward achieving his or her training goals and in meeting the complex psychological and medical needs of our veterans. Training is sufficiently broad to build the foundation of knowledge, skills, and proficiencies that define clinical psychology, and of sufficient depth to achieve competence and expertise in the major area of study of serious mental illness. This is accomplished through involvement in general requirement activities and didactics with all other Psychology Residents (as described elsewhere in training materials), as well as focused didactics and clinical experiences on Team Z. Time spent on activities related to Team Z and what would be considered to be the major area of study specifically in SMI is at least 80% of the resident's time. Training activities include attention to advancing development of core skills such as: assessment, treatment interventions and psychotherapy, consultation and multi-disciplinary teamwork, research and scientific inquiry, supervision and teaching, ethics, cross-cultural and diversity sensitivity, professional values, interpersonal skills, consultation and interprofessional skills. With this approach, residents will be prepared to leave their residency well-prepared to function successfully as an independent scientist practitioner with requisite expertise in working with persons with SMI. Another goal of the residency is to train the resident to function in leadership positions

and systems focusing on work with persons with SMI. Further, the resident will be prepared to transition to practice with an interprofessional team, promoting client-centered care and interprofessional collaboration.

Our training philosophy is strongly based in the scientist-practitioner model. Our program endorses the view that good clinical practice is based on the science of psychology. In turn, the science of psychology is influenced by the experience of working with complex cases. As a consequence, our approach to training encourages clinical practice that is evidence-based and consistent with the current state of scientific knowledge. Residents are trained to implement evidence-based practices for persons with SMI and critically evaluate new interventions. This approach is based on the belief that clients deserve access to treatments that have been proven to be effective for their specific concerns and condition(s). At the same time, we acknowledge the considerable complexities of clients in this setting and the limitations of our empirical base, especially in regards to SMI. We aim to produce psychologists who are capable of contributing to the profession by investigating clinically relevant questions through their own clinical research. While individual residents may ultimately develop careers that emphasize one aspect of the scientist-practitioner model more than the other, our expectation is that clinicians will practice from a scientific basis and that scientists will practice with a strong and informed clinical sensibility.

A developmental training approach will be used in which learning objectives are achieved primarily through experiential clinical placements under supervision and mentoring by one or more supervisors. In addition to developing core clinical psychological skills, which build upon the skill base attained through their pre-doctoral training and residency, we encourage greater reliance on self as the resident develops his or her professional identity as a psychologist. Training considerations take precedence over service delivery. Each resident's training plan is individually created to meet the specific training needs of the resident and to develop competence in a full range of community mental health and psychosocial rehabilitation skills. After orienting to the programs and training opportunities available, residents establish a training plan with their primary mentor. The resident's individual training needs and interests will determine the proportion of time allocated across settings. 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. Each resident receives supervision from several faculty members during the year, based on adjunctive rotations and specific experiences on Team Z.

THE RECOVERY APPROACH: Our primary aim is to promote the individual's recovery, measured not only as a reduction in symptoms but also as improved functioning and life satisfaction. The Minneapolis VAHCS endorses the beliefs and attitudes of the Psychiatric Rehabilitation Association (PRA). The mission of the PRA is to advance the availability and practice of psychiatric rehabilitation so that all individuals with serious mental illness have access to the supports they need to recover. This is based on the belief that individuals recovering from mental illnesses are able to successfully live and work in the community, enjoy active social lives, attend school, practice their faith, maintain a healthy lifestyle – all while managing their own illness with the supports they may need. Several team members have obtained their credentials as a Certified Psychiatric Rehabilitation Practitioner (CPRP) and promote the application of clinical practices that are consistent with recovery principles. The practice of psychosocial rehabilitation allows the clinician to provide leadership on interprofessional teams, consultation to other staff and systems of care, program design,

implementation and evaluation, and policy analysis and advocacy. We adhere to the core principles and values as identified by PRA:

- Psychiatric rehabilitation practitioners convey hope and respect, and believe that all individuals have the capacity for learning and growth.
- Psychiatric rehabilitation practitioners recognize that culture is central to recovery, and strive to ensure that all services are culturally relevant to individuals receiving services.
- Psychiatric rehabilitation practitioners engage in the processes of informed and shared decision making and facilitate partnerships with other persons identified by the individual receiving services.
- Psychiatric rehabilitation practices build on the strengths and capabilities of individuals.
- Psychiatric rehabilitation practices are person-centered; they are designed to address the unique needs of individuals, consistent with their values, hopes and aspirations.
- Psychiatric rehabilitation practices support full integration of people in recovery into their communities where they can exercise their rights of citizenship, as well as to accept the responsibilities and explore the opportunities that come with being a member of a community and a larger society.
- Psychiatric rehabilitation practices promote self-determination and empowerment. All individuals have the right to make their own decisions, including decisions about the types of services and supports they receive.
- Psychiatric rehabilitation practices facilitate the development of personal support networks by utilizing natural supports within communities, peer support initiatives, and self- and mutual-help groups.
- Psychiatric rehabilitation practices strive to help individuals improve the quality of all aspects of their lives; including social, occupational, educational, residential, intellectual, spiritual and financial.
- Psychiatric rehabilitation practices promote health and wellness, encouraging individuals to develop and use individualized wellness plans.
- Psychiatric rehabilitation services emphasize evidence-based, promising, and emerging best practices that produce outcomes congruent with personal recovery. Programs include structured program evaluation and quality improvement mechanisms that actively involve persons receiving services.
- Psychiatric rehabilitation services must be readily accessible to all individuals whenever they need them. These services also should be well coordinated and integrated with other psychiatric, medical, and holistic treatments and practices.

INTERPROFESSIONAL COLLABORATION: In 2012, the Department of Veterans Affairs began funding interprofessional training programs to nurture the development of highly trained mental health professionals who are able to provide patient-centered interprofessional team-based care. Clinical Psychology residents with Team Z will have the unique opportunity to be involved in the Interprofessional Practice and Education (IPE) training program. This is a training program housed

within Team Z offering specific educational instruction and clinical experiences that are designed to allow trainees from multiple disciplines (Nursing, Pharmacy, Psychology, and Social Work) to learn with, from, and about each other. Interactive learning methods are implemented, including seminars and discussions, observation of other clinicians, problem focused approaches, role playing, and clinical placements. This group learning facilitates the development of shared attitudes toward a model of mental illness, approaches of service provision, and values in general clinical practice. The IPE program places deliberate attention to the development and exploration of team process, not just clinical content and specific tasks to be completed. Clinical experiences are emphasized, so that trainees will see the connection between their educational experiences and ongoing clinical practice. The goal of the IPE program is to facilitate interprofessional collaboration (IPC) which is considered to be a key to enhancing mental health services provided to clients, families, and associated providers in the community; improving patient outcomes, cost efficiency, health care satisfaction; and training clinicians who are prepared to function in client-centered, team-based models of mental health outpatient care.

Although SMI residents share the same broad goals and competencies of the other clinical psychology residents, all trainees involved on Team Z will also be expected to develop competencies in specific domains of interprofessional practice, as identified by the Interprofessional Education Collaborative Expert Panel (2016) for professionals in the United States:

- Values and ethics for interprofessional practice – work with individuals of other professions to maintain a climate of mutual respect and shared values
- Roles and responsibilities – use the knowledge of one’s own role and those of other professions to appropriately assess and address the healthcare needs of patients and to promote and advance the health of populations
- Interprofessional Communication – communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease
- Teams and teamwork – apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver and evaluate patient-/population-centered care and population health programs and policies that are safe, timely, efficient, effective and equitable

SENSITIVITY TO DIVERSITY: Our training program is sensitive to individual differences and diversity and is predicated on the idea that psychology practice is improved when we develop a broader and more compassionate view of what it is to be human – including human variations and differences. Our practice is improved further as we better understand the complex forces that influence a person's psychological development, including cultural, social and political factors. For these reasons, professional growth requires that training experiences offer opportunities for trainees to expand beyond their vision of the world and learn to understand the perspective of others. When this occurs, our practice can be more responsive to the needs of individuals and less constrained by our biases. For these various reasons, MVAHCS Psychology training programs place high value on attracting a diverse group of trainees and on maintaining an awareness of diversity issues during the

training year. Please see other sections of the training website that fully describe our program philosophy on diversity.

PRIMARY CLINICAL RESPONSIBILITIES: Clinical training involves practice experiences primarily on Team Z, which is housed in the Outpatient Mental Health clinic area in the main building of the MVAHCS. Team Z includes a team secretary and the disciplines of Nursing, Peer Support, Pharmacy, Psychiatry, Psychology, Social Work, and Vocational Rehabilitation. The weekly team meeting includes time to discuss client/family requests or needs, provide updates on client progress, review findings from recent procedures or assessments, and consult on cases. Treatment planning is completed in a collaborative manner, incorporating input from providers as well as consultation with the veteran and family regarding personal goals, preferences, values, and cultural considerations. It is not uncommon for providers from different disciplines to co-facilitate groups, hold joint meetings with clients to coordinate care, and consult with primary or specialty care. There are monthly journal club sessions, in which all team members are encouraged to present material relevant to their own practice and share with other disciplines on the team. Team members are located in the same clinic area and have ready access to one another. The resident will be located in the same office area as the other Team Z clinicians, thus assuring proximity of supervision and consultation when needed. Further, because the team collaborates in cross-discipline training efforts, the resident will have multiple clinicians to serve as role models for providing care and who will be available for consultation. Specific responsibilities will vary depending on training goals, resident experience, and availability of/need for services on the team. These will be coordinated with the resident's supervisor(s). Options may include:

- Intake interviews
- Diagnostic clarification/personality assessment
- Cognitive screening
- Neuropsychological assessment
- Inpatient psychiatric unit (1K) assessments
- CBSST pre- and post-group evaluations
- Collaborative treatment planning
- Individual therapy
 - Care coordination
 - Supportive therapy
 - Structured/focused psychotherapy (CBT, ACT, Behavioral)
 - Skills training
 - Psychiatric Rehabilitation Readiness assessments
 - Wellness Recovery Action Plans (WRAP)
- Family therapy - includes Behavioral Family Therapy (Mueser & Glynn, 1999)
- Group therapy
 - Cognitive Behavioral Social Skills Training (CBSST; McQuaid, Granholm, et al, 2000)
 - Social Skills Training (SST; Bellack, et al, 2004)
 - Multiple Family Therapy group (McFarlane, 2002)
 - Family Education Workshops (adapted from McFarlane, 2002)

- Psychiatric Rehabilitation Readiness (Center for Psychiatric Rehabilitation at Boston University, 2004)
- Wellness Management and Recovery (IMR/WMR; SAMHSA, 2003)
- Dual Diagnosis group (enhanced IMR; Meyer, Gingerich, Fox Smith, & Mueser, 2013)
- Support and Family Education (SAFE; Sherman, 2008)
- Behavioral Management for Auditory Hallucinations – Managing Voices (Buccheri, Trygstad & Dowling, 2000)
- Social Cognition and Interaction Training (SCIT; Roberts, Penn, & Combs, 2015)
- Provide clinical supervision to a lower-level Psychology practitioner (usually an advanced graduate student during their practicum clinical placement)
- Observation of Treatment Review Panel (TRP) meetings
- Observation of other disciplines on the team (medication management, Tardive Dyskinesia evaluations, etc)
- Lectures to medical students on topics such as Assessment of Psychosis or Psychological Assessment
- Consultation with other providers/teams/programs

SECONDARY CLINICAL PLACEMENTS: In addition to clinical work on the SMI Team and attending weekly seminars and supervision sessions, residents have several secondary requirements and electives designed to round out their residency year and provide experience with all key integrated psychosocial rehabilitation services across different levels of care. These experiences serving veterans with SMI will be offered through the Veterans Bridge to Recovery (VBR) program which is a Psychosocial Rehabilitation and Recovery Center (PRRC), the Mental Health Intensive Case Management (MHICM) program, the Psychiatric Partial Hospitalization (PPH) Program, and Therapeutic and Supported Employment Services (TSES). Each of these multidisciplinary programs emphasizes client-centered care, involving family and connecting with community resources. This training model allows for experiences with other programs that provide the continuum of services to veterans with SMI. In addition to these secondary placements with associated psychosocial rehabilitation programs, at least one clinical experience is expected to be in an area not exclusively serving veterans with SMI in order to meet training criteria of a minor rotation as required for all clinical psychology residents. Descriptions of these available adjunctive opportunities can be found on the MVAHCS Psychology Training website under Training Experiences - Clinical Experiences (in addition to selected focus or specialty area). Common adjunctive activities for prior SMI residents have included Dialectical Behavior Therapy (DBT) and Addictions Recovery Service (ARS).

Mental Health Intensive Case Management (MHICM): MHICM is the equivalent to an Assertive Community Treatment (ACT) program in the community, with the goal to promote, maintain and/or restore the mental health of persons with SMI who tend to use the greatest percentage of inpatient psychiatric services. The majority of services are provided in the community and/or at the veteran's home. The multidisciplinary MHICM team composed of Nursing, Peer Support, Psychiatry, Social Work, and Vocational Rehabilitation meets at least weekly to discuss new referrals, treatment plans for existing clients, and pending discharges for veterans who have succeeded on achieving recovery. Because MHICM blends clinical services with community resources, residents will have opportunities

to assist veterans and family members with real world problems where they occur and help identify resources to improve the veteran's quality of life.

Psychiatric Partial Hospitalization (PPH): The PPH program is a time-limited, intensive alternative to full hospitalization. Veterans enrolled in PPH are coping with an acute psychiatric episode and/or substance use concern, and are seeking more intensive outpatient services to avoid hospitalization. Organized within a therapeutic community, or milieu setting, the focus is on providing recovery-based services. The multidisciplinary PPH team composed of Nursing, Peer Support, Psychiatry, Psychology, Social Work, Program Specialist, and Creative Arts therapist meets three times per week to discuss new referrals, individualized treatment plans, and client progress. The broad range of treatments include, but are not limited to, case management, educational therapy, group therapy, music therapy, mind-body intervention, creative arts therapy, and medication management. Residents can expect to be involved in all aspects of the partial hospitalization programming, including interdisciplinary assessment, treatment and rehabilitation planning, relapse prevention, medical management, and interventions targeting the veteran, family (such as Friend and Family Day) and relevant community supports (such as therapeutic trip to Minneapolis Institute of Arts).

Supported Employment (SE) through Therapeutic and Supported Employment Services (TSES): Supported Employment is an evidence-based practice for persons with SMI. SE is a recovery-oriented program that helps individuals with SMI obtain and maintain competitive employment of their choice in the community with placement and long-term follow-along services. As SE is integrated with mental health services, the Vocational Rehabilitation Specialist (VRS) attends SMI and MHICM team meetings and works closely with the multiple disciplines represented on each team. The VRS spends a significant portion of time in the community meeting with veterans and employers in job search, job development, job coaching, and follow-along support activities. Residents will have opportunities to observe intake assessments, vocational plan development, collaborative treatment planning, community meetings with veterans and assisting them in job search activities or providing follow-along support services.

Veterans Bridge to Recovery (VBR): The Psychosocial Rehabilitation and Recovery Center (PRRC; locally called Veterans Bridge to Recovery, or VBR) is a recovery-oriented milieu treatment program for individuals with serious mental illnesses. This program is located in downtown Minneapolis in order to connect veterans with community resources. The multidisciplinary VBR team composed of Nursing, Occupational Therapy, Peer Support, Psychology and Social Work meets twice per week to discuss administrative and clinical issues. VBR is a long-term program with emphases on goal-setting, skills training, healthy living, and community integration. The program utilizes a variety of evidence-based treatments such as Wellness Management and Recovery, Wellness Recovery Action Planning, and Social Skills Training. Staff spend a significant portion of their time in the community with veterans participating in group activities that enhance skills for community living. Residents will have opportunities to conduct intake assessments, psychosocial rehabilitation counseling/coaching, educational groups, collaborative treatment planning, community integration outings, and to work across teams and programs to help veterans with SMI access needed services.

RESEARCH PROJECT: Training in research/dissemination consists of a program evaluation, research, or dissemination project that is developed by the resident and overseen by the research mentor. Residents in the SMI emphasis area may spend up to 25% of their time in research activities, based

on a 40-hour work week. (Please note that this is a different maximum for research activities during the official 40-hour work week than the other MVAHCS Psychology postdoctoral residents, who may coordinate to spend up to 49% of their time in research). Because residents typically work 45 to 50 hours per week, additional time both on and off site can also be used for research, depending on a resident's individual goals and the complexity of the research project. Research time devoted per week will vary over the course of the training year. Mentors assist residents in defining projects that can be completed within the training year. Residents may take advantage of collaborating with several of our very productive clinical researchers on staff. Presently, clinical research with veterans with SMI is focused on evaluating the efficacy of interventions for individuals with serious mental illness. Several interventions, including Family Psychoeducation, a cognitive-behavioral group, cognitive skills training and WRAP group involvement are the focus of ongoing investigations. A family study of schizophrenia that examines cognitive and brain-based markers of vulnerability to illness is also being conducted.

DIDACTICS/MEETINGS: In addition to the seminars required as part of the larger Psychology Post-Doctoral Residency program and meetings specific to an adjunctive rotation, the following activities are required for the Team Z Resident:

Team Meeting: The interprofessional Team Z meets once per week for one hour to review administrative issues and to discuss client/family requests or needs, update on client progress, review findings from recent procedures or assessments, and consult on cases.

Interprofessional Practice and Education (IPE) didactic seminars/consultation group: Residents will attend a meeting with all other trainees on Team Z each week. Presentations will focus on topics such as general mental health issues, serious mental illness, assessment/diagnosis/ treatment, psychiatric rehabilitation, interprofessional collaboration, leadership, and teamwork. Consultations will involve formal case presentations, informal case reviews, and group discussion regarding plan of care. Participants will be asked to reflect on learning experiences, observations of team process and dynamics, IPE group expectations/norms, team decision making, giving and receiving feedback, addressing conflict, turning to other disciplines for mentoring and networking, and individual progress towards goals. Trainees will have the opportunity to discuss issues related to interprofessional roles and collaborative practice. Material will initially be presented by faculty and possibly by other stakeholders such as veterans and family members, though later trainees themselves will present clinical information and results of group projects.

Team Z Journal Club: This seminar meets over the lunch hour once per month. This meeting provides an informal opportunity for Team Z members to present and discuss literature relevant to their practice and translate the literature to activities in the clinic with the veterans that we serve.

Psychiatry Grand Rounds: Didactic presentations for all mental health providers are held weekly at the MVAHCS and cover a wide range of mental health topics and medical illnesses by both local and visiting speakers.

RESIDENTS IN SMI EMPHASIS AREA: Residents with the SMI emphasis area have come from various graduate programs including Washington State University, University of Minnesota, Kent State University, University of Missouri at St. Louis, SDSU/UCSD Joint Doctoral Program in Clinical

Psychology, University of St. Thomas, Washington University in St. Louis, University of Illinois-Urbana/Champaign, and Wayne State University. Their internship programs included Minneapolis VA Healthcare System, Ann Arbor VA Healthcare System, Hazelden (Center City, MN), Indian Health Board of Minneapolis, Southwest Consortium (Albuquerque, NM) and Hennepin County Medical Center (Minneapolis, MN). They have gone on to work at locations such as St. Peter Regional Treatment Center (St. Peter, MN), Sanford Health (Fargo, ND), Hennepin County Medical Center, New Mexico Veterans Affairs Healthcare System (Albuquerque, NM), and Minneapolis VA Healthcare System.

TRAINING STAFF: Available resident mentors in what would be considered the SMI major area of study are Drs. Hegeman and Rodgers. Amy Wood, LICSW, our Local Recovery Coordinator (LRC), may also be available to work with residents. Recent research mentors have include Drs. Harris, Nienow, Sponheim and Urosevic, though other research mentors could be arranged based on an individual resident's research interests. Residents will have the opportunity to work with other staff from multiple professions during the course of their primary and secondary placements.

Appendix V: MIRECC Post-Doctoral Fellowship in Mental Illness Research & Treatment Brochure

VA Advanced Fellowship Program in Mental Illness Research and Treatment at the VISN 5 Mental Illness Research, Education, and Clinical Center (MIRECC)



VA Maryland Health Care System Baltimore Medical System

Melanie Bennett, Ph.D.

Director, MIRECC Education Core
209 West Fayette Street (VA Annex)
Baltimore, MD 21201

410-637-1859; Melanie.Bennett@va.gov

<http://www.mirecc.va.gov/visn5/research/fellowship.asp>

Overview of the Fellowship

The VA Advanced Fellowship Program in Mental Illness Research and Treatment at the VISN 5 MIRECC has two 2-year fellowship positions: one position for an MD Fellow from psychiatry, neurology, radiology, internal medicine, or other areas of medicine and one position for an Allied Health Fellow from clinical psychology, counseling psychology, social work, nursing, or pharmacy. The goal of our program is to train fellows to become leading clinical researchers in the area of serious mental illness. Fellows develop independent programs of research on topics related to psychosocial treatment development and implementation of recovery-oriented services. The program provides opportunities for mentored research training in psychosocial treatment development; individual, group, family, and community interventions; health services and implementation research; and research in psychopharmacology. Fellows engage in supervised clinical training, delivering clinical services both in settings that serve Veterans with serious mental illness as well as in other programs within fellows' areas of interest. In addition, fellows participate in educational activities with local, VISN-wide, and national reach within VA and benefit from academic experiences focused on biostatistical methods, health informatics, grant writing, and overall career development. Fellows spend approximately 65% of their time in research-related research and clinical activities, 25% of their time in clinical service and training activities, and 10% of their time in didactic and administrative activities. We are committed to ensuring a range of diversity among within our Fellowship and welcome applications from candidates representing different geographic areas, ages, racial and ethnic backgrounds, sexual orientations, disabilities, and life experiences.

We are one of 25 sites in the national VA Advanced Fellowship Program in Mental Illness Research and Treatment. Our Fellowship Program follows the broad organizational structure of the national program, which aims to provide clinical research activities in concert with clinical experiences over a two-year time frame. MIRECC Fellowship sites around the nation are linked electronically and by two-way interactive videoconference for learning, information sharing, and the development of a national laboratory in advanced psychiatry and psychology. Our program is affiliated with the University of Maryland, School of Medicine, Department of Psychiatry; this provides an outstanding collaborative and interdisciplinary setting for fellows. Our program has been in existence and offering postdoctoral training since 2003. Our fellows have established careers as experts in serious mental illness research and clinical care in VA, academic, and hospital settings.

The VA Capitol Health Care Network (VISN 5) serves Veterans from the entire state of Maryland, and portions of Virginia, West Virginia, and Pennsylvania, as well as the District of Columbia. Fellows' offices and research activities are housed in the Baltimore VA Medical Center, located in downtown Baltimore and adjoining the University of Maryland School of Medicine and Medical Center.

Applicants for the post-doctoral psychologist fellowship position must have graduated from an American Psychological Association (APA) or Canadian Psychological Association (CPA) accredited doctoral program in clinical or counseling psychology (or be on track to complete their graduate program prior to beginning the fellowship) and must have completed an APA- or CPA-accredited internship.

A successful candidate for the fellowship program will have participated in active programs of research with resultant presentations/publications and will have a history of specialty training in serious mental illness. The fellowship adheres strongly to a scientist-practitioner model of training. The candidate will demonstrate a commitment to the scientist-practitioner model as evidenced by history of research in serious mental illness, as well as training in empirically supported treatments for those with these conditions. Successful candidates will also demonstrate a commitment to serving Veterans and an interest in VA. Those who do not meet these eligibility requirements will be notified by the site as soon as possible.

Detailed information about the VA Advanced Fellowship Program in Mental Illness Research and Treatment at the VISN 5 MIRECC can be found on the national MIRECC website at <http://www.mirecc.va.gov/mirecc-fellowship.asp> and at the VISN 5 website at <http://www.mirecc.va.gov/visn5/>. Potential applicants are encouraged to contact Dr. Melanie Bennett at Melanie.Bennett@va.gov for more information and to discuss details of the opportunities available for fellows.

MD applicants must have completed ACGME-accredited training, be board eligible or board certified, and have an active, unrestricted U.S. license to practice. International medical graduates must also have a current visa and an ECFMG certificate that is valid indefinitely. Applicants on a J-1 visa must also have current ECFMG sponsorship. Eligible psychologists and allied health professionals must be U.S. citizens. Psychologist applicants must have graduated from an American Psychological Association (APA) or Canadian Psychological Association (CPA) accredited doctoral program in clinical or counseling psychology (or be on track to complete their graduate program prior to beginning the fellowship) and must have completed an APA- or CPA-accredited internship. For the eligibility requirements for other Allied Health disciplines, please contact margaret.gere@va.gov.

The Postdoctoral Fellowship abides by the policies stated in the Association of Psychology Post Doctoral and Internship Centers (APPIC), American Psychological Association (APA) and VA Office of Academic Affiliation (OAA) regulations. Applicants are referred to the APPIC website, www.appic.org, APA website, www.apa.org, and OAA website, www.va.gov/oaa/ for a detailed description of the policies. The VAMHCS is an Equal Opportunity Employer. Our postdoctoral fellowship program values cultural and individual diversity and welcomes applicants from all backgrounds.

Application Requirements and Procedures

Applications are now being accepted. Potential applicants are encouraged to email Dr. Melanie Bennett, Director of Fellowship Training (Melanie.Bennett@va.gov), to arrange a call to learn more about the program. All applicants should submit the following documents:

1. A letter of interest that outlines career goals, expectations, and goodness of fit with the mission of the VA Advanced Fellowship Program in Mental Illness Research and Treatment at the VISN 5 MIRECC
2. A current curriculum vitae
3. Official graduate transcripts
4. Three signed letters of recommendation, one of which must be from an internship supervisor

These documents can be emailed directly to Dr. Bennett or, for psychologist applicants, can be submitted through the APPA CAS portal (<http://appic.org/AAP-APP/APP-Postdoc-Application-Information>).

All questions and inquiries should be sent via email to:

Melanie Bennett, Ph.D.
Director of Fellowship Training
VISN 5 MIRECC
209 West Fayette Street (VA Annex Building, 7th Floor)
Baltimore, MD 21201
410-637-1859
Melanie.Bennett@va.gov

Program Goals & Objectives

The primary goal of the VA Advanced Fellowship Program in Mental Illness Research and Treatment at the VISN 5 MIRECC is to develop outstanding academic, clinical service, and healthcare system leaders. We strive to train fellows who will lead mental health research and service in the 21st century and build the evidence base for mental health interventions by effectively translating research findings into clinical practice and programming, large-scale training of service providers, and focused educational activities. The program provides fellows with advanced training in mental health research, clinical experience in settings that serve individuals with serious mental illness, and opportunities to develop their skills in teaching and training in didactic, academic, and clinical venues. Many Fellows pursue careers focused predominantly on academic research and education in mental health. Others pursue leadership careers that emphasize clinical service, program development and implementation, quality improvement and program evaluation, and clinician education and training within the field of mental health. The program aims to train Fellows for careers in mental health both within and outside of the VA system.

Program Structure and Training Experiences

As noted above, Fellows spend approximately 65% of their time in research-related research and clinical activities, 25% of their time in clinical service and training activities, and 10% of their time in didactic and administrative activities. These activities are outlined in detail below. The national Fellowship Program coordinates and delivers a bi-monthly seminar for fellows across the system that provides an in-depth overview of key topics in mental health research and clinical practice by experts in the field. Fellows at all MIRECC Fellowship sites are linked by means of a monthly Video Teleconference (V-Tel) seminar hosted by the Hub Site.

Fellows establish individual goals and timelines in collaboration with their mentors at the beginning of the Fellowship program. Within this individualized program, there is a core set of research, service delivery, and educational activity goals that fellows work to achieve during their involvement with the program. Successful completion of these goals indicates that Fellows demonstrate competency in the research, educational, and clinical activities listed below. Mentors assess the progress of each Fellow at regular intervals.

Research Training

MIRECC investigators mentor fellows in clinical research on serious mental illness. Investigators are experts in the development of psychosocial interventions aimed at improving health, functioning, community engagement, and recovery. Specific topic areas include smoking cessation, weight loss, chronic medical illness self-management, self-stigma, detection and treatment of hepatitis C, medication use, sleep disorders, and negative symptoms. Research on family support and

engagement in care has included implementation and evaluation of family psycho-education programs, family outreach interventions, and multi-family group therapy for reducing marital conflict and disability. Investigators and collaborators within our affiliate institution (the University of Maryland, School of Medicine) have expertise in research in psychopharmacology, neuroimaging, and pharmacogenetics. As we work to address VA priorities in care, we have expanded our methods and programs to address a broader range of psychiatric conditions including posttraumatic stress disorder and traumatic brain injury. Several MIRECC investigators are leaders in the field of research on reducing the stigma associated with serious mental illness; others are contributing to emerging research in the areas of patient-centered care, shared decision-making, and on developing strategies to enhance community engagement.

Fellows pursue a range of specific clinical research training experiences, including:

- review literature and define a specific research question within the field of serious mental illness
- design a pilot project aimed at collecting data to inform a particular line of research
- complete all regulatory processes and procedures (IRB approval, VA R&D approval, etc.)
- collect data and work with the MIRECC Data Management Sub-Unit of the Research Core to prepare data for analysis
- work with the MIRECC Biostatistics Sub-Unit of the Research Core to analyze data and understand results
- work with the MIRECC Administrative Data Sub-Unit of the Research Core to answer questions related to VA service use in the VAMHCS and VISN 5
- write and submit manuscripts (minimum of 2 per year) on original research
- present research findings at national conferences
- learn how to plan a program of research that connects publications and pilot research and findings to writing grant applications and obtaining research funding
- write a grant application

Conducting a pilot project allows fellows to gain experience in study design, advanced methodological and statistical approaches to mental health research, gaining approval from various regulatory agencies, and planning for legal and ethical issues involved in human subject's research. Fellows also learn how to access and use VA and other mental health electronic databases for research purposes. These experiences will lead fellows to prepare and submit manuscripts for publication and to gain a full understanding of federal (VA and NIH) funding mechanisms and experience in preparing grant applications.

Fellows become involved in clinical research. This means that, for many fellows, their research activities involve service delivery, including the development and testing of new assessment measures, intervention programs, and training tools. Fellows' research yields clinical products such as treatment manuals, new measures, and clinical training protocols. Fellows often work with Veterans, family members, and VA mental health clinicians to develop and test new tools and treatments. Fellows' research routinely contributes to the improvement of clinical services within the VAMHCS.

Clinical Training

Within our Center, research directly impacts our clinical service delivery. We have a range of service delivery opportunities for fellows; as with research, fellows are encouraged to identify supervised experiences that are of interest to them and to create a clinical training plan that meets their personal goals. We offer a range of clinical training opportunities that encompass the development of both generalized clinical competencies and specific training in the assessment and treatment of serious mental illness. Clinical training involves learning evidence-based practices for different groups of Veterans with mental illness, providing individual and group interventions throughout the VAMHCS, receiving

supervision from clinical psychologists who are experts in delivery of the clinical service that the fellow is providing, and adapting interventions to overcome implementation barriers. Fellows can gain supervised clinical experience in any of the following treatment settings: inpatient psychiatry, outpatient mental health, substance abuse treatment service, opioid agonist clinic, trauma service (both inpatient and outpatient), military sexual trauma, psychosocial rehabilitation, mental health intensive case management, primary care-mental health integration, and neuropsychiatry. Given the great diversity of the Veteran population, fellows are afforded many opportunities to work with Veterans of different cultures, races, ethnicities, religions, and backgrounds, and in this way develop enhanced awareness and appreciation of cultural and individual differences as well as the skills for providing evidence based services to diverse patients and families. In this way fellows attain cultural competence regarding the delivery of mental health services to Veterans living with serious mental illness. In addition, in their clinical work, fellows interface with a dynamic and diverse inter-professional team that includes psychiatry, psychology, social work, nursing, and peer support services. Clinical experiences are graduated in complexity over the course of the two-year training program, such that over time fellows are exposed to more complex cases or increased responsibility for more aspects of a Veteran's overall care needs. All of the fellows' clinical training experiences are supervised by licensed clinical psychologists who are experts in the use and implementation of evidence-based practices with Veterans seeking care within the VA system. In the context of our program, supervised service delivery includes:

- learning evidence-based practices for different groups of Veterans with mental illness
- administering qualitative and quantitative assessments
- providing assessment feedback
- conducting group and/or individual interventions
- receiving and/or providing clinical supervision
- providing consultation to direct service providers on clinical topics
- providing clinical didactics to direct service providers
- training direct service providers in evidence-based assessments or interventions
- developing assessment, intervention, and training materials for use in direct service delivery
- disseminating assessment, intervention, and training materials for use in direct service delivery
- training in concepts of inter-professional care, its applicability in mental health settings, and skills for becoming an effective inter-professional team member
- providing clinical supervision to more junior trainees in the Fellow's discipline; this training will include learning supervisory concepts, providing direct clinical supervision, and receiving supervision of that supervision.
- using the empirical literature to enhance patient care by incorporating evidence-based approaches into assessment, treatment planning, treatment implementation, and evaluation of treatment outcomes.
- training in complex ethical and legal issues regarding service provision within the MIRECC's specialty area and receive supervision on applying this knowledge to clinical decision-making with specific patients receiving care from the Fellow
- identifying areas in their own clinical practice as part of the MIRECC Fellowship where the evidence-base is insufficient to guide clinical decision-making and develop the ability to generate research questions and methodologies that, if conducted, would have the potential to expand the relevant evidence base in the area of clinical service delivery
- training in clinical technologies in mental health practice such as teleconsultation

Activities to Enhance Fellows' Competence as Educators

Fellows serve as part of the MIRECC's Education Core and get involved in ongoing educational activities within the Center. These include projects planning regular conferences to educate clinicians, Peer Specialists, veterans with serious mental illness, family members, and community service providers on topics related to working with individuals with serious mental illness. The MIRECC plans and delivers regional and national webinars on mental health recovery and routinely collaborates with

clinical staff to provide trainings in evidence based treatments for individuals with serious mental illness. For example, our center runs the VA Evidence Based Practice roll-out of Social Skills Training (SST) in which we have trained, to date, over 600 VA staff across the country, including 53 Peer Specialists, 48 Master Trainers, and 216 fellows of different disciplines across the VA system. We host a Recovery Resource Table at the Baltimore VAMC where we provide mental health resources for veterans and family members. The VISN 5 MIRECC was instrumental in establishing the VAMHCS Clozapine Treatment Team (CTT) in which MIRECC investigators provide consultation and expertise on clozapine-related clinical or administrative questions from providers across VISN 5. Fellows get involved in planning and implementing such educational and training activities in line with their interests and career goals. In addition, fellows have many opportunities to develop and present didactic presentations to psychology externs and interns and to mentor these trainees in clinical or research activities.

Fellows are provided with opportunities to expand their experience in using the latest educational tools such as on-line lectures, video-presentations, and chat rooms. Fellows are introduced to and obtain experience in the procedures involved in telemedicine, the use of video streaming technology, and video conferencing. Additionally, Fellows increase their experience in the supervising and advising others in research, educational, and clinical activities. Through skills obtained in translational research and use of state-of-the-art educational tools, Fellows also enhance their abilities to disseminate research findings in a public forum and to a wide range of audiences effectively. In the context of our program, involvement in educational and training activities includes:

- observe experts who provide effective mental health education to colleagues, trainees, staff, patients, and families
- teach/present to colleagues, staff, trainees, patients, families and members of the community about their areas of interest/expertise
- mentor pre-doctoral psychology trainees and psychiatry residents in research activities
- receive supportive, constructive feedback on teaching strengths and areas for improvement
- develop course content and materials for psychology, nursing, and social work trainees
- learn about state-of-the art educational tools including telemedicine and video streaming technology

Didactics

Fellows also participate in a range of didactics and career development activities that enhance their expertise in the practice of clinical psychology. There are structured didactics provided by the Fellowship Hub Site that address an array of topics including advanced research methodologies, professional writing, biostatistics, and research ethics. Fellows also attend a bi-monthly Science Meeting at the MIRECC that brings in clinicians and researchers to present their work on a range of topics. At least two of these presentations each year are devoted to topics related to diversity/individual differences, at least two are devoted to clinical service topics, and at least two are devoted to research methods. Of note, fellows are required to present at this Science Meeting on some aspect of their clinical or research training experience. In addition, fellows attend and present at the University of Maryland, School of Medicine, Division of Psychiatric Services Research Journal Club, a weekly meeting focused on review and discussion of research on clinical or implementation topics within the field of serious mental illness. Fellows are also invited to attend clinically-focused didactics, including the VA Inter-professional Fellowship Program in Psychosocial Rehabilitation (PSR) and Recovery Seminar Series (for which our MIRECC is the Hub Site), the VA Social Skills Training EBP Workshop (of which our MIRECC is the lead and coordinating training site), and the seminars presented as part of the VISN 5 PTSD and Neuropsychology Fellowships. These clinically-oriented didactics are an enhancement to the clinical training that fellows receive and include topics such as evidence based interventions for serious mental illness (social skills training for schizophrenia, cognitive processing therapy for PTSD, Motivational Interviewing for health behavior change, applications of the recovery model to services for

Veterans with serious mental illness) and implementation research. Because of our affiliation with a regional medical school, fellows are also encouraged to take advantage of the rich didactic environment by attending day-long seminars, grand rounds presentations, lectures, and trainings. They receive support from the medical center to attend local conferences including those locally coordinated continuing education programs through the Chesapeake Health Education Program. Didactics ensure that our fellows are immersed in an atmosphere of training that values excellent clinical care, high quality (and mission critical) clinical research, and appropriate integration of science and practice. There is also a professional development seminar that brings together Fellows from all psychology programs in the VAMHCS including a trauma fellowship, two neuropsychology fellowships, and a newly developed fellowship in HIV/HEP C care. Offered since 2010, this seminar is facilitated by a clinical psychologist with no direct supervisory relationship with the Fellows. The seminar meets bi-monthly and is used to review career trajectory, career goals, training goals, and their progress toward licensure and independent practice. This is an especially good way for our fellows to learn from those in other disciplines, exchange ideas, and make professional contacts that will last past fellowship and into their formal careers.

Requirements for Completion

Fellows develop individualized training plans. Those pursuing academic research careers should be competitive for the academic employment market in terms of numbers of publications, teaching and supervision experience, ability to collect research data, and plans to submit grant applications in their field of study including VA Career Development Awards or NIH K-Awards. Fellows pursuing careers that will involve service delivery, administration, policy development, and/or education/training will be ready to pursue entry-level leadership roles health in the VA healthcare system and/or other academic institutions that integrate research such that the above activities are grounded in the empirical literature. In such cases, fellows will be prepared to serve as expert in serious mental illness and to develop programming or policy that will serve to enhance the services provided to these individuals.

Fellows are evaluated twice yearly in seven areas:

Scholarly Inquiry and Clinical Research: Fellows will pursue a program of clinical research with guidance from a team of mentors. Fellows will become proficient in the process of developing research ideas and communicating these ideas for various scholarly purposes.

Application of Current Scientific Knowledge to Clinical Practice: Fellows will develop competency in the administration of measures for clinical assessment and diagnosis as well as in the use of empirically supported treatments. Opportunities exist for Fellows to gain competence in neuropsychological evaluation

Consultation, Supervision, and Teaching: Fellows will gain advanced skills in clinical consultation, clinical-research supervision, and teaching through experiences that allow him/her to interact within his/her area of expertise and knowledge with Veterans, MIRECC investigators, research staff, and mental health treatment teams. Opportunities exist for Fellows to work with junior trainees in psychology and family members.

Organizational Management and Administration: Fellows will gain experience in organizational management and administration pertinent to their career development and clinical research program. Fellows may choose training experiences that facilitate the development of advanced competencies in program evaluation.

Professional Conduct, Ethics, and Legal Matters: Fellows will become competent (as appropriate for an entry level professional) in professional and collegial conduct, knowledge of the ethical guidelines of clinical assessment, diagnosis and delivery of interventions and services. Fellows will also become competent in their knowledge of guidelines that govern the

appropriate conduct of human subjects research, and they will become appropriately familiar with the wide array of legal issues pertinent to the proper conduct of clinical psychology and human subjects related research.

Cultural and Individual Diversity Issues: Fellows will further develop their awareness, appreciation, and handling of cultural and individual diversity in conceptualizing, preparing, and executing research and clinical work. This will include adding to their cultural competence regarding the design, delivery and evaluation of mental health services for a diverse range of Veterans and families.

Confidence and Professional Identity: Fellows will develop a strong professional identity and confidence and professional demeanor commensurate with their entry-level status in the profession.

Our program has serious mental illness as its area of emphasis. As such, all stated program goals will address issues related to serious mental illness in some way (development, treatment, service design, program implementation, etc.). While Fellows can pursue research and clinical experiences that are not specifically focused on serious mental illness during their training, all Fellows will engage in research and clinical activities that are directly related to this area of emphasis.

Fellows are rated using the following indicators:

1 = Below Expectations, Intensive supervision needed. Trainee does not demonstrate basic competency. Intensive supervision needed and remedial plan required (below fellow entry level expectations).

2 = Entry Level Expectation, Close supervision needed. Trainee demonstrates basic competency. Close supervision is needed and further growth necessary. A remedial plan may be needed (expected fellow entry level).

3 = Progressing Well, Regular/typical supervision needed. Trainee demonstrates an intermediate level of competency, typical for trainees throughout the training year. Performance is acceptable, but regular/typical supervision is needed and further growth is desirable (minimal fellow completion level).

4 = Proficient, Intermittent supervision needed. Trainee demonstrates an intermediate to advanced level of competency, typical of trainees at the end of the training year. Performance demonstrates skillfulness. Intermittent supervision needed (preferred fellow completion level).

5 = Exceptional, Minimal supervision needed. Trainee demonstrates consistently advanced level of competence, well beyond that which is expected for trainees at the end of the training year. Performance demonstrates capacity for independent practice. Minimal supervision needed (above expected level for fellowship).

Expectations for successful completion of the fellowship are:

Mid-Year, Year 1: All competency items should be rated as a 2 or higher (expected fellowship entry level). If a competency item is rated as a 1, then a remedial action plan is required for that item. A remedial action plan may be developed for items rated at a 2.

End of Year 1: All competency items should be rated as a 3 or higher. If a competency item is rated as a 1 or 2, then a remedial action plan is required for that item. Any remedial action plan

initiated prior to this date must be progressing well in the estimation of the Director in order to successfully move forward in the fellowship in good standing.

Mid-Year, Year 2: All competency items should be rated as a 3 or higher. If a competency item is rated as a 1 or 2, then a remedial action plan is required for that item. Any remedial action plan initiated prior to this date must be completed as determined by the Director in order to successfully move forward in the fellowship in good standing.

End of Year 2: All competency items will be rated at the level of 3 or higher (minimal fellowship completion level). There will be no 1-2 ratings. Any remedial action plan initiated prior to this date must be completed in order to successfully complete the fellowship program.

Facility and Training Resources

The VA is organizationally comprised of 23 Veteran's Integrated Service Networks (VISNs). VISN 5, the VA Capitol Health Care Network, serves the state of Maryland, the District of Columbia, and the greater Martinsburg West Virginia area. VISN 5 includes four VA Medical Centers: Baltimore VAMC, Perry Point VAMC, Washington, D.C. VAMC, and the VAMC in Martinsburg, West Virginia. The VAMCs at Baltimore and Perry Point are incorporated within the VA Maryland Healthcare System (VAMHCS); the MIRECC is housed within the VAMHCS.

MIRECCs are VA-based centers that are multidisciplinary centers focused on improving the provision of health care to veterans suffering from mental illness. This goal is achieved through basic, clinical, and applied research and by improving the understanding of mental health service outcomes through education and training of personnel and the development and implementation of improved mental health services, delivery models, and systems. The mission of the VISN 5 MIRECC is to maximize recovery and community functioning for Veterans with mental health disorders through treatment development and implementation, community partnership, and service evaluation and enhancement. This goal is achieved by implementing evidence-based clinical programs and practices for the treatment of Veterans with mental health disorders, conducting research that leads to the development and evaluation of novel treatment strategies, developing and providing educational and training programs to enhance dissemination of evidence-based clinical programs and practices throughout the VA system of care. In support of this mission, the VISN 5 MIRECC supports a sophisticated research infrastructure including secretarial and administrative services, a biostatistics core, an assessment group, expertise in human subjects' research, and ample computer, office, and videoconferencing equipment. The VISN 5 MIRECC provides a variety of research and administrative services to MIRECC investigators and fellows, thereby enhancing the scientific quality of the work and reducing the costs of individual projects. The MIRECC provides laboratory and assessment space, computer facilities, and expertise and consultation that will aid in project organization and administration. The Assessment Core facilitates centralized training in the use of instruments, coordinates reliability exercises, and makes available a common set of clinical and functional assessments to MIRECC investigators. The Biostatistics Core provides consultation in statistical analysis, database technology, and data management to MIRECC investigators. Of particular importance to the Consortium are the MIRECC subunits on Subject Recruitment and VA Regulatory Compliance, staffed with experts to assist MIRECC investigators in coordinating recruitment of participants and complying with all human subjects' regulations at the local, VISN, and national levels. In addition, fellows can learn and access ongoing consultation in qualitative research methods through interaction with the MIRECC Qualitative Core which hosts didactic and consultation activities to providing ongoing education and support in qualitative methodology. MIRECC investigators maintain a large portfolio of VA and NIH grants and conduct treatment dissemination programs for VA on social skills training and family psycho-education. In addition, VISN 5 MIRECC investigators play a role in mental health services at the VAMHCS, sitting on leadership committees and participating in program evaluation and planning groups. The VISN 5 MIRECC has also developed effective referral relationships with clinical staff in the VAMHCS mental health care clinics.

The VISN 5 MIRECC is located in downtown Baltimore, close to the Baltimore VA Medical Center, the University of Maryland Baltimore (UMB), and the University of Maryland Medical Center. UMB is the professional campus of the University System of Maryland and one of three major research universities in the state. The Schools of Medicine, Pharmacy, Dentistry, Law, Nursing, and Social Work are assembled on a 32-acre site in downtown Baltimore. UMB ranks in the top ten percent of institutions receiving federal funding from the National Institutes of Health, and qualifies for Carnegie Classification as both a research institution and a specialized medical institution. The Health Sciences Library at UMB is a recognized leader in state of the art information technology, with six levels and 190,000 square feet in which it houses 400,000 volumes and approximately 20,000 print and e-journal titles all of which can be accessed using the online catalog, and which also provides access to the resources of 15 other libraries in the University System of Maryland. It provides access to computerized literature search bases (e.g. Medline, PsycINFO, Neuroscience Citation Index, etc.). Many of the journals can be accessed on-line from various full-text services. Co-located with UMB is the University of Maryland Medical Center, the main hospital of the University of Maryland Medical System (UMMS). UMMS is a multi-hospital system with academic, community, and specialty services reaching every part of the state.

The VISN 5 MIRECC has active collaborations with the Department of Psychiatry at the UMSOM with extensive communications and a strong working relationship across institutions.

The Department of Psychiatry is home to Divisions and Centers which house resources that fellows can utilize to enhance their training. Most MIRECC investigators have dual appointments within the Department, either in the Division of Psychology or the Division of Psychiatric Services Research. Other departmental centers and investigators that can be utilized by fellows to enhance their training including the Maryland Psychiatric Research Center [dedicated to providing treatment to patients with schizophrenia and related disorders, educating professionals and consumers about schizophrenia, and conducting basic and translational research into the manifestations, causes, and treatment of schizophrenia.], the Clinical Neurobehavioral Center [dedicated to conducting research combining neuro-scientific, behavioral-pharmacological, and clinical-psychological methods into an integrated program of human laboratory and clinical outpatient research and treatment studies designed to identify new medications to treat substance use disorders], and the UM Center for Brain Imaging Research.

Fellows benefit substantially from the close ties between the UMSOM, VISN 5, and the VAMHCS. The VAMHCS and UMB have a close, collaborative relationship. The Baltimore VAMC is located adjacent to the UMMC, with a connecting bridge that allows staff to move freely between the two facilities. As noted, many faculty members across a range of disciplines hold joint VA-UMB appointments, participate in training residents in a range of fields, collaborate on research projects, and share resources.

Primary Training Staff

Melanie Bennett, Ph.D. [Associate Director, Education Core and Director, VA VISN 5 Advanced Fellowship Program in Mental Illness Research and Treatment, VISN 5 MIRECC; Associate Professor, Department of Psychiatry, University of Maryland School of Medicine]. Dr. Bennett has extensive expertise in the development of interventions for individuals with serious mental illness. Much of her work has centered on the assessment and treatment of substance use disorders in people with schizophrenia and other forms of serious mental illness. She is proficient in motivational interviewing and has studied strategies for enhancing motivation to engage in health behavior change. She also does work in assessment and treatment of negative symptoms and in fostering mental health recovery in young adults with early psychosis. Dr. Bennett has been funded by NIH and VA to do her work in substance abuse treatment development and implementation. Dr. Bennett is a licensed psychologist.

Clayton Brown, Ph.D. [Director, Biostatistics Sub-Unit, Research Core, VISN 5 MIRECC; Associate Professor, Department of Epidemiology and Public Health, University of Maryland School of Medicine]. Dr. Brown is a biostatistician who has extensive experience in the design and analysis of randomized clinical trials of clinical and health service interventions in the areas of substance abuse and serious mental illness. He has been the lead statistician/co-investigator for multiple NIDA, NIMH, and VA funded randomized clinical trials on topics including cognitive remediation intervention and behavioral treatment for substance abuse in seriously mentally ill patients.

Robert Buchanan, MD [Associate Director, Research Core, VISN 5 MIRECC; Professor, Department of Psychiatry, University of Maryland School of Medicine; Acting Director, Maryland Psychiatric Research Center (MPRC)]. a Professor of Psychiatry in the Department Psychiatry, University of Maryland School of Medicine; Interim Director of the MPRC; Chief of the MPRC Outpatient Research Program and Director of the Maryland Early Intervention Program (EIP). Major research interests include schizophrenia phenomenology; the neuroanatomical and behavioral investigation of the pathophysiology of schizophrenia; and the development of novel pharmacological approaches for negative symptoms, cognitive impairments, treatment-resistant positive symptoms, and the metabolic disturbances and other side effects associated with antipsychotic treatment. He has conducted a series of proof of concept and clinical trials examining antipsychotic-reduction strategies in the acute and maintenance treatment of schizophrenia; the use of adjunctive pharmacological agents for the treatment of negative symptoms and cognitive impairments; and the comparative efficacy of clozapine and olanzapine for positive and negative symptoms and cognitive impairment in partially responsive outpatients with schizophrenia. He currently has grant funding to evaluate novel therapeutic approaches for the treatment of people with schizophrenia, including the use of adjunctive oxytocin to CBSST for enhancement of social role function; combined anti-inflammatory treatment for persistent positive symptoms; and valacyclovir for cognitive impairments in people with schizophrenia, who are early in the course of their illness. He has been involved in multiple aspects of the Measurement and Treatment Research to Improve Cognition in Schizophrenia (MATRICS) project, including the identification of potential pharmacological targets for the treatment cognitive impairments and the organization of the FDA/NIMH workshop to develop guidelines for the conduct of clinical trials of cognitive-enhancing drugs. He served as Co-P.I. on the Treatment Units for Research on Neurocognition and Schizophrenia (TURNS), was the MPRC site P.I., and is was responsible for the design and conduct of TURNS clinical studies. He has had an ongoing role in the development and update of the Schizophrenia Patient Outcomes Research Team (PORT) psychopharmacological treatment recommendations.

Amy Drapalski, Ph.D. [Director, Administrative and Clinical Cores, VINS 5 MIRECC; Associate Professor (Volunteer), Department of Psychiatry, University of Maryland School of Medicine]. Dr. Drapalski is a graduate of the VISN 5 fellowship program. Her research focuses on the development and implementation of interventions to reduce internalized stigma in people with mental illness, as well as topics related to mental health recovery, family interventions in SMI and topics related to the health and mental health needs of women veterans. Dr. Drapalski has several active grants and has participated in 16 peer reviewed journal articles. Dr. Drapalski is a licensed psychologist.

Clare Gibson, Ph.D. [Psychologist, VA Maryland Health Care System]. Dr. Gibson completed her Ph.D. in clinical psychology at the University of North Carolina at Chapel Hill where her training and research focused on social cognitive processes in schizophrenia and psychosocial interventions for individuals with serious mental illness. She completed her predoctoral clinical internship at the VAMHCS/University of Maryland Internship Consortium in the serious mental illness (SMI) track. Dr. Gibson then went on to complete a one year postdoctoral fellowship in VA's Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery (PSR) at VA Connecticut Health Care System (the Paul Errera Community Care Center) & Yale School of Medicine. Dr. Gibson's interests are in psychosocial treatments for SMI and factors related to recovery particularly internalized stigma. Her professional interests include integrating recovery into mental health systems and self-care for mental health professionals. Dr. Gibson is a licensed psychologist.

Richard Goldberg, Ph.D. [Director, VISN 5 MIRECC; Professor, Department of Psychiatry, University of Maryland School of Medicine]. Dr. Goldberg is an established VA and NIH funded investigator, has overseen large clinical trials as PI, and has contributed to interventionist training and fidelity monitoring for innovative interventions targeting seriously mentally ill Veterans. As a funded NIMH and VA investigator he has accrued ample experience in working with peer providers and contributed to several grant efforts focusing on the quality of medical services targeting seriously mentally ill individuals. He also has training and research experience in conducting qualitative research focusing on consumer and provider perspectives of care. He is also the National Director of the VA Psychosocial Rehabilitation Training Program and the Hub-site Director of the National VA Inter-professional Psychosocial Rehabilitation and Recovery Post-Graduate Fellowship Training Program. Dr. Goldberg is a licensed psychologist.

Samantha Hack, Ph.D. [Research Investigator and Assistant Director, Education Core, VISN 5 MIRECC; Volunteer Assistant Research Professor, University of Maryland School of Social Work] Dr. Hack's research focuses on person-centered care for serious mental illness. She has studied racial disparities, particularly among African American men, in mental health treatment for serious mental illness and the development of Veteran-focused interventions that support consumer participation in collaborative treatment planning and delivery. Dr. Hack's work in these areas has been funded by the VA and the University of Illinois. She is a national consultant with VA Social Skills Training for Serious Mental Illness, and a licensed social worker.

Seth Himelhoch, MD [Research Investigator, VISN 5 MIRECC; Professor, Department of Psychiatry, University of Maryland School of Medicine and Clinical Core Director, VA VISN 5 MIRECC]. Dr. Himelhoch is a board certified psychiatrist and has subspecialty expertise in psychosomatic medicine. He has expertise in conditions that co-occur with serious mental illness including PTSD, substance abuse, hepatitis, and HIV. Dr. Himelhoch's research focuses on developing and studying the efficacy of innovative strategies aimed at improving the health and welfare people with co-occurring psychiatric and substance use disorders.

Elizabeth Klingaman, Ph.D. [Research Investigator, VISN 5 MIRECC; Assistant Fellowship Director]. Dr. Klingaman is a graduate of the fellowship program at VISN 5. She received her PhD in Counseling Psychology from the University of Maryland College Park and completed her predoctoral internship at the VA Eastern Colorado Health Care System in Denver, Colorado. Her research interests include improving sleep and other health behaviors among Veterans with serious mental illness through the use of adapted evidence-based practices. She is also interested in the neurocognitive effects of health behaviors (e.g., sleep, exercise). During her fellowship, Dr. Klingaman applied for and received the official intent to fund notice for an RR&D CDA-2 (Career Development Award) to generate guidelines for tailoring Cognitive-Behavioral Therapy for Insomnia to the needs of Veterans with serious mental illness, and to test the efficacy of this intervention with this population. She recently obtained funding through a Mental Health Quality Enhancement Research Initiative (MH QUERI) Locally Initiated Project and a MIRECC pilot to collect data on the intersection of sleep dysregulation and health behaviors among Veterans with serious mental illness. She is collaborating with colleagues at the Maryland Psychiatric Research Center on projects to fully characterize the functional outcomes of poor sleep among people with psychotic disorders. In collaboration with the VA National Evaluation of MOVE! Outcomes team, and various collaborators at the VISN 5 MIRECC, she has explored the importance of addressing multiple lifestyle and health behaviors as critical to the holistic recovery of Veterans with serious mental illness. She also serves as a National Trainer and Consultant for Social Skills Training for Schizophrenia, a VA EBP Rollout through the VISN 5 MIRECC. Dr. Klingaman is a licensed psychologist.

Julie Kreyenbuhl, PharmD, Ph.D. [Director, Research Core, VISN 5 MIRECC; Associate Professor, Department of Psychiatry, University of Maryland School of Medicine]. Dr. Kreyenbuhl's research

focuses on the pharmacoepidemiology of serious mental illness and she has contributed extensively to the development of evidence-based treatment guidelines for schizophrenia. Current research interests include developing and testing the effectiveness of computer technology-based interventions such as Smartphones for individuals with serious mental illnesses in the areas of enhancing medication adherence and activating patients to participate in the prevention and management of medication side effects. Dr. Kreyenbuhl has received grant funding from the National Institute of Mental Health, NARSAD, and the Veterans' Health Administration.

Alicia Lucksted, Ph.D. [Research Investigator, VISN 5 MIRECC; Associate Professor, Department of Psychiatry, University of Maryland School of Medicine]. Dr. Lucksted's work focuses on applied research towards improving public mental health services for people with serious mental illnesses, internalized stigma regarding mental illness and its impact on recovery, self-help interventions among mental health consumers and family members, and qualitative methods in mental health services research. She has experience in community mental health clinical work, quantitative and qualitative mental health services research methods, intervention design and evaluation, recovery-based paradigms of treatment, and project management. As a mental health services researcher, she has led and contributed to numerous studies developing and evaluating psychosocial interventions and their use, via both qualitative and quantitative methods. Dr. Lucksted is a licensed psychologist.

Deborah Medoff, Ph.D. [Director, Data Management Sub-Unit, Research Core, VISN 5 MIRECC; Associate Professor, Department of Psychiatry, University of Maryland School of Medicine]. Dr. Medoff is a quantitative psychologist and an expert in research methods, statistics and measurement with extensive experience designing and analyzing research on serious mental illness. She provides methodological and statistical consultation to the VISN 5 MIRECC, the Center for Mental Health Services Research and the Mental Health Systems Improvement Collaborative. She has interests in the statistical analysis of neuroimaging data (PET, MRI, fMRI) and in the application of Covariance Structure Modeling to assess network models of brain function.

Anjana Muralidharan, Ph.D. Anjana Muralidharan, Ph.D. [Clinical Research Psychologist, Assistant Director – Clinical Core, National Trainer/Consultant – Social Skills Training Program; VISN 5 MIRECC]. Dr. Muralidharan is a clinical research psychologist with a specialization in psychiatric rehabilitation and recovery from serious mental illness (SMI). She completed her Clinical Psychology Ph.D. at Emory University and her clinical internship at the Boston Consortium for Clinical Psychology Internship Program in 2013. She is a licensed psychologist with clinical proficiency in evidence-based treatments (EBT's) for adults with SMI and severe emotional disturbance, including psychoeducation, skills training, and cognitive-behavioral approaches in individual, family, and group-based formats. Her areas of research expertise include family and social support for recovery from SMI, the promotion of patient- and family-centered care for individuals with SMI, and the functional rehabilitation of older adults with SMI. Dr. Muralidharan is the recipient of a VA Rehabilitation Research and Development Career Development Award to develop enhanced expertise at the intersection of aging, SMI, and functional rehabilitation, with a focus on the development of innovative, interdisciplinary interventions for older adults with psychotic disorders.

Amanda Peeples, Ph.D. [Director, Qualitative and Mixed Methods Unit, VISN 5 MIRECC]. Dr. Peeples earned her Ph.D. in Gerontology from the University of Maryland, Baltimore County. She has conducted research examining stigma and social relations, issues of autonomy and choice, and everyday life in community, long-term, and dementia care settings. Dr. Peeples specializes in qualitative methods and analysis, particularly participant observation and ethnographic interviewing. She works with MIRECC investigators to include state of the art qualitative data collection and analysis methods in their research projects. Her planned future research will focus on the needs and experiences of older Veterans with serious mental illness, in particular on the long-term care needs and end-of-life planning for these Veterans.

Jason Peer, Ph.D. [Local Recovery Coordinator, VA Maryland Health Care System] Dr. Peer is a former MIRECC fellow with the VA Maryland Health Care System. He completed his clinical psychology internship at the VAMHCS and University of Maryland-Baltimore Psychology Internship Consortium. Since completing his postdoctoral training, Dr. Peer has worked at the VAMHCS as a clinical psychologist in the PRRC and Recovery Center. He recently became the facility Local Recovery Coordinator which enables him to be a part of cutting edge research, recovery based interventions, and clinical practice.

Eric Slade, Ph.D. [Director, Administrative Data Sub-Unit, Research Core, VISN 5 MIRECC; Associate Professor and Director, Department of Psychiatry, Division of Psychiatric Services Research, University of Maryland School of Medicine]. Dr. Slade is an economist who specializes in mental health services research. His research focuses on evaluating the economic and service system impacts of service interventions and medications using information from administrative databases, clinical trials, clinical records, and surveys. His current research interests include the cost-effectiveness of VA mental health care for veterans with PTSD. Dr. Slade has published more than 45 studies of mental health services utilization, costs, and employment outcomes, and has led several research projects funded by various sources including the National Institute of Mental Health, the NARSAD foundation, and the U.S. Department of Veterans Affairs.

Neil Weissman, Psy.D. [Psychologist, VA Maryland Health Care System]. Dr. Weissman has been an attending psychologist for the VA since 1992 and has supervised interns and fellows for these 19 years. He currently services in the Baltimore VA Psychosocial Rehabilitation and Recovery Center and works with individuals with serious mental illness. He has received specialized training in CBT, is certified supervisor in Emotionally Focused Couples Therapy from the International Center for Excellence in Emotionally Focused therapy, and is a trainer in Motivational Interviewing (MI) for the National VA Evidence Based Practice Roll-Out of MI.

Administrative Policies and Procedures

The term of the VA Advanced Fellowship Program in Mental Illness Research and Treatment is full-time for two years beginning on or about Labor Day and ending on or about that day two years later. There is funding available for these 2 full-time positions and the current stipend is \$45,961 per annum. State and Federal income tax and FICA are withheld from residents' checks. Annual and sick leave are accrued at the rate of 4 hours per pay period and the fellows are entitled to 10 federal holidays per year. Five days of additional authorized absence may be approved for attendance at conferences, workshops, or other educational activities. Fellows may also apply for up to \$500 of tuition expenses for training or conference experiences consistent with their training goals. Fellows are eligible for federal health insurance but not life insurance or retirement programs. Procedures for due process in case of problematic performance are in place, as are grievance procedures, both for fellows and psychology staff. A copy of these documents will be provided upon the start of fellowship. Our privacy policy is clear: we will collect no personal information about you when you visit our website.

Statement of Nondiscrimination

Equal opportunity laws and Department of Veterans Affairs (VA) regulations prohibit discrimination based upon race, color, national origin, Limited English Proficiency (LEP), age, sex, handicap or reprisal. This applies to all programs or activities conducted by VHA. This policy establishes a civil rights administrative complaint procedure to process allegations of discrimination on the basis of race, color, national origin, LEP, age, sex, handicap, or reprisal. A combination of procedures are modified as outlined in Title VI of the Civil Rights Act of 1964, Executive Order 13166, Title IX of the Education Amendment of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and VA Policy as outlined in Title 38 Code of Federal Regulations (CFR) Chapter 1, Parts 15, 18, and 38.

EEO, Diversity Statement

The Department of Veterans Affairs (VA) is committed to ensuring equal employment opportunity (EEO), promoting diversity and inclusion, and resolving workplace conflict constructively to maintain a high performing workforce in service to our Nation's Veterans. To that end, the Department will vigorously enforce all applicable Federal EEO laws, regulations, Executive Orders, and Management Directives to ensure equal opportunity in the workplace for all VA employees. For additional information, please consult the VA EEO Policy at <http://www.diversity.va.gov/policy/statement.aspx> or contact the VAMHCS EEO office.

VA San Diego Healthcare System/University of California San Diego Interprofessional Fellowship in Psychosocial Rehabilitation and Recovery Oriented Services

**(PSR Fellowship)
2019-2020**

Program Brochure

Veterans Affairs San Diego Healthcare System (VASDHS)
3350 La Jolla Village Drive (116B)
San Diego, California 92161



Introduction

The purpose of this brochure is to describe the VASDHS/UCSD Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery Oriented Services (PSR Fellowship). The VASDHS/UCSD PSR Fellowship was established under the leadership of Eric Granholm, Ph.D. in 2007, and is part of [a national program](#) composed of six VA sites, coordinated by the VISN 5 Mental Illness Research, Education, and Clinical Center (MIRECC) in Baltimore, Maryland. The broad purpose of the PSR Fellowship program is to develop future mental health leaders with vision, knowledge, and commitment to transform mental health care systems in the 21st century by emphasizing functional capability, rehabilitation, and recovery of individuals with serious mental illness. The VASDHS/UCSD PSR Fellowship offers a **major area of study in serious mental illness (SMI)** to clinical psychology residents as well as residents from other disciplines including social work, vocational rehabilitation, nursing, and/or psychiatry. At least 85% of resident time will be devoted to training in psychosocial rehabilitation of people with SMI (primarily psychotic disorders) at the CARF-accredited VASDHS Psychosocial Rehabilitation & Recovery Center throughout the training year and a 3-month rotation at the VASDHS inpatient psychiatry unit. We offer one psychology resident per year an exposure to clinical psychology which involves up to 15% of supervised time working with non-SMI individuals at the VASDHS Wellness & Vocational Enrichment clinic.

Training for clinical psychology residents in the VASDHS/UCSD PSR Fellowship program is based on the scientist-practitioner model, focused on creating a foundation in clinical and research/dissemination practices that will prepare psychologists for careers as independent practitioners able to translate the scientific literature into sound, evidenced-based interventions and to evaluate and disseminate these approaches. Training for psychology residents adheres to the training manual for the larger [VASDHS/UCSD Clinical Psychology Postdoctoral Residency Program](#), which has been accredited by the American Psychological Association since 2010. This brochure describes the PSR Fellowship program for *all* disciplines. At the end of the PSR Fellowship program, all residents are prepared for VA or university medical center careers that integrate clinical, training, research and leadership activities. The fellowship primarily emphasizes training in professional practice, specifically the provision of psychosocial rehabilitation services. Residents will learn to deliver high quality clinical care, to be critical contributors to and consumers of the scientific literature, and to let each of these areas inform the other.

The VASDHS/UCSD PSR Fellowship program was recognized as an “exemplary training site” in SMI with a **Certificate of Commendation** from Division 18 of the American Psychological Association (APA) in 2017 and in 2018 won the APA Division 18 **President’s Excellence in Training Award** “in recognition as an outstanding psychology training program, preparing learners to provide recovery-oriented, evidence-based services to adults diagnosed with serious mental illness.”

Facilities

PSR Fellowship residents work primarily at the **Center of Recovery Education (CORE)**, the VASDHS’s CARF-accredited [Psychosocial Rehabilitation and Recovery Center](#) that is co-located at the La Jolla main hospital and the Rio Clinic community based outpatient clinic (CBOC) in Mission Valley. CORE was awarded the 2017 **Jeffrey Christopher Memorial Award** by the San Diego County Wellness and Recovery Summit “for excellence in improving the quality of life and connection to care for the people who live with mental health challenges and their families.” The [VASDHS](#) provides a full

range of patient care services including inpatient and outpatient care, with state-of-the-art technology as well as education and research. VASDHS is a teaching hospital system whose main campus is situated adjacent to the UCSD campus. Outpatient care is also available at five CBOCs located in Mission Valley, the Rio Clinic, Oceanside, Escondido, and Chula Vista. The VASDHS Mental Health Care Line serves Veterans who reside in San Diego and Imperial counties and provides general and specialized inpatient and outpatient psychiatric services.

[UCSD](#) is one of nine campuses of the University of California. UCSD curricula and programs have been singled out for top rankings in national surveys at both undergraduate and graduate levels. In terms of federal research and developmental funding, it is currently in the top six universities. The [UCSD Department of Psychiatry](#) was established in 1970 and has over 130 full-time faculty members. A primary objective of the Department of Psychiatry at UCSD is to offer an eclectic program of training that emphasizes the integration of relevant biological, psychological, family and preventive medicine, and sociological variables in the understanding of human behavior. The UCSD Department of Psychiatry is strongly integrated within the VASDHS, and together they offer a rich clinical and research environment. Many successful joint programs are currently in operation under the umbrella of an inter-agency sharing agreement. Noteworthy among these programs is a four-year Residency in General Psychiatry; a two-year Fellowship in Child Psychiatry; psychiatric fellowships in Geropsychiatry, an APA-accredited Joint Doctoral Program in Clinical Psychology; and an APA-accredited Internship in Professional Psychology. The mission of both the UCSD School of Medicine and the VASDHS include a strong emphasis on clinical care, professional training, and research; and both are nationally renowned for strong clinical, teaching, and research programs.

The VASDHS Psychology Service, part of the Mental Health Care Line, is focused on providing evidence-based assessments and treatments to improve the emotional and cognitive well-being of Veterans. It is an academically oriented service that shares the VA mission of excellence in clinical care, training, and clinically-focused research. Currently accessible to the postdoctoral residents are over 60 part-and full time doctoral-level clinical psychologists, as well as psychiatrists, social workers, nursing staff, psychology technicians, vocational rehabilitation specialists, occupational therapists, peer support specialists, and administrative support staff. Many of the major sub-specialties of clinical psychology are also represented on the staff, including neuropsychology, geropsychology, couple therapy, substance use disorder treatment, behavioral medicine, posttraumatic stress disorder, and related psychology research. There are facilities at the VA for computer assisted psychological testing and videotaping of therapy sessions. All medical records charting and scheduling is done electronically.

Qualifications, Funding, and Benefits

Requirements for consideration are: 1a) Psychology applicants: completion of an APA-accredited doctorate in clinical or counseling psychology, which includes completion of one's dissertation (proof of completion of all requirements for the doctorate may be required, e.g., transcript showing completion or a letter from the Director of Training) and an APA-accredited internship in professional psychology; 1b) Other applicants: completion of a postgraduate degree (M.D., Ph.D., R.N., M.S.W, M.A., M.S.); 2) US citizenship (as required by VA); and 3) Males born after December 31, 1959 must have registered for the draft by age 26 years (as required by VA). Desirable qualifications include a commitment to and some experience working with people with SMI, and career goals involving clinical, research, leadership and dissemination activities involving evidence-based practices in university-affiliated, VA

or other medical center settings. Recruitment of individuals from diverse social and economic backgrounds and diverse cultural and demographic groups is a high priority.

All residents are funded through postdoctoral stipends from the Office of Academic Affiliations (OAA) Department of Veterans Affairs. Stipends come with health benefits plus co-pay and are currently: **\$51,101** for post-doctoral psychology residents; **\$33,249** for post-masters residents; **\$36,523** for post-masters nursing residents; and equivalent to the salary of residents at our affiliate UCSD for psychiatry residents. Funds from VASDHS Psychology, Psychiatry, and Education Service budgets are used to cover program needs such as office and testing supplies, computers, copying educational materials, publication of program brochures, etc.

Psychology residents in the PSR Fellowship occupy 2 of the 13 1-year postdoctoral positions offered by the VASDHS/UCSD Clinical Psychology Postdoctoral Residency Program for the 2019-2020 training year. There are psychology residency positions in each of the following emphasis areas: Posttraumatic Stress Disorder (PTSD; 2 locations); Substance Abuse Rehabilitation and Recovery Program (SARRTP); Mood Disorders and Interdisciplinary Care; Geropsychology and Home-based Primary Care; Family Mental Health; Lesbian, Gay, Bisexual, and Transgender (LGBT) Mental Health; Psychosomatic and Behavioral Medicine Program (Primary Care Mental Health Integration (PCMHI) and Psycho-Oncology; Inpatient Consultation Liaison (C&L) Service and Pain Clinic Service; PCMHI and Tobacco Cessation. Further details on these positions can be found in the brochure on the [website](#) for the clinical psychology postdoctoral fellowship program (the brochure also includes post-residency positions taken by psychology graduates of the clinical psychology program). Psychology applicants may apply to both the PSR Fellowship program and any of these other positions/emphasis areas if desired.

Financial and Other Benefit Support for Upcoming Training Year

Annual Stipend/Salary for Full-time Residents	\$51,101 for psychology; \$33,249 for post-masters social work/voc rehab; \$36,523 for post-masters nursing; equivalent to psychiatry residents for MDs	
Annual Stipend/Salary for Half-time Residents	None	
Program provides access to medical insurance for trainee?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If access to medical insurance is provided:		
Trainee contribution to cost required?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage of family member(s) available?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage of legally married partner available?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage of domestic partner available?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Hours of Annual Paid Personal Time Off (PTO and/or Vacation)	104	
Hours of Annual Paid Sick Leave	104	
In the event of medical conditions and/or family needs that require extended leave, does the program allow reasonable unpaid leave to interns/residents in excess of personal time off and sick leave?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Other Benefits (please describe): 10 paid federal holidays		

Training Program Structure

Training focuses primarily on clinical assessment and evidenced-based treatment of psychotic and comorbid disorders within a multidisciplinary setting. Additionally, the program allows an opportunity for

program evaluation and research, as well as teaching and dissemination through direct, mentored supervision of psychology interns and/or practicum students (availability varies by rotation), and formal presentations and lectures to academic, medical, and community audiences. The program is designed to offer a broad range of experiences to develop a number of core professional competencies (described below) that build on the interests of the resident and the particular strengths of our faculty and department. Residents have a shared responsibility in designing and planning their residency experience in collaboration with their mentoring committee. The residency requires a 365 day commitment from September 1 to August 31.

Residents generally work 40 hours per week, although professional responsibilities may extend the work week beyond its customary 40 hours at various times throughout the year. Some residents will choose to work more than 40 hours per week. Residents and supervisors will negotiate the exact schedule to meet the needs of the clinic and the resident. Residents will complete 2,080 hours of supervised professional experience across the training year, which is well above the minimum of 1,500 postdoctoral supervised professional experience hours required for psychology licensure in California. General office hours are 8:00 a.m. to 4:30 p.m. Monday through Friday; any deviation from this schedule must be approved by the primary supervisor and the Training Director. In each calendar year there are 10 federal holidays. There are 13 sick leave days and 13 annual leave days, which are accrued during residency. There are no part-time residents.

The 12-month training year begins with an orientation week in which residents are oriented to the VASDHS and receive an introduction to their clinical placements. Orientation includes an overview of policy and procedures, competency objectives and evaluation procedures. VASDHS requires residents to participate in an abbreviated New Employee Orientation (NEO). Trainees also must complete a 90-minute online training that is intended to take the place of all the hospital annual mandatory training modules. The site can be accessed at: <http://vaww.va.gov/oa/mandatory.asp>.

During the orientation period, the supervisors and residents evaluate each trainee's strengths and weaknesses and develop an individualized training plan for the residency year. This plan outlines the resident's responsibilities, including the proportion of time devoted to each training activity. Every resident must have a training plan approved by the Training Director by the end of the first month of training.

Training includes: 1) **supervised clinical experiences** with Veterans on a multidisciplinary treatment team (primarily the outpatient CORE program, but also a mini-rotation on the inpatient psychiatry unit, and for one psychology fellow, some time at the outpatient Wellness and Vocational Enrichment (WAVE) clinic (60-80% effort, including face-to-face clinical hours, preparation for clinical efforts, and if desired for psychology residents, provision of supervision to junior trainees); 2) **didactics and training activities** (10-15% effort, including weekly seminars and receipt of clinical supervision); and 3) **research/dissemination activities** (variable effort, up to 20%).

Residents are expected to:

- Collaborate with and directly provide services to people with mental illness;
- Conduct evidence-based assessments and deliver evidence-based practices;
- Obtain experience with the delivery of clinical supervision (for psychology residents)
- Participate on interprofessional treatment teams;
- Attend required seminars and trainings;

- Conduct research/program evaluation and disseminate evidence-based services through outreach efforts;
- Assist with clinic administration.

A developmental training approach will be used for the clinical training in which learning objectives are accomplished primarily through experiential clinical learning under supervision and mentoring by the resident's supervisors. A resident's clinical training follows a progression from observing supervisor modeling (*in vivo* service delivery and role plays in supervision), to delivering services with direct observation of resident-delivered services by the supervisor and/or with supervisor and resident as co-therapists, to increasingly autonomous, albeit monitored and supervised, service delivery. In the beginning of the training year, caseloads are lower, with increasing intensity as the year progresses.

Training

Residency positions are funded by the Department of Veterans Affairs OAA. **The goal of the residency is to train residents to deliver evidence-based and recovery-oriented PSR services for people diagnosed with psychotic disorders, disseminate these approaches, and critically evaluate new approaches. Moreover, PSR Fellowship program residents learn to function in leadership positions on interprofessional teams working with veterans with SMI.** The rationale for focusing on evidence-based psychosocial rehabilitation services is that veterans and other consumers of mental health treatment deserve access to treatments that are known to be effective. Dissemination of evidence-based approaches is critical because many mental health providers do not have access to or do not avail themselves of such training. Residents will be prepared to help other mental health professionals appreciate the value of evidence-based care and train their colleagues to deliver such care. Residents learn to deliver evidence-based services in a recovery model context, including developing personalized functioning goals and participating actively in treatment by choosing from a menu of treatment program opportunities, including inpatient and outpatient services, medication management, vocational skills development, psychoeducation, social skills training, illness management and recovery, cognitive/behavioral therapy, substance use/dual-diagnosis treatment, and community integration resources. The goal is to both reduce symptoms and improve quality of life by improving functional behaviors. Finally, clinicians must be good consumers of the scientific literature to keep their clinical practice state-of-the-art.

Clinical training in the PSR Fellowship occurs primarily within the CORE program, which is co-located at both La Jolla and Mission Valley (Rio Clinic). All PSR residents also complete a mini-rotation on the inpatient psychiatry unit in La Jolla (12 weeks @ approx. 9 hours per week) and one resident may spend a small amount of time (approx. 5-7 hours per week) working at the WAVE clinic at the Rio Clinic. Residents' individual training needs/interests will determine the proportion of time allocated across settings. This clinical training model provides experiences with all key integrated PSR services across inpatient, outpatient, and community-based settings, while being flexible enough to accommodate individual interests and training needs. All PSR Fellowship residents assist veterans in developing and following recovery plans and provide a full continuum of evidence based psychosocial rehabilitation services including screenings, formal assessments, consultation, individual and group treatment, and psychoeducation. **The primary supervisors for the fellowship are Dimitri Perivoliotis, Ph.D. (Director of Training), Christina Fink, M.S. CRC, Yuliana Gallegos Rodriguez, Ph.D., Jeanette Petrini, LCSW, and Rebecca Williams, Ph.D. Additional supervision may be provided by Eric Granholm, Ph.D. (Chief of the Psychology Service) and Fiza Singh, M.D. (CORE Medical Director).**

Supervision

All PSR residents receive at least four hours of supervision per week, and at least two of these hours are individual supervision; for psychology residents, these are with two psychologists licensed in California; for other residents, at least one of the supervisors is from the same discipline as the resident. At least one hour of weekly individual supervision comes from the primary supervisor (for psychology residents, this is a CA licensed psychologist). Additional individual supervision comes from secondary supervisors, who may be selected for individual cases or to provide regular supervision throughout the year. Individual supervision involves direct observation of clinical care and may also include use of video/audio recording. Additional supervision may come from group supervision. Supervision assignments are documented in the training plan.

Psychology residents will ideally have an opportunity for training in providing supervision by supervising the clinical work of a psychiatry resident, clinical psychology intern, clinical psychology practicum student or other trainee. We offer 6 hours of training in "Supervision in Clinical Psychology," typically during the first quarter of the training year.

Seminars

Seminars required for all PSR Fellowship residents (regardless of discipline):

PSR Seminar/CBT for Psychosis Peer Supervision: This seminar meets weekly for 60 minutes throughout the entire training year. It focuses on the recovery model and delivery of recovery-oriented evidence-based psychosocial rehabilitation interventions for consumers with psychotic disorders. Twice per month, CBT for psychosis training and peer supervision are conducted during the seminar for residents who provide psychotherapy (i.e., psychology and social work), with the goal being that they achieve competence in the approach by the end of the training year. It is organized by Dr. Perivoliotis.

PSR Fellowship Cross-Site Didactic Seminar: This seminar series is held on the 2nd Wednesday of each month for 90 minutes and is attended by residents in all seven VA PSR Residency Programs nationally. The seminar, therefore, offers an opportunity to interact and learn from experiences of local residents, as well as residents around the country via internet teleconferencing. Topics include (but are not limited to) recovery model and practices in serious mental illness, education / dissemination projects across sites, and psychosocial rehabilitation interventions. It is organized by the PSR Fellowship hub site.

Laws and Ethics Seminar (during the fall): The 2-hour ethics portion of the seminar covers: 1) code of conduct, 2) avoiding ethical complaints, 3) patient-therapist relationship issues, 4) record keeping guidelines, 5) forensic issues, and 6) research ethics. The 2-hour legal portion of the seminar covers: 1) informed consent, 2) HIPPA, 3) confidentiality, 4) reporting laws, and 5) an individual's access to their own medical record. It is organized by the VA psychology training directors, including Sandra Brown, Ph.D., ABPP, Amy Jak, Ph.D., ABPP, Brian Buzzella, Ph.D., ABPP, Autumn Backhaus, Ph.D., and Laurie Lindamer, Ph.D.

Cultural Diversity Seminar: This seminar meets approximately twice per month (dates are skipped near holidays) for 60 minutes across the training year (2nd and 4th Wednesdays of each month). It incorporates didactic presentations with case presentations by residents. Potential topics are decided by the seminar leader with input from the residents and include: cultural competence in psychotherapy, assessment and treatment of lesbian, bisexual gay, transsexual (LBGT) clients, assessment and

treatment of persons with disabilities, acculturation models for various ethnic minority groups, and diversity issues in the supervisory relationship. It is led by Autumn Backhaus, Ph.D.

Seminars required for PSR Fellowship psychology residents (optional for other disciplines):

Professional Development Seminar: This seminar meets once per month (1st Wednesday of the month) for 60 minutes for the entire training year and focuses on professional development issues. It is led by Stephanie Orbon, Ph.D., Brian Buzzella, Ph.D., ABPP and Laurie Lindamer, Ph.D.

Substance Use Disorders Seminar (unless they already have fulfilled this California licensure requirement): This seminar meets weekly for 60 minutes for a total of 15 meetings (September – December). The content of the seminar covers the required areas to meet the California Board of Psychology licensure requirement on the evaluation and treatment of alcohol and other substance use disorders. It is organized by Ryan Trim, Ph.D.

Supervision in Clinical Psychology Seminar: This seminar meets once, for six hours, during the Fall. Potential topics include: 1) models of supervision, 2) clinical competency, 3) goals of supervision, 4) reducing anxiety in supervision, 5) silence, 6) countertransference, 7) supervision and ethics, 8) risk management, 9) self-care for the therapist and supervisor, and 10) diversity awareness. It is organized by the VA psychology postdoctoral training directors, including Brian Buzzella, Ph.D., ABPP, Autumn Backhaus, Ph.D., and Laurie Lindamer, Ph.D.

Clinical Psychology Postdoctoral Residency Seminar: Psychology residents will meet monthly (3rd Wednesday of each month) for 60 minutes for the entire training year. This seminar provides the opportunity for residents to check-in with the training director about their experiences in the training program and to participate in additional professional development activities. It is led by Stephanie Orbon, Ph.D., Brian Buzzella, Ph.D., ABPP and Autumn Backhaus, Ph.D.

Other Educational Opportunities for Residents

Fellows also have the opportunity to attend the following optional educational seminars:

Psychiatry Department Grand Rounds: Range of topics from molecular biological approaches for psychiatric disorders to public policy implications of psychiatry.

Psychiatry Department Professional Development Series: Advanced seminars on professional development topics.

Research/Dissemination Project Opportunities and Expectations

Residents are required to engage in some clinical research and/or dissemination activity across the training year. Such activities might include piloting a new clinical service or evaluating a current program offering. To complete such projects, residents will have support in protecting time (e.g., reducing their clinical case load) to conduct these clinical research/dissemination activities. Up to 8 hours, per week, may be requested. The nature of the project will be determined in collaboration with the PSR Fellowship supervision team. The project, and the associated adjustment in training activities, must be reflected in the resident's training plan and approved by the primary supervisor and Director of Training. The project selected should be of a scope consistent with the amount of protected time being requested. For example, a resident might choose to evaluate client satisfaction and other key outcomes in the CORE program, before and after they implement an intervention they design or modify from existing validated interventions (e.g., using Cognitive Behavioral Therapy [CBT] approaches in a novel way to promote behavior change). If the project does not require the number of

hours being requested, or if the project is completed prior to the conclusion of the training year, an adjustment to the resident's time will occur (e.g., their clinical case load will increase). The project is developed by the resident and overseen by a research/dissemination mentor, who may be any member of the PSR Fellowship supervisory team.

Residents are required to present their projects locally or at a national conference (e.g., NAMI, Psychosocial Rehabilitation Association). PSR residents nationally are typically funded by the VA to attend and present at one national recovery-oriented conference (in the past this was PRA's Wellness and Recovery Summit), but funding for the 2019-20 year has not yet been announced.

Core Competencies

Core competencies (or standards of practice) are those skill sets that are essential to all practicing clinicians. Residents are expected to develop expertise in the core competencies of their respective discipline by the end of the training program. For psychology residents, the PSR Fellowship follows the core competencies of the VASDHS/UCSD Clinical Psychology Postdoctoral Residency Program, which address the professional psychological competencies, skills, abilities, proficiencies and knowledge in the content areas outlined in the APA *Standards of Accreditation (SoA; listed below)*. For residents from other disciplines, the PSR Fellowship broadly follows these same content areas but specific competencies within them differ by discipline. Residents are assigned supervisors from their own disciplines to ensure that they develop expertise relevant to their disciplines.

I. Psychological Assessment, Diagnosis, and Consultation (SoA Domains: "Theories and effective methods of *psychological assessment, diagnosis* and interventions," and "*Consultation, program evaluation, supervision, and/or teaching*"): By the end of the residency, residents should be able to formulate a multi-axial diagnosis by integrating data from a variety of sources, including clinical interview, family history, medical history, mental status examinations, and psychological testing data. All residents must demonstrate expertise in psychological assessment. By the end of the residency, the resident should be able to develop a testing battery to answer a specific referral question, administer and score a wide variety of psychological tests in a standardized fashion, interpret test data, integrate test data with history and other sources, write a report that clearly answers the referral question, and provide clear, relevant, treatment recommendations. All residents must be able to assist consumers and other providers in formulating treatment plans and setting attainable treatment goals, as well as linking consumers with needed resources to achieve them.

II. General Principles of Evidenced-Based Interventions (SoADomain: "Theories and effective methods of psychological assessment, diagnosis and *interventions*"): All residents are expected to understand and demonstrate an advanced understanding and application of psychotherapeutic techniques common to all theoretical approaches including empathy, rapport, relationship building, and history-taking, and must become proficient in the procedures involved in specific individual and group evidence-based practices relevant to their position and rotations.

III. Rehabilitation and Recovery (SoADomain: Theories and effective methods of psychological assessment, diagnosis and *interventions*): The goal of psychiatric rehabilitation is to enable individuals to transcend limits imposed by mental illness, social barriers, internalized stigma and second-class personhood, so that the individual can achieve their goals and aspirations in living, learning, working and socializing roles. To this end, residents must instill hope in verbal communication, make encouraging statements regarding an individual's potential for recovery, and

promote hopefulness for recovery, including identifying strengths. Residents must emphasize treatment choices and participation in the healthcare process, and integrate the use of community resources and entitlement programs into treatment planning and goal achievement. Residents must also communicate with family members, friends, neighborhood and other natural community supports when appropriate to support efforts to change and goal attainment.

IV. Laws and Ethics (SoA Domain: “Professional conduct, ethics and law, and other standards for providers”): Postdoctoral residents must demonstrate sound professional clinical judgment and behavior in the application of assessment and intervention procedures with individuals; familiarity with and understanding of professional and legal standards in professional psychology, and a thorough working understanding of APA ethical principles and standards.

V. Cultural Diversity (SoADomain: “Issues of cultural and individual diversity”): Residents are expected to demonstrate expertise in cultural diversity. Cultural and ethnic issues cut across all core competency areas. Residents develop expertise in cultural diversity through exposure to a multiethnic staff and patient population, through coursework, clinical supervision and consultation. By the end of the residency, residents are expected to 1) identify cultural/ethnic issues relevant to the case; 2) explain how these issues affect psychiatric presentation, psychological test data, response to staff and treatment interventions, and 3) modify assessment/treatment approach based on supervisory and consultant input. The VASDHS has a culturally diverse patient population, which ensures adequate contact to develop skills in this area.

VI. Supervision (SoADomain: “Consultation, program evaluation, *supervision*, and/or teaching”): Residents receive supervision and are provided opportunities to supervise other providers (e.g., clinical psychology interns and practicum students), under the guidance of their own supervisor. Residents come to supervision prepared to discuss cases, including but not limited to providing video- or audio-tape of sessions and using theoretical framework to describe a case, assessment or treatment plan. Residents seek supervision for complex cases, and communicate in a professional manner with supervisors and supervisees. Open discussion and acceptance of constructive feedback during supervision is essential to the learning process.

VII. Clinical Research/Dissemination Skills (SoADomains: “Consultation, program evaluation, supervision, and/or *teaching*” and “Strategies of scholarly inquiry”): Postdoctoral residents receive training in program evaluation and clinical research. These include the following skills: a) formulating testable hypotheses / identifying a service need; b) designing and carrying out a research/program evaluation project; c) presenting findings to other professionals.

VIII. Organization, Management and Administration (SoADomain: “Organization, management and administration”): Residents must use time-management skills to maintain an efficient practice, comply with program and local facility policies and procedures that support training and patient care, and complete administrative tasks that support training and patient care, in order to function as effective practitioners.

IX. Interprofessional Practice (SoADomains: “Theories and effective methods of *psychological assessment, diagnosis* and interventions,” and “*Consultation*, program evaluation, supervision, and/or teaching”): Residents receive training in interprofessional practice including clarity regarding roles, approaches, and resources. Residents develop expertise in interprofessional practice through team-work and communication. By the end of the residency, they are expected to collaborate effectively with other professionals in practice and in research.

Opportunities for Working with Diverse Patient Populations and for Developing Multicultural Competence

The program is organized and administered in such a way that respect for and understanding of cultural and individual diversity of faculty, staff, residents and consumers is fundamental and a core part of training at the VASDHS. A wide array of age groups (aside from minors), Veteran cohorts, and ethnic/racial/cultural backgrounds are represented within the patient population of the VA. The Veteran population also represents a unique cultural group within our community. There are 249,594 Veterans in San Diego County and in fiscal Year 2017, VASDHS served 83,014 Veterans. 22,238 of those Veterans were seen in mental health clinics for a total of 168,944 mental health visits. Veterans served within VASDHS mental health clinics were 84% male. With respect to age, 3% were under age 25, and 21% were age 65 or older. 47% were White non-Hispanic, 17% Hispanic, 14% African American, 9% Asian, 2% Hawaiian/Pacific Islander, and 1% American Indian. With respect to Veteran culture, the Navy represents the most frequent branch of service, and Persian Gulf Era Veterans (which includes Iraq and Afghanistan Veterans) is the largest cohort at 61%.

Each resident will receive training regarding sensitivity to issues of cultural and individual diversity. Issues related to cultural and individual diversity are covered in a bi-weekly seminar and also are discussed in other seminars, and residents will have the opportunity to join the CORE Diversity Committee. Issues related to cultural diversity are included in the evaluation forms filled out by the residents concerning their supervisors, and supervisors are encouraged to make discussion of such issues an integral part of case conceptualization and treatment strategy development. Each resident also completes an evaluation of multicultural competence at the beginning and the end of the training year to assess the change in their level of cultural competence.

Evaluation Process

Supervisors and residents are expected to exchange feedback routinely as a part of the supervisory process; the evaluation procedures are meant to formalize this continuous information flow. It is the responsibility of the Training Director and supervisors to ensure that evaluation occurs in a timely and constructive fashion, and residents are encouraged and expected to take an active role. To that end, it is essential that residents understand the philosophy and logistics of evaluation as they begin training. The Training Director will review the overall evaluation process during initial orientation processes, and each individual supervisor should review exit competencies for the specific position at the beginning of the year.

In collaboration with their supervisors, residents will complete a self-assessment of their own skills and knowledge for each core competency at the beginning of the training year. Strengths and weaknesses that emerge from this self-assessment, as well as the resident's application materials, will be used to develop a training plan. Supervisors will complete competency-based evaluations of residents at mid-year and end-of-training. The mid-point evaluations are intended to be a progress report for residents to increase self-awareness and awareness of supervisor's perceptions, discrepancies between self-ratings and supervisor ratings, and to help the Resident focus on specific goals and areas of needed improvement as training progresses. Residents are rated as "having a problem," "progressing well," (consistent with where they would be expected to be given their training), or having developed competence in each rated area. In the event that a supervisor suspects that a resident is not fulfilling critical competencies, Due Process procedures are in place to work towards resolution of the problem

is possible. The Due Process procedure is reviewed in detail with residents at the beginning of the year.

Residents will also be asked to provide a written evaluation of each supervisor at end-of-training. Residents and supervisors are expected to discuss these evaluations to facilitate mutual understanding and growth.

As part of a continual quality improvement plan, the Training Director(s) will conduct a self-study with residents at mid-year and at the conclusion of each training year. The areas reviewed are caseload mix and volume, balance of activities (clinical, teaching, research), amount and quality of supervision, adequacy of facility resources, and professional relationships between the residents and other healthcare professionals. The findings and minutes are distributed to the entire faculty for review and action when appropriate.

The PSR Fellowship hub site also administers a feedback survey to PSR residents nationally at the middle and end of the training year.

Application and Selection Process

To apply for the PSR Fellowship, applicants should submit the following:

1. A brief **statement of interest** (maximum 2 pages), with the following:
 - a) For psychology applicants, the emphasis area to which you are applying (i.e., PSR only or PSR and other position(s)), including a rank ordering of your preferred rotations. Please describe why you are applying to each emphasis area
 - b) A brief summary of educational, clinical and research experiences relevant to recovery-oriented PSR of people with SMI, and any other specific area(s) of interest
 - c) A summary of your training needs and goals for the residency
 - d) A statement of your career goals
2. A **current curriculum vitae** or resume
3. **Three letters of reference**, preferably from clinical and research supervisors

Psychology applicants should submit these materials via the APPA CAS portal at <http://www.appic.org/About-APPIC/Postdoctoral/APPA-Postdoc-Application-Information> by 11:59pm on **December 9, 2018** and should be available for interview on **Friday, February 1, 2019**. Other interview dates and phone interviews may also be possible.

Applicants from other disciplines should email the materials to dperivol@ucsd.edu by **February 19, 2019**. Interviews for these candidates will occur in person or by phone (depending on applicant preference) throughout **March, 2019**.

Selection of residents is done by the PSR Fellowship Training Director and supervisors, and for psychology candidates additionally applying to other emphasis areas, our Postdoctoral Selection Committee (consisting of the Training Director and supervisors for each emphasis area), with input from other staff members using the following criteria (not in order of priority):

1. Breadth and quality of previous general clinical training experience
2. Breadth, depth, and quality of training experience in recovery-oriented PSR for people with SMI, and any other specific areas of emphasis

3. Quality and scope of scholarship, as indicated partially by research, conference presentations, and publications
4. Relationship between clinical and research interests/experience of the applicant,
5. Evidence of accomplishments
6. Thoughtfulness of information provided in the cover letter
7. Goodness of fit between the applicant's stated objectives and the training program and medical center's resources
8. Strength of letters of recommendation from professionals who know the applicant well.

The top applicants will be invited to interview with the PSR Fellowship Training Director, supervisors, and other relevant faculty. The applicants are reassessed based on their interviews using similar criteria to those stated above, with the opportunity to obtain further and clarifying information as needed, as well as an assessment of interpersonal skills. Final admission and hiring of residents is dependent on VASDHS Human Resources Service approval, which includes a federal background check, physical examination, and education/credential verification.

The program is an Equal Opportunity Employer. Our commitment to diversity includes attempting to ensure an appropriate representation of individuals along many dimensions, including (but not limited to) gender, sexual orientation, age, ethnic/racial minorities, and persons with disabilities. We provide a supportive and encouraging learning environment for students, regardless of ethnic background or physical needs, and applicants from diverse backgrounds are encouraged to apply.

The program has nondiscriminatory policies and operating conditions and avoids any actions that would restrict program access and participation. In recent years, California state law and University of California policy have prohibited the specific inclusion of race/ethnicity factors in the recruitment of staff and faculty. More recently, however, the University has initiated an Equal Opportunity/Affirmative Action Program to increase faculty and staff diversity with some success. There is no discrimination in faculty hiring and retention practices, resident recruitment and selection processes, or patient eligibility criteria concerning access to the various evaluation and treatment programs.

Contact Information

Questions about the VASDHS PSR Fellowship program can be addressed to the program's training director:

Dimitri Perivoliotis, Ph.D.

VA San Diego Healthcare System

3350 La Jolla Village Dr. (116B)

San Diego, CA 92161

Email: dperivol@ucsd.edu (please email with questions first)

Telephone: (619) 228-8028

Web: http://www.sandiego.va.gov/careers/psychology_training.asp

Questions regarding the broader VASDHS / UCSD Clinical Psychology Postdoctoral Residency Program can be directed to the coordinator of that program:

Audrey Bascom

Psychology Postdoctoral Residency Program Coordinator (116)

(same address as above)

Telephone: (858) 552-8585 x2565

Fax: (858) 822-0231

Email: Audrey.Bascom@va.gov

Web: http://www.sandiego.va.gov/careers/psychology_training.asp

Questions related to the psychology postdoctoral residency program's accreditation status should be directed to the Commission on Accreditation:

Office of Program Consultation and Accreditation

American Psychological Association

740 1st Street, NE

Washington, DC 20002

Phone: (202) 336-5979

Email: apaaccred@apa.org

Web: www.apa.org/ed/accreditation

Appendix VII: VA CT/Yale University Post-Doctoral Residency in PSR Brochure



Postdoctoral Residency with Major Area of Study in Psychosocial Rehabilitation, Accredited as a Postdoctoral Residency in Clinical Psychology

Two Tracks:

1. *Psychosocial Rehabilitation*
2. *Psychosocial Rehabilitation and LGBT Healthcare*

VA Connecticut Healthcare System

Errera Community Care Center
114-52 Boston Post Road
West Haven, CT 06516

<https://www.connecticut.va.gov/careers/psychologytraining.asp>

Application Due Date: January 1, 2019

Accreditation Status

The psychology residency program is accredited by the Commission on Accreditation of the American Psychological Association. Our next accreditation site visit will be in 2021.

Questions related to the program's accredited status should be direct to the Commission on Accreditation:

Office of Program Consultation and Accreditation
American Psychological Association
750 1st Street, NE, Washington, DC 20002
Phone: (202) 336-5979 / E-mail: apaaccred@apa.org
Web: www.apa.org/ed/accreditation

Application & Selection Procedures

Eligibility Criteria:

Applicants for the Psychology Postdoctoral Residency Program must meet the following minimum requirements:

1. Successful completion of all requirements towards earning a doctoral degree (including dissertation defense) from an APA-Accredited Clinical or Counseling Psychology graduate program.
2. Successful completion of an APA-Accredited Psychology Pre-doctoral Internship Program.
3. U.S. Citizenship.

4. Successfully meet mandatory requirements for appointment as a Federal Employee, including, but not limited to: willingness to participate in the government's drug testing procedures and consent to participate in fingerprinting and a background check to verify your application information and/or criminal history. Applicants who do not successfully pass this background check and/or drug test are ineligible for our program. Male applicants born after 12/31/1959 must have registered for the draft by age 26 to be eligible for any US government employment, including selection as a paid VA trainee. Male applicants must sign a pre-appointment Certification Statement for Selective Service Registration before they can be processed into a training program. Exceptions can be granted only by the US Office of Personnel Management; exceptions are very rarely granted.

Application Process:

Applications are due no later than **January 1st**. To apply, please send the following:

1. A cover letter detailing:
 - a. Your experiences with serious mental illness, recovery-oriented clinical services, and/or community-based clinical work
 - b. How this fellowship will meet your training and career goals
 - c. Expected date of dissertation defense
 - d. Whether you are interested in the PSR General Psychosocial Rehabilitation track or the PSR/LGBT Healthcare Track, or if you would like to be considered for both tracks
2. Curriculum Vitae
3. 3 letters of recommendation

Application materials can be sent in one package or separately. Electronic copies are preferred. For recommendation letters, any of the following will be accepted: a) scanned pdf files of original letters that include signatures, b) emailed letters, if sent directly from the recommender's work email account, or c) hard copies of signed letters sent via mail.

Application materials for the general fellowship should be sent to the attention of:

Joanna Fiszdon, Ph.D.
 Acting Director of Psychology Training, Psychosocial Rehabilitation Interprofessional Fellowship
 VA Connecticut Healthcare System-116B
 950 Campbell Ave
 West Haven, CT 06516
joanna.fiszdon@va.gov
 203-932-5711 x2231

Application materials for the LGBT track should be sent to the attention of:

Lynette Adams, Ph.D.
 LGBT Track Director, Interprofessional Fellowship in Psychosocial Rehabilitation
 VA Connecticut Healthcare System-116B
 950 Campbell Ave
 West Haven, CT 06516
Lynette.Adams@va.gov
 (203) 932-5711 x5402

Applicants interested in both fellowship tracks should send separate applications for each track

Application Selection:

All completed applications are reviewed and ranked by training faculty. Based on a systematic review of all applications, a subset of candidates are invited to interview.

Compensation and Benefits

Each psychology postdoctoral resident receives a stipend of \$51,233 plus benefits for the one year residency from September 2018 to August 2019 (this amount may be adjusted annually).

The VA allocates additional funds for FICA and other benefits that include health and life insurance.

All residents receive an affiliation with Yale School of Medicine which provides them with library and other privileges.

The Postdoctoral Residency with Major Area of Study in Psychosocial Rehabilitation, Accredited as a Postdoctoral Residency in Clinical Psychology

Overview

The VA Connecticut Healthcare System (VACHS) offers psychology postdoctoral training with Major Area of Study in Psychosocial Rehabilitation (PSR), a therapeutic approach that encourages individuals with severe mental illnesses (SMI) to develop his or her fullest capacities through learning and environmental supports. This funded training program resulted from a Veterans Health Administration (VHA) initiative first announced in 2002 as part of the U.S. Department of Veterans Administration's national initiative to promote psychosocial rehabilitation training, research, and program development. The residency follows the scientist-practitioner model and is an interdisciplinary mental health program that offers training in clinical services, program development, research, and education. In addition to psychology residents, the fellowship includes trainees from various mental health disciplines, including psychiatry, nursing, social work, occupational therapy, chaplaincy, and rehabilitation counseling. The VACHS residency sponsors up to 7 trainees, with 2 designated psychology positions; one slot is for the general PSR track, and the second is for PSR/LGBT healthcare track, described in the section below.

The residency is hosted by VACHS at the West Haven campus. Residents report to the Psychology Service for matters of professional conduct and development. The residents are primarily based at the Errera Community Care Center (ECCC), but also interact with other programs in the Mental Health Service Line such as the Outpatient Mental Health Clinic, the Inpatient Mental Health Recovery Unit, among other settings.

The psychology residency experience is unique for each resident and is comprised of clinical, consultation, program development, teaching and/or research opportunities. Residents participate as members of interdisciplinary teams for approximately 20 hours per week for their primary clinical placements for the duration of the training year. In addition, residents have secondary requirements that average from two to six hours per week, as well as seminars, supervision, and electives to round out their residency experience. Approximately 40% of residents' time is devoted to direct service delivery, with approximately 80% of clinical care focused on providing services to individuals with Serious Mental Illness (SMI)..

LGBT Healthcare Track of the PSR Training Program

One psychology resident in the 2018-2019 training year will have a training plan that has an emphasis on Lesbian, Gay, Bisexual, and Transgender (LGBT) Veteran Healthcare. The resident in this track will participate in a primary PSR placement (up to 20 hours a week) with the Wellness Center at the ECCC. In addition to weekly PSR seminars and supervision offered to all residents, secondary requirements will focus on LGBT Healthcare. These experiences will include participation in the LGBT committee, assignment of LGBT-identified individual therapy cases, providing training to clinical staff on topics pertaining to LGBT healthcare, consultation across the hospital on LGBT cases, development and facilitation of support groups for LGBT-identified Veterans, and training in providing resources and evaluations for Veterans who are planning on or are engaging in gender transition. Additional secondary experiences will be based on the individual training plan of the LGBT-track resident.

**If you have an interest in being considered for the LGBT-Track of the PSR fellowship, please clearly state this in your cover letter/application materials, and indicate whether you would like to be considered only for the LGBT Track or both the LGBT and the General PSR Tracks. To be considered for the LGBT track, please also send materials to:*

Lynette Adams, Ph.D.
 LGBT Track Director, Psychosocial Rehabilitation Interprofessional Fellowship
 Psychology Service (116B)
 VA Connecticut Healthcare System
 950 Campbell Ave,
 West Haven, CT 06516
Lynette.Adams@va.gov
 (203) 932-5711 x5402

VA Connecticut has been identified as a leader in LGBTQ Health Equality in the Health Equality Index, a designation by the Human Rights Campaign, since 2014.



PSYCHOLOGY SETTING

Overview of VA Connecticut Healthcare System

VA Connecticut Healthcare System (VACHS) consists of two major medical centers (West Haven Newington campuses) as well as six Community Based Outpatient Clinics. Care in this system emphasizes an outpatient, primary care model of healthcare delivery with an expanding array of community-based services. Inpatient medical, surgical, psychiatric, and rehabilitation services, as well as tertiary care outpatient services are also available. Similar to other VA settings throughout the nation, the Psychology Service at VACHS has witnessed a rapid growth in recent years. Moreover, VACHS hosts an impressive complement of at least a dozen research psychologists supported through VA and other funding sources. Many of these research psychologists serve as additional research mentors for the various psychology trainees at VACHS.



and

well
the

The credentials of psychologists at VACHS are exceptional and diverse. The vast majority of psychologists at VACHS hold an academic appointment with Yale University and/or the University of Connecticut, and regularly contribute to peer-reviewed scholarly publications. Within their respective areas of specialization, the notoriety of several members of our Psychology Service as existing and/or emerging experts within their areas is evident. Members of our Service regularly serve in leadership roles within the American Psychological Association as well as other national or international professional organizations. Psychologists from VACHS are also regularly involved in cutting-edge programs spearheaded by VA Central Office. For example, members of the Psychology Service have contributed towards national VA projects aimed at addressing the ongoing and emerging needs of Veterans include: (a) leadership roles related to national VA Initiatives, including promotion of effective, evidence-based pain management; (b) consultant roles such as participation in the VA Smoking and Tobacco Cessation Technical Advisory Group; (c) implementation of National VA Health Promotion Programs, including successful implementation of the Managing Obesity/Overweight in

Veterans Everywhere (M.O.V.E.!) throughout VACHS; and (d) development of novel VA-Sponsored Public Health Programs within emerging areas such as health promotion among Veterans with severe mental illness and tobacco cessation among Veterans infected with HIV. In addition, several staff psychologists at VACHS are actively involved in one or more focused areas emphasized by the VA's Mental Health Strategic Plan – including Geriatrics, Home-Based Primary Care, Interprofessional Care, Neuropsychology, Primary Care - Mental Health Integration, Recovery Models of Care (such as Psychosocial Rehabilitation), Traumatic Brain Injury, Auditory Disorders, and Women's Needs.

Psychology Training At VACHS

VACHS provides a wealth of training opportunities for future psychologists. At the practicum level, VACHS has a long-standing history of recruiting ambitious trainees from several local psychology training programs including Yale University, University of Connecticut, Connecticut College, and University of Hartford. Formal academic affiliations and training plans are developed for each practicum student, which includes written evaluations that are submitted to the student's host institution as well as maintained within VACHS.

At the psychology internship level, VACHS hosts two (2) APA-accredited training programs: (1) A Clinical Psychology Predoctoral Internship Program sponsored by the West Haven Campus, which typically trains 9 full-time, paid interns per year; and (2) Internship training at the Newington Campus, which is part of the Greater Hartford Clinical Psychology Internship Consortium, and typically trains 6 full-time, paid interns per year.

In addition to our APA-Accredited Clinical Psychology Postdoctoral Residency Program with Major Area of Study in Psychosocial Rehabilitation at VACHS, postdoctoral residency training for future psychologists is available through the following training programs, each of which typically accepts 1-3 clinical psychology postdoctoral residents per year: (1) the Clinical Health Psychology Postdoctoral Residency Program; (2) the MIRECC Fellowship Program; and (3) the Clinical Neuropsychology Postdoctoral Residency Program.

COMMITMENT TO DIVERSITY

VACHS is proud to serve Veterans from all backgrounds. VACHS serves a growing proportion of women veterans, and has an active Women's Clinic, Women Veterans Program Manager, and LGBT Veterans Coordinator. An on-site seminar with VACHS psychology faculty focuses on diversity. Fellows are required to consider how diversity issues may affect their research and clinical work.

Psychology trainees are invited to sit on the Psychology Diversity Committee, which meets monthly. The role of this committee is to identify and address needs of the overall psychology service pertaining to the inclusive environment at VACHS, disseminate information on diversity related resources and educational opportunities that might be of interest to the service line, and identify strategies to address gaps in recruitment and retention of diverse trainees and staff. Trainee input is important to this process, and we value the knowledge and skills that many of our trainees bring to this program.

VACHS is committed to the recruitment of resident from a range of diverse backgrounds. As per the Standards on Accreditation, "Cultural and individual diversity includes, but is not limited to age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and social economic status." We actively welcome applications from applicants from historically underrepresented backgrounds, and we work to attract a diverse cohort of Fellows each year. Our Fellowship abides by federal equal opportunity employment laws and policies. As stated by VA Secretary 11/17/2016, "VA does not tolerate unlawful discrimination, including workplace harassment, based on race, color, religion, national origin, sex (including gender identity, transgender status, sexual orientation, and pregnancy), age (40 or older), disability, genetic information, marital status, parental status, political affiliation, or retaliation for opposing discriminatory practices or

participating in the discrimination-complaint process. This applies to all terms and conditions of employment, including recruitment, hiring, promotions, transfers, reassignments, training, career development, benefits, and separation.” We are proud to have worked with Fellows at different life stages, including Fellows starting families or with young children. A lactation room is available for Fellows.

The surrounding areas of West Haven and New Haven are home to a diverse population. The greater New Haven area represents a moderately sized city with many cultural opportunities including various restaurants, theaters, local social and advocacy groups, and museums. Our affiliate, Yale University, hosts several affinity groups supporting education, advocacy, community building, and more. These groups are typically open to Fellows <https://your.yale.edu/community/diversity-inclusion/affinity-groups>. Grand Rounds and other discussions at Yale School of Medicine have included topics such as understanding the health needs of sexual and gender minority individuals, dealing with patients who voice racist views, and translating minority stress research into LGB-affirmative interventions.

WEST HAVEN, NEW HAVEN, AND SURROUNDING AREAS

West Haven, next-door New Haven, and nearby areas are located on Connecticut’s shoreline, with easy access to Long Island Sound beaches, hiking in nearby state and local parks, and a wide variety of dining options, theaters, concert venues, and museums. New Haven is a vibrant university city with several neighborhoods featuring walking access to restaurants, theaters, parks, farmers’ markets, yoga studios, and more. See <http://visitnewhaven.com/> for more information. Yale University provides access to many cultural events accessible to Fellows, including talks by international artists, scientists, and world leaders, free art museums, symphony performances, and dance lessons. The annual New Haven International Arts and Ideas Festival and summer concert series feature free concerts on the historic New Haven Green. Family friendly options include a local Children’s Museum, many city and state parks, a nearby “rail trail” for family bike trips, and a free outdoor summer movie series. It is also situated within driving distance of number of major metropolitan areas, both of which offer enormous opportunities for cultural, educational, and recreational experiences!

Travel to the area: West Haven and New Haven are located on the MetroNorth train line, with train access to New York’s Grand Central Station within 90 minutes, and access to Boston via car or train in about 2.5 hours. Both cities are on the I-95 corridor, providing easy highway access to other East Coast cities for bus or car trips. Fellows have taken weekend trips to New York, New Jersey, Boston, Philadelphia, Washington DC, Baltimore, Maine, Rhode Island, Cape Cod, Nantucket, Martha’s Vineyard, and Block Island.

Overview of the Errera Community Care Center (ECCC)

The ECCC of VACHS is the host site of the residency ECCC is housed in a beautifully renovated 1920s the past two decades, through a steady process of modification and development, the ECCC has evolved leading centers of innovation in psychosocial and in the integration of the psychosocial and approaches.



program. The factory. Over program into one of the rehabilitation biomedical

At the ECCC, multidisciplinary teams of mental health professionals provide an array of community-based rehabilitative programs including: day and crisis intervention programs (for individuals struggling with mental illness and/ or substance abuse disorders, homelessness, and/or aging); vocational programs; housing programs (ranging from subsidized to non-subsidized, supported to non-supported); homeless outreach and advocacy; clinical case management programs and wellness programs. Believing in recovery and hope, and utilizing the principles of psychiatric rehabilitation, ECCC staff members partner directly with the Veteran being served to identify his or her goals and needs. Rehabilitation care plans build on the person's strengths and help the individual compensate for the negative effects of the psychiatric disability. Where possible, services and supports are provided in the community to enhance natural support systems, and to advance independence and integration that enable each individual to live and function at optimal levels in the least restrictive environment possible.

Critical to the full spectrum of services provided at the ECCC are the community partnerships that have been established and nurtured with the State of Connecticut Departments of Mental Health and Addiction Services, Department of Labor, AT&T, National Alliance on Mental Illness, Department of Housing and Urban Development, local housing authorities, politicians, homeless coalitions and shelters, and numerous mental health and health provider agencies with access to a wide range of people in recovery in the region.

The ECCC programs are accredited both by Joint Commission of Accrediting Hospital Organizations and Committee Accrediting Rehabilitation Facilities (CARF). VA Northeast Program Evaluation Center (NEPEC) data on several of the ECCC programs (Mental Health Intensive Case Management, Compensated Work Therapy, Critical Time Intervention, Supported Employment, and Healthcare for Homeless Veterans) demonstrate that the ECCC is successfully reaching its goals of efficiently delivering effective treatment in the right place and at the right time. Specifically, the ECCC has implemented a cost-effective community based treatment continuum of care aimed at reducing hospital usage and clinical symptoms while improving quality of life and community involvement. More importantly, Veterans report increased satisfaction with the newer outpatient models of care and feeling better about themselves as they are more responsible for the positive choices they make in their own lives.

VACHS's ECCC program has repeatedly been identified by the VA nationally as one of the best models for the long-term care for Veterans with severe mental illnesses (SMI). The ECCC serves as a mentor to developing programs nationally. Team members are consistently requested to serve as faculty in national VA trainings for working with individuals with SMI.

THE RESIDENCY PROGRAM

This residency enhances many components of the residents' previous training and equips them with a specialized set of skills that have been demonstrated to be effective with individuals with severe and persistent mental illnesses and/or substance use disorders, as well as those individuals working to reintegrate back into their communities. A goal for the residents is to engage in assessment, crisis intervention, psychotherapy and psychoeducation, vocational rehabilitation, relapse prevention and planning, and rehabilitative skills training. An associated goal for residents when working with individuals, groups, and families, is to learn and then apply evidence-based psychotherapeutic and psycho-educational techniques. Our training philosophy is strongly based on the scientist-practitioner model. Residents are taught evidence-based practices, such as Social Skills Training, Illness Management and Recovery, and Acceptance and Commitment Therapy. Using their knowledge and acquired skills residents engage in a scholarly pursuit that culminates in a presentation that each resident makes at a national conference. The practice of psychosocial rehabilitation is one in which psychologists and post-doctoral psychology residents can provide leadership on interdisciplinary teams; consultation to providers and systems of care; program design, implementation and evaluation; and policy analysis and advocacy.

Residents integrate into the various clinical programs of the ECCC for the duration of the training year where they provide individual, group and/or family interventions (including biopsychosocial assessment, psychotherapy, psycho-education, clinical case management, and program consultation). Direct practice experiences are coupled with seminars that teach the principles and practices of evidence-based and evolving practices such as: Social Skills Training, Acceptance and Commitment Therapy, Illness Management Recovery, Supported Employment, supported housing, clinical case management, psychopharmacology, Boston University Psychiatric Rehabilitation Model, family psycho-education and psychotherapy models, Psychiatric Advanced Directives, and Dialectical Behavioral Therapy.

THE RESIDENCY TRAINING EXPERIENCE

At the beginning of the training year, residents in the PSR track spend the first few weeks orienting to VACHS, the Mental Health Service Line, and the ECCC programs. Each resident spends one day with each ECCC program, attending rounds, meetings and groups, and shadowing staff members. Each resident meets with the primary preceptor from the clinical team to learn about the role of and expectations for the resident with the program. At the end of the orientation period, residents discuss their impressions and training needs with the Director of Training and then submit their top three choices for primary placements. Residents are encouraged to choose placements with which they do not have prior experience in order to diversity their knowledge and skills. The Residency Training Committee then reviews resident selections and program fit before finalizing placements. Since the residency Training Committee often selects residents with a diversity of clinical interests, residents' first choices are most often honored.

Fellows in the PSR/LGBT track will orient with all other residents in the beginning of the year and work all year directly with the Wellness Clinic as their primary placement. They will have opportunity to engage in consultation with other programs at the Errera Center, and depending on interest or need, may have opportunities to provide clinical services, groups, or trainings with any of the other placements.

PRIMARY CLINICAL PLACEMENTS

The residents participate as members of interdisciplinary teams for approximately 20 hours per week for their primary clinical placements for the duration of the training year. In addition to attending weekly seminars and supervision sessions, residents have several secondary requirements and electives designed to round out their residency experiences (described below).

A number of distinct clinical programs are available to residents for primary placements. Within each of these programs, residents work closely with a wide range of allied healthcare providers (including: nurses, social workers, psychiatrists, occupational therapists, vocational specialists, recreational therapists, medical residents, dietitians, art therapists, etc.), family members, and other community partners. Each program provides a primary preceptor to facilitate administrative and clinical flow for the resident within the context of the team. Clinical supervision is provided by a licensed staff member from the resident's respective discipline. Primary placement opportunities include:

- Psychosocial Rehabilitation Recovery Center (PRRC), also known as the Community Reintegration Program (CRP)
- Compensated Work Therapy/ Vocational Services
- Critical Time Intervention (CTI)
- Healthcare for Homeless Veterans (HCHV)
- The Homeless Patient Aligned Care Team (HPACT)
- The HUD-VA Supported Housing (HUD-VASH) Program
- Mental Health Intensive Case Management Program (MHICM)
- ECCC Wellness Center
- Incarcerated Veterans Re-Entry Program
- Veterans Justice Outreach Program
- Next Steps (Psychosocial Rehabilitation Residential Treatment Program on 7 East)
- Inpatient Recovery Rotation (8-East; staff permitting)

Brief descriptions of these programs available to residents for primary clinical placements are below.

SECONDARY PLACEMENT OPPORTUNITIES

During the remaining 20 hours of the week, residents attend weekly seminars, supervisory sessions, and have several secondary experiences designed to round out their understanding and knowledge of community mental health and psychosocial rehabilitation. These secondary experiences include both the required and optional opportunities listed here:

- **Required:** Designing, developing and implementing an Educational Dissemination Project (EDP) – that can be presented at the United States Psychiatric Rehabilitation Association's (PRA) Annual Conference. Each EDP should be informed by or based on an existing body of knowledge--either theoretical literature or up- to-date treatment/implementation research. EDP's can vary considerably and could consist of a writing a literature review manuscript, implementing a focus group, evaluating an existing treatment program, designing and evaluating a new group or program, evaluating the impact of a new policy initiative, participating in an ongoing research study and presenting research findings, submitting a grant application, etc.
- A four month assessment rotation for psychology and social work fellows. Depending on availability of discipline supervisors, fellows choose either Next Steps (Psychosocial Rehabilitation Residential Treatment Program on 7 East) conducting biopsychosocial assessments or risk assessments in the Psychiatric Emergency Room. A description of each is provided here:
 - Next Steps -- Conducting a weekly intake evaluation on 7E, the residents gain experience in person-centered, strengths-based diagnostic assessment. Next Steps serves veterans who are struggling with serious mental illness and/or substance use disorders, and who are homeless or living in conditions not conducive to recovery. The residents work with Veterans newly admitted to Next Steps and conduct diagnostic clinical assessments, needs assessments, and work on initial goal-setting. Each resident spends about an hour interviewing the Veteran, and 1-2 hours doing a chart review and writing up the Biopsychosocial. They then summarize their report to Howard Steinberg, Ph.D., the Director of Next Steps.
 - Psychiatric Emergency Room -- The overall educational goal of this rotation is to provide an introduction to risk assessment. Fellows work with acutely ill patients, performing risk assessments and assessing co-morbid substance use and medical problems. They help to formulate plans and are involved in important clinical decision making. Fellows function as the primary clinician for the patients assigned to you for the day. There are two main types of patient assessments: new patient presentations and reassessments (patients who have already been seen once by a clinician and now need an assessment for disposition). Fellows are involved in calling family and providers for collateral information, assisting with admission/discharge/transfer and writing notes. Fellows choose either Tuesday or Friday as their PER day. Morning report begins at 8am in the nurses station and Dr. Fuehrlein or Carol Sanders then assign each patient to a clinician. Fellows are expected to be there for the full day, but are excused for all required educational activities including didactics as long as they sign out their patients to another clinician.
- A four month rotation facilitating an Acceptance and Commitment Therapy group for 45 minutes once each week. This will also require advance preparation time and weekly group supervision.
- Two four-month rotations co-facilitating Social Skills Training groups.

Optional:

The list below includes activities that have been established by residents in previous years as well as new opportunities, but the resident may develop their own projects as well.

- Conducting community consultation with community partners (local agencies)
- Wellness Center – group or individual work, intake assessments
- Wellness Center – clinical research
- PTSD Outpatient Firm – carry 2-3 clients
- PTSD Firm co-facilitate 1 group
- Coordinate and facilitate monthly training for Peer Specialists
- Facilitate Wellness Groups in the Substance Abuse Day Program, PRRC or Positively Silvers (55+) program
- Facilitate and design a Community Reintegration Program group
- Conduct research with the Northeast Program Evaluation Center
- Conduct a waitlist group for the Compensated Work Therapy program
- Develop a vocationally oriented group
 - Adjustment to Disability
 - Stigma in the Workplace
 - Job Club
- Facilitate Illness Management and Recovery groups through CRP
- Work with the Giant Steps Art Therapy Program
- Homes for the Brave, co-facilitate psycho-educational group
- Legion Woods, local permanent supported housing program partnered with VA,
- Columbus House and The Connection (two community agencies). Provide clinical case management support.
- Create own or join inpatient unit recovery group programming (staff permitting)
- Women’s Clinic – individual work or co-facilitate a Military Sexual Trauma group

- Individual or group cognitive rehabilitation through the Cognitive Skills Clinic with Joanna Fiszdon, Ph.D. Psychosocial rehabilitation treatment research for individuals with psychosis with Joanna Fiszdon, Ph.D.
- Participate in the Annual Homeless Count - join homeless staff one evening in January canvassing a community.
- Participate with homeless outreach and engagement teams
- Provide clinical supervision to a peer provider
- Work on housing development and community policy initiatives
- Liaison with community partners
- Facilitate arts programming (music and art)

Each resident’s training plan is individually tailored to meet specific training needs to develop competence in a full range of community mental health and psychosocial rehabilitation skills. After orienting to the programs and opportunities available, residents meet with faculty to select placements and design their training plans. Each resident receives supervision from several faculty members during the year. In addition, each resident is part of a coordinated training experience in which the residents regularly interact with each other and have a weekly meeting to discuss their training experiences, and development of professional identity and competence.

PRIMARY CLINICAL PLACEMENTS FOR THE RESIDENCY

Psychosocial Rehabilitation Recovery Center (PRRC), also known as the Community Reintegration Program (CRP)

The PRRC is comprised of interdisciplinary team including (at any given time) occupational therapists, peer staff, social workers, psychologists, nurses, psychology interns, psychiatrists, psychiatry residents, and others. The structure of PRRC includes both PSR model groups and clinical case management. PRRC serves Veterans who have chronic, severe psychiatric illnesses and substance abuse disorders as well as Veterans in crisis. PRRC staff strive to help Veterans avoid inpatient hospitalizations, minimize the length of hospital stays, resolve current crises, help Veterans focus on maintaining safety, and help Veterans build/expand social support and maintain sobriety. The goal is to help Veterans build recovery skills so that they work towards, and reach their goals. As a team member, the resident both co-facilitates groups and provides clinical case management. As the year progresses residents have the opportunities to design and implement their own groups.

Residents are assigned 6-10 clinical case management clients and are expected to meet with them with them daily as needed. This number of clients will fluctuate depending on specific circumstances. Resident's preferences to work with someone of a particular age, diagnosis, or other aspect/demographic will be honored as much as possible. Residents are expected to attend morning rounds and afternoon team meetings 3-5 times each week and to complete requisite assessments, care planning and documentation.

Compensated Work Therapy/ Vocational Services

The mission of the ECCC Vocational Service Programs is to assist Veterans' return to full, productive community participation, enabling each Veteran to work and function at their highest potential in the least restrictive setting possible. As such, much of the work is designed to offer individualized services to these ends. Vocational counselors provide assessment services including situational assessment, job seeking skills training, referral to community resources, supported employment, benefits counseling, and advocacy for psychiatric and medical treatment. Primary placement opportunities in CWT Transitional Work Program for the residents involve Vocational Counseling & Guidance, individual adjustment to disability counseling, assistance in developing employment goals, connecting Veterans with state services, job placement, and developing psycho-educational support groups.

Critical Time Intervention (CTI)

The CTI program is designed to assist Veterans who are chronically homeless and have serious mental illness (SMI) secure stable housing and reintegrate into the community. CTI offers intensive case management services in collaboration with a community, non-profit partner operated transitional housing program, "Homes for the Brave" (HFTB). The CTI team provides services in the areas of psychiatric rehabilitation and medication management, money management, substance abuse treatment, Vet to Vet supports, vocational resources, permanent housing, and family interventions. CTI is a time limited intervention, lasting a minimum of nine months and a maximum of one year. The primary goal of CTI is to reduce the re-occurrence of homelessness among persons with serious mental illnesses by increasing support when an individual first moves to more independent housing. Residents carry a caseload of 4-6 clients and provide a range of psychotherapeutic interventions. For some of the clients, residents serve as the primary clinician and for others they provide clinical case management and liaison with VA staff from the outpatient clinics and HFTB staff. Residents attend weekly CTI staff meetings (twice per week) and complete all requisite assessments and documentation.

Healthcare for Homeless Veterans (HCHV)

The HCHV Program name is an umbrella title for VA homeless programs funded through the Strategic Healthcare Group for Mental Health Services of the Veterans Health Administration. HCHV services are targeted to homeless Veterans with mental health diagnoses and/or substance abuse problems who do not come to the VA medical center on their own. The team spends considerable time in the community, learning the terrain of the homeless and participating in local "sweeps" of areas known to be frequented by homeless individuals. HCHV staff provides community case management to Veterans in the early stages of their involvement with HCHV.

The residents, alongside HCHV staff, reach out and engage, serving homeless Veterans who have severely limited resources and who suffer from persistent psychiatric and substance abuse disorders. Clinicians and residents assess mental and healthcare needs and then link homeless Veterans with needed health care and other services, including basic needs. They help the Veteran access the full-range of multidisciplinary, bio-psycho-social and vocational programs through the VA Errera Community Care Center, and through an array of partnerships with federal, state, municipal and community-based partnerships. The resident may also be involved in developing quality permanent supported housing sites and services available to homeless Veterans.

Homeless Patient Aligned Care Team (H PACT)

In 2012 a Homeless Patient Aligned Care Team was started at the Errera Community Care Center under the Direction of David Rosenthal, MD. Its mission is to provide tailored healthcare to Veterans who are homeless. Residents have the opportunity to provide integrated primary care services to the population in collaboration with the Wellness Center.

The HUD-VA Supported Housing (HUD-VASH) Program

The HUD-VASH Program is a cooperative effort between the VA Connecticut Healthcare System, the U.S. Department of Housing and Urban Development and the City of West Haven Public Housing Authority. Through the HUD-VASH Program, Section 8 Vouchers are made available to homeless Veterans with psychiatric illnesses and/or substance abuse histories who need intensive clinical case management supports to obtain and maintain housing and live on their own. The program is designed to serve Veterans who are chronically homeless and require financial and structural supports to end the cycle of homelessness. The resident serves as a VASH clinician facilitating transitions and supports the Veteran as he or she strives to remain stably housed. The VASH clinician typically assists the Veteran in finding a suitable apartment, explaining the program to prospective landlords, contacting social service agencies; as well as teaching the Veteran important skills such as budgeting, shopping and navigating public transportation.

Mental Health Intensive Case Management Program (MHICM)

The Mental Health Intensive Case Management Program (MHICM) has a mission is to identify the highest users of inpatient psychiatric services and through assertive community based outreach promote, maintain, and/or restore the mental health of this Veteran population. The goal is to decrease the use of costly inpatient psychiatric services and to improve community functioning and adaptation. Veterans must have greater than thirty days of inpatient psychiatric hospitalization and/or three or more admissions within the previous calendar year. All admissions occur when Veterans are on the inpatient unit just prior to their discharge. A diagnosis of a severe mental illness must be present and may include psychotic, affective and/or personality disorders although a priority is given to Veterans with psychotic disorders. The four clinical characteristics of the MHICM program are: 1) Intensity. Veterans are seen as frequently as clinically indicated (one to five times/week). 2) Flexibility and Community Orientation. The majority (95%) of Veteran contacts occur in community settings where access to community networks are available and maximum clinical leverage may be obtained. 3)

Practical Problem Solving. Clinical contacts emphasize practical problem solving, crisis resolution and adaptive skill building using community and clinical resources. 4) Continuity of Care. The MHICM staff are primary mental health providers.

As a MHICM team member, the resident serves as the primary clinician for 4 Veterans in the MHICM program. Service is provided primarily in the community either on an individual basis or teamed with another clinician, as indicated by the needs of the Veteran. In addition, the resident provides back-up coverage to other members of the team. There may be an opportunity to lead or co-lead a clinical group, and participate in therapeutic group activities in the community or at the ECCC. Team members attend two weekly rounds, one for administrative issues and acute clinical issues and the other for clinical issues only. Upon intake of a new Veteran to the program, the resident is expected to complete a treatment plan, bio-psycho-social assessment, and patient education note.

The ECCC Wellness Center

The ECCC Wellness Center offers a comprehensive range of wellness services including physical exercise (with medical clearance), nutritional counseling, and health psychology treatments (e.g. CBT-Insomnia, smoking cessation) The Wellness Center team is staffed by a Ph.D. Psychologist, a Registered Dietitian, and Exercise Specialists who coordinate services to improving each Veteran's overall physical, nutritional and emotional wellness. The Wellness Center's fitness center is equipped with cardiovascular exercise equipment such as elliptical machines, treadmills, bicycle machines, a multi-gym trainer and a range of weights, which provide opportunities for strength training and conditioning. The team provides community-based treatment and consultation to Veterans and other ECCC clinical teams related to health behaviors such as exercise, diet, sleep, pain, and more.

Residents can be involved in a number of different roles depending on interest, including structured individual health psychology treatments, leading and initiating wellness groups, conducting community interventions, consulting to others ECCC teams, and helping with research and program evaluation.

Incarcerated Veterans Reentry Program

The Incarcerated Veterans Reentry Program provides services to incarcerated veterans in federal, and state institutions to help them achieve successful reentry and to become productive members of the community.

Outreach/ Pre-Release Services

Incarcerated Veterans Specialist Provides outreach services in federal and state correctional institutions, including:

- Education on VA eligibility and benefits and in enrolling for health benefits at VA facilities
- Needs assessment for community reentry and linkage to local services
- Post-release referrals to VA pro-grams and community resources

Post-Release Services

- Substance abuse treatment
- Vocational and independent living skills programs
- Community Transitional Residence
- Programs a supportive and structured community placement to help veterans live and work successfully outside of an institution
- Ongoing support and short term case management
- Coordination of treatment with local, state and federal probation and pa-role agencies, to ensure seamless services and support to Veterans

IVR Program Duties for a PSR Fellow include:

- Provide education, consultation and referral assistance to incarcerated Veterans.

- Work closely with DOC personnel and officers, local law enforcement, courts, judges, probation, parole and other state and federal agencies.
- Refer for community case management, treatment planning, program referral, placement assistance and advocacy to Veterans involved in the criminal justice system.
- Assist in finding incarcerated Veterans therapeutic supports, transitional housing as an alternative to incarceration.
- Assist DOC staff on the Veterans Service Unit at Cybulski Correctional Institute, continue to consult and provide reentry counseling on that unit two days a week.

Veterans Justice Outreach Program

The purpose of the VJO program is to end unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible Veterans in contact with the criminal justice system have access to Veterans Health Administration (VHA) medical, mental health and substance services.

The Connecticut VJO program is designed to provide outreach services to eligible Veterans who are involved with the criminal justice system. Justice-involved Veterans can be at risk for homelessness and struggling with issues of substance abuse, mental illness and/or physical health problems. The goal of the program is to provide a consultation, and the assessment necessary, to facilitate access to VA services by providing the court with an individualized treatment plan that can be used as an alternative to incarceration.

Responsibilities of the VJO:

The VJO is responsible for acting as the clinical liaison between the VA and the criminal justice system to provide outreach, assessment, and case management for eligible justice-involved Veterans across the state. The VJO is also responsible for providing psycho-educational trainings and consultations to DOC, local law enforcement agencies, the courts and other community agencies regarding how substance abuse and mental illness, including Post Traumatic Stress Disorder, Traumatic Brain Injury and other combat related disorders, impact the Veteran's daily functioning and may contribute to criminal justice system involvement.

Interested Fellows would be able to assist with

- Serving Veterans who are eligible for VHA healthcare.
- Assess Veterans' treatment needs to identify appropriate VA and non-VA services.
- Refer and link Veterans to comprehensive health care services.
- Communicate with the court in regards to a Veteran's medical, mental health and substance abuse treatment (which may include program attendance, treatment progress, evaluation, and discharge planning) as long as there is a valid authorization signed by the Veteran in place.
- Link court-monitored Veterans to Evidence Based Treatment specific to their needs.

Next Steps (Psychosocial Rehabilitation Residential Treatment Program on 7-East, PR RTP)

The PR RTP serves veterans who are struggling with serious mental illness and/or substance use disorders, and who are homeless or living in conditions not conducive to recovery. The program provides coordinated services in a safe, supportive, and sober residence with an emphasis on connection to long-term outpatient services. Interns will have the opportunity to serve as a member of an interprofessional team providing individual clinical case management, conducting intake evaluations, and facilitating treatment groups.

Inpatient Recovery Rotation (8-East; staff permitting)

VACT's inpatient recovery unit offers short-term treatment services for acute episodes of psychiatric illness and/or substance abuse. The unit's goal is to support Veterans such that they can improve their level of functioning, develop connection with outpatient treatments that will help promote community integration, and connect or reconnect them with their recovery.

This rotation provides training in 1) delivering consultation to a multidisciplinary team comprised of physicians, social workers, nurses, and other staff; 2) conducting brief, recovery-oriented therapy for the broad range of acute clinical presentations on the unit; 3) conducting psychoeducational and psychotherapeutic groups in an inpatient setting, including evidence-based practices; 4) adaptation of recovery principles (collaborative goal-setting, Veteran-centered care, etc.) to an inpatient setting; 5) provision of supervision of a psychology intern from a recovery perspective; and 6) other specific goals as determined by the PSR Fellow.

Resident and Program Evaluation

Resident progress is assessed by clinical supervisors during the course of informal and formal supervision. Written and oral feedback is provided to residents, at a minimum, at 4-months, 8-months, and at the conclusion of 12-months of training. Residents review each evaluation form with the appropriate supervisor(s) before evaluation forms are signed by both faculty members and residents. Though the process of supervision may provide the primary feedback to the resident regarding progress toward goals and the development of targeted skills, the formal evaluations are considered essential for overview and the mutual communication of resident and supervisors regarding progress. Training plans should be revised accordingly to reflect new goals and objectives. This process is highly interactive between the resident and faculty. It is also further structured and monitored by the Residency Training Committee, which meets monthly.

Residents are also asked to evaluate the supervision provided by supervisor and primary preceptor at 4-months, 8-months and 12-months. At each four month interval, residents are also asked to complete the Professional Identity and Confidence Survey. The resident is also invited to complete program evaluation about the residency that looks at orientation, didactics and rotations. The form is used for feedback to the program. Residents are encouraged to provide honest and open feedback about their training experiences on all of these forms.

Seminars

Principles of Psychosocial Rehabilitation (Required): This weekly didactic seminar mirrors our training philosophy on the scientist-practitioner model is taught by Sandy Resnick, Ph.D., and Marcia Hunt, Ph.D. and is designed to provide participants with a broad and thorough understanding of community psychology and PSR interventions, principles, theories, and current research. Seminars focus on the current evidence-based practices for people with severe mental illness, ethics and boundaries (and how they differ from those in traditional mental health), and other relevant topics. Readings are provided to enhance discussion during seminars. In the second half of the seminar, participants are encouraged to teach at least one seminar on an area of interest, and to submit abstracts for talks to be given at conferences such as the United States Psychosocial Rehabilitation Association yearly conference. If applicable, time is devoted to teaching the mechanics of giving PSR presentations, and providing feedback to participants as they rehearse these talks for presentation for larger audiences.

The Leadership in Public Mental Health Systems (Required): This monthly seminar series is co-facilitated by Anne Klee, Ph.D and Allison Ponce, Ph.D. as an elective for the Department of Psychiatry of the Yale School of Medicine. It is comprised of discussions on leadership, management styles and professional development. The sessions are typically held in the leader's office. Participants meet with a range of leaders and managers, who lead discussions on topics ranging from mentoring, decision-making, workforce development, career paths, negotiation styles and politics in organizations to leadership in education and community organizations.

Clinical Consultation Meetings for Acceptance and Commitment Therapy, Social Skills Training, Illness Management and Recovery (ACT and SST Required): Residents have the opportunities to learn these evidence-based practices. These consultation meetings run independently of one another. Residents attend respective consultation meetings while running these respective groups. Consultation meetings include processing past group sessions, reviewing skills, role playing exercises, and learning various theories as well as practice tools and techniques.

Individual Process with Training Faculty (Required): Residents meet with a faculty member to discuss program matters including administrative needs, educational plans, professional development, and systems issues.

Professional Development Meetings for all Psychology Post-doctoral Residents (Required): Alicia Heapy, Ph.D., Research Psychologist, and Anne Klee, Ph.D. facilitate a monthly meeting for all psychology post-doctoral residents at VACHS on professional development. Topics include: applying for a career development award, licensure requirements, studying for the EPPP, obtaining employment, and managing a research and clinical career.

Diversity Seminar (Required): Meets monthly over the course of the year for all psychology post-doctoral residents at VACHS. Topics and speakers are selected to increase self-awareness and improve delivery of care.

Consultation Seminar (Required): Meaghan Stacy, Ph.D., provides training and discussion of consultation at the individual, team, and system levels. This monthly, hour-long seminar includes didactic components and opportunities to discuss and get group feedback about residents' consultation efforts. Other Discipline Directors of Training serve as discussants to provide multiple perspectives.

VACHS Psychology Colloquia (Required): The Psychology Service offers monthly colloquiums on the 2nd Thursday of each month. Local and national speakers present on an array of topics.

MEDICAL ROUNDS/MEETINGS (Elective)

Yale School of Medicine, Department of Psychiatry Grand Rounds (Elective): Held weekly at the Connecticut Mental Health Center involve didactic presentations on a wide variety of mental health topics and medical illnesses (respectively) by both local and visiting scholars.

Interdisciplinary Comprehensive Pain Management Rounds (Elective): Residents can participate in the Interdisciplinary CPMC Rounds that are held weekly on Monday mornings for 60-90 minutes. Participating disciplines include experts from Anesthesiology, Neurology, Nursing, Physical Therapy, Pharmacy, and Psychology. There are two goals of this meeting. The primary goal is to develop comprehensive and integrative assessment and treatment plans for referred patients. Pre-doctoral psychology interns and post-doctoral residents are responsible for presenting results of a comprehensive pain assessment of patients referred to the CPMC. This presentation informs the development of the assessment and treatment plan. The Interns and Residents are subsequently responsible for documenting this discussion and plan and for coordinating implementation of the plan. The second objective of this meeting is an educational one. In addition to the exchange of knowledge as a function of the case discussions, members of the team volunteer to provide brief (typically 20-30 minute) presentations on a pain-relevant topic of interest.

Yale School of Medicine - Psychiatry Electives

Yale Department of Psychiatry publishes elective courses open to trainees in the department. There are over 25 courses offered yearly and cover a broad range of topics including: (several on) psychotherapy, psychiatric epidemiology, neuropsychology testing, and psychiatry and the law.

Yale School of Medicine, Department of Psychiatry Division of Mental Health Services and Treatment Outcomes Research.

Facilitated by Jack Tsai, PhD and held monthly for the Yale School of Medicine and VA community. Speakers come from all over the country to present.

VACHS Mental Health Service Line Educational Meetings

The Mental Health Service Line offers seminars to the entire service on relevant clinical topics for practitioners on the second Thursday of each month from 10 am -11 am.

Training Staff

There are over 80 professionals comprising the Psychology Service clinical, research, and post-doctoral staff at the West Haven campus. The staff represents a variety of orientations and psychology residents will have an opportunity to be supervised by different staff members. In addition, some consultation/supervision is often available from other ECCC staff and Yale consultants during the year of training. A brief description of current interests of members of both clinical and research staff involved with the residency follows:

Lynette J. Adams, Ph.D., is the Women Veterans Program Manager at VA Connecticut Healthcare System. Her clinical interests are in serious mental illness and LGBT Healthcare. Her research interests are in the area of emotion regulation. Other general interests include diversity, social justice, and supervision/training. She is the director of the LGBT Track within the Interprofessional Fellowship and facilitates the diversity seminar series for psychology interns.

John E. Beauvais, Ph.D., has clinical and research interests in the area of Clinical Neuropsychology. He is actively researching the neuropsychological aspects of patients with HIV infection and with Multiple Sclerosis. He also researches innovative approaches to assessment (e.g., the Tactile Wisconsin Card Sorting Test).

Joshua S. Bullock, Ph.D., has a clinical and research interest in serious mental illness and psychosocial rehabilitation. Clinical and supervisory activities include individual and group psychotherapy in outpatient and day program settings, as well as supervision of trainees in community case management and evidence based practices for serious mental illness.

Jason C. DeViva, Ph.D., has clinical and research interests in the areas of PTSD, sleep, and treatment utilization. Clinical and supervisory activities include outpatient individual and group cognitive-behavioral therapy for Veterans with posttraumatic stress disorder and associated conditions, as well as consultation in the administration of acceptance and commitment therapy in a variety of settings.

Christine Franco, Ph.D. has research and clinical interests in the field of addictions, specifically within the area of gambling and gambling treatment. Her current clinical work includes individual psychotherapy and rehabilitative recovery and support for Veterans diagnosed with co-occurring mental health and substance use disorders.

Joanna Fiszdon, Ph.D., serves as the Director of Psychology Training for the PSR fellowship. She is also the Director of the Cognitive Skills Clinic, Director of the Incentive Work Therapy Program and Director of the Psychosocial Rehabilitation section of the Psychology Service. Dr. Fiszdon's research interests focus on: neurocognition, social cognition, and other factors affecting functional outcomes, as well as the development and evaluation of behavioral interventions for individuals with psychotic disorders. Dr. Fiszdon is actively involved in peer-reviewed research and dissemination, and has ongoing studies, including a trial of motivational enhancement for cognitive rehabilitation.

Alex Gonzales-Harsha, Psy.D., is director of the ECCC Wellness Center, and has research and clinical interests in the impact organizational culture on system functioning, and the impact of health behavior on mental health. He is interested in promoting staff wellness around the ECCC and broader medical center.

Alicia A. Heapy, Ph.D., is a research psychologist involved in protocol development and refinement, participant recruitment, evaluation and treatment of participants and data management and analysis in two ongoing clinical trials of psychological treatments for chronic pain. Her research interests include diabetic regimen adherence, clinical trials research and chronic pain.

Marcia Hunt, Ph.D., serves as the Program Manager for the VA Central Office Mental Health Intensive Case Management Program based at the Northeast Program Evaluation Center in West Haven. She has research and clinical interests in psychosocial rehabilitation and recovery-oriented care, family therapy, aging and lifespan development, and the development and support of valued social roles for marginalized individuals--including those with serious and persistent mental illness.

Anne Klee, Ph.D., CPRP, serves as the Director of the Interprofessional Fellowship on Psychosocial Rehabilitation, the Director of Peer Services and as the Director of Community Development and Partnerships. She has clinical and research interests in the field of psychosocial rehabilitation, peer support, technology, supportive housing, and health promotion among individuals with severe mental illness.

Stephanie Lynam, Psy.D. has clinical and research interests in serious mental illness, chronic homelessness and psychosocial rehabilitation. Clinical and supervisory activities include individual and group psychotherapy in outpatient settings, as well as supervision of trainees in community case management, evidence based practices for serious mental illness and multidisciplinary collaborative assessment approaches to inform treatment of individuals diagnosed with severe mental illness.

David T. Pilkey, Ph.D., has research and clinical interests in the field of addictive behaviors. He is the director of the Substance Abuse Day Program, a multidisciplinary treatment team. Current research is focused in alcohol and tobacco cessation.

Sandra G. Resnick, Ph.D., is Deputy Director of the Department of Veterans Affairs Northeast Program Evaluation Center (NEPEC), where she is responsible for development and implementation of Measurement Based Care, national program evaluation of the Compensated Work Therapy (CWT) program, and overseeing the national dissemination and implementation of supported employment. She conducts research in several areas of psychiatric rehabilitation, and has clinical interests in the application of positive psychology for those with severe mental illness.

Meaghan Stacy, Ph.D. he has clinical and research interests in the area of SMI, psychiatric rehabilitation, as well as stigma and recovery-oriented attitudes. She has been involved in the inpatient transformation to recovery-oriented care, and the SMI Re-Engagement Directive. She leads certain seminars and supervises some training experiences.

Howard R. Steinberg, Ph.D., has clinical and research interests in the field of addictive behaviors. He is currently involved in clinical research investigating treatments for concurrent alcohol and tobacco use.

Jack Tsai, Ph.D., is primarily engaged in clinical services and research related to severe mental illness, homelessness, and posttraumatic stress disorder. He is focused on improving health services for individuals in these populations through program evaluation, testing new interventions, and understanding access to care.

Wayne Zito, Psy.D., has research background in the area of vocational and cognitive remediation for individuals diagnosed with schizophrenia. Clinical and supervisory activities include outpatient group and individual psychotherapeutic interventions for patients diagnosed with SMI and severe personality disorders.

**POSTDOCTORAL RESIDENCY ADMISSIONS, SUPPORT,
AND INITIAL PLACEMENT DATA**

Post-Doctoral Residency Program Tables (Updated: 8/24/2018)

Postdoctoral Program Admissions

Briefly describe in narrative form important information to assist potential applicants in assessing their likely fit with your program. This description must be consistent with the program's policies on resident selection and practicum and academic preparation requirements:

The VA Connecticut Healthcare System (VACHS) offers psychology postdoctoral training with an emphasis in Psychosocial Rehabilitation (PSR), a therapeutic approach that encourages individuals with severe mental illnesses (SMI) to develop his or her fullest capacities through learning and environmental supports. The residency follows the scientist-practitioner model and is an interdisciplinary mental health training program that offers training in clinical services, program development, research, and education. The psychology residency experience is unique for each resident and is comprised of clinical, consultation, program development, teaching and/or research opportunities. Residents participate as members of interdisciplinary teams for approximately 20 hours per week for their primary clinical placements for the duration of the training year; these placements involve working with individuals with serious mental illness, homelessness, and/or addiction. Placements often involve community-based clinical work. In addition, residents have secondary requirements that average from two to six hours per week, as well as seminars, supervision, and electives to round out their residency experience. Approximately 40% of residents' time is devoted to direct service delivery.

Residents integrate into the various clinical programs of the ECCC for the duration of the training year where they provide individual, group and/or family interventions (including biopsychosocial assessment, psychotherapy, psycho-education, clinical case management, and program consultation). Direct practice experiences are coupled with seminars that teach the principles and practices of evidence-based and evolving practices such as: Social Skills Training, Acceptance and Commitment Therapy, Illness Management Recovery, Supported Employment, supported housing, clinical case management, psychopharmacology, Boston University Psychiatric Rehabilitation Model, family psycho-education and psychotherapy models, Psychiatric Advanced Directives, and Dialectical Behavioral Therapy.

Please note, *the LGBT Healthcare Track*, will have a training plan that has an emphasis on Lesbian, Gay, Bisexual, and Transgender (LGBT) Veteran Healthcare. The resident in this track will participate in a primary PSR placement (up to 20 hours a week) like all other residents with the expectation that the fellow in the LGBT track will provide LGBT-affirming services within that placement and act as a liaison to the LGBT Veteran Care Coordination Program. In addition to weekly PSR seminars and supervision offered to all residents, secondary requirements will focus on LGBT Healthcare (e.g., individual and group therapy to LGBT-identified individuals, completion of readiness evaluations for transgender Veterans requesting cross-sex hormones). Additional secondary experiences will be based on the individual training plan of the LGBT-track resident.

Describe any other required minimum criteria used to screen applicants:

Applicants are eligible if:

- They have successfully completed all requirements of a doctoral degree from an APA-Accredited Clinical or Counseling Psychology graduate program (including dissertation defense)
- They have successfully completed an APA-Accredited Psychology Pre-doctoral Internship Program
- Are U.S. Citizens
- Successfully meet mandatory requirements for appointment as a Federal Employee, including, but not limited to: willingness to participate in the government's drug testing procedures and consent to participate in fingerprinting and a background check to verify your application information and/or criminal history. Applicants who do not successfully pass this background check and/or drug test are ineligible for our program. A male applicant born after 12/31/1959 must have registered for the draft by age 26 to be eligible for any US government employment, including selection as a paid VA trainee. Male applicants must sign a pre-appointment Certification Statement for Selective Service Registration before they can be processed into a training program. Exceptions can be granted only by the US Office of Personnel Management; exceptions are very rarely granted.

Further, applicants are evaluated based on their cover letter, curriculum vitae, and recommendation letters that indicate: 1) previous experience with serious mental illness, recovery-oriented clinical services, and/or community-based clinical work; and 2) interest in a career providing recovery-oriented care for individuals with serious mental illnesses.

Please note that *the LGBT track* additionally assesses previous experience with and interest in LGBT healthcare.

Financial and Other Benefit Support for Upcoming Training Year*

Annual Stipend/Salary for Full-time Residents	\$51,233
Annual Stipend/Salary for Half-time Residents	N/A
Program provides access to medical insurance for resident?	<u>Yes</u> No
If access to medical insurance is provided	<u>Yes</u> No
Trainee contribution to cost required?	<u>Yes</u> No
Coverage of family member(s) available?	<u>Yes</u> No
Coverage of legally married partner available?	Yes <u>No</u>
Coverage of domestic partner available?	
Hours of Annual Paid Personal Time Off (PTO and/or Vacation)	96-104 hours (4 hours of Annual Leave earned after every full 2-week pay period that is worked)
Hours of Annual Paid Sick Leave	96-104 hours (4 hours of Sick Leave earned after every full 2-week pay period that is worked)
In the event of medical conditions and/or family needs that require extended leave, does the program allow reasonable unpaid leave to residents in excess of personal time off and sick leave?	<u>Yes</u> No
Other Benefits (please describe):	<ul style="list-style-type: none"> - Residents can opt for supplemental dental and vision - 10 annual federal holidays - Liability Protection for Trainees: <i>When providing professional services at a VA healthcare facility, VA sponsored trainees acting within the scope of their educational programs are protected from personal liability under the Federal Employees Liability Reform and Tort Compensation Act 28, U.S.C.2679 (b)-(d)</i> - Authorized Absence

*Note. Programs are not required by the Commission on Accreditation to provide all benefits listed in this table.

Initial Post-Residency Positions
(Aggregated Tally for Preceding 3 Cohorts)

	2014-17	
Total # of residents who were in the 3 cohorts	9	
Total # of residents who remain in training in the residency program	0	
	PD	EP
Community mental health center	0	0
Federally qualified health center	0	0
Independent primary care facility/clinic	0	0
University counseling center	0	0
Veterans Affairs medical center	0	5
Military health center	0	0
Academic health center	0	1
Other medical center or hospital	0	0
Psychiatric hospital	0	2
Academic university/department	0	0
Community college or other teaching setting	0	0
Independent research institution	0	0
Correctional facility	0	0
School district/system	0	0
Independent practice setting	0	1
Not currently employed	0	0
Changed to another field	0	0
Other	0	0
Unknown	0	0

Note. "PD" = Post-doctoral residency position; "EP" = Employed Position. Each individual represented in this table is counted only one time. For former trainees working in more than one setting, selected setting represents their primary position.

Operationalized Eligibility Requirements

The Department of Veterans Affairs (VA) adheres to all Equal Employment Opportunity and Affirmative Action policies. As a Veterans Health Administration (VHA) Health Professions Trainee (HPT), you will receive a Federal appointment, and the following requirements will apply prior to that appointment

1. **U.S. Citizenship.** HPTs who receive a direct stipend (pay) must be U.S. citizens. Trainees who are not VA paid (without compensation-WOC) who are not U.S. citizens may be appointed and must provide current immigrant, non-immigrant or exchange visitor documents.
2. **U.S. Social Security Number.** All VA appointees must have a U.S. social security number (SSN) prior to beginning the pre-employment, on-boarding process at the VA.
3. **Selective Service Registration.** Male applicants born after 12/31/1959 must have registered for the Selective Service by age 26 to be eligible for U.S. government employment, including selection as a paid or WOC VA trainee. For additional information about the Selective Service System, and to register or to check your registration status visit <https://www.sss.gov/>. Anyone who was required to register but did not register before the age of 26 will need to apply for a Status Information Letter (SIL) and request a waiver. Waivers are rare and requests will be reviewed on a case by case basis by the VA Office of Human Resources Management. This process can take up to six months for a verdict.
4. **Fingerprint Screening and Background Investigation.** All HPTs will be fingerprinted and undergo screenings and background investigations. Additional details about the required background checks can be found at the following website: <http://www.archives.gov/federal-register/codification/executive-order/10450.html>.
5. **Drug Testing.** Per Executive Order 12564, the VA strives to be a Drug-Free Workplace. HPTs are not drug-tested prior to appointment, however are subject to random drug testing throughout the entire VA appointment period. You will be asked to sign an acknowledgement form stating you are aware of this practice. See item 8 below.
6. **Affiliation Agreement.** To ensure shared responsibility between an academic program and the VA there must be a current and fully executed Academic Affiliation Agreement on file with the VHA Office of Academic Affiliations (OAA). The affiliation agreement delineates the duties of VA and the affiliated institution. Most APA-accredited doctoral programs have an agreement on file. More information about this document can be found at <https://www.va.gov/oaa/agreements.asp> (see section on psychology internships). Post-degree programs typically will not have an affiliation agreement, as the HPT is no longer enrolled in an academic program and the program is VA sponsored.
7. **TQCVL.** To streamline on-boarding of HPTs, VHA Office of Academic Affiliations requires completion of a Trainee Qualifications and Credentials Verification Letter (TQCVL). An Educational Official at the Affiliate must complete and sign this letter. For post-graduate programs where an affiliate is not the program sponsor, this process must be completed by the VA Training Director. Your VA appointment cannot happen until the TQCVL is submitted and signed by senior leadership from the VA facility. For more information about this document, please visit <https://www.va.gov/OAA/TQCVL.asp>
 - a. **Health Requirements.** Among other things, the TQCVL confirms that you, the trainee, are fit to perform the essential functions (physical and mental) of the training program and immunized following current Center for Disease Control (CDC) guidelines and VHA policy. This protects you, other employees and patients while working in a healthcare facility. Required are annual tuberculosis screening, Hepatitis B vaccine as well as annual influenza vaccine. *Declinations are EXTREMELY rare.* If you decline the flu vaccine you will be required to wear a mask while in patient care areas of the VA.
 - b. **Primary source verification of all prior education and training** is certified via the TQCVL. Training and Program Directors will be contacting the appropriate institutions to ensure you have the appropriate qualifications and credentials as required by the admission criteria of the training program in which you are enrolled.

8. **Additional On-boarding Forms.** Additional pre-employment forms include the Application for Health Professions Trainees (VA 10-2850D) and the Declaration for Federal Employment (OF 306). These documents and others are available online for review at <https://www.va.gov/oaa/app-forms.asp>. Falsifying any answer on these required Federal documents will result in the inability to appoint or immediate dismissal from the training program.
9. **Proof of Identity per VA.** VA on-boarding requires presentation of two source documents (IDs). Documents must be unexpired and names on both documents must match. For more information visit: <https://www.oit.va.gov/programs/piv/media/docs/IDMatrix.pdf>

Additional information regarding eligibility requirements for appointment as a psychology HPT can be found at the end of this brochure.

Additional information regarding eligibility requirements (with hyperlinks)

- Trainees receive term employee appointments and must meet eligibility requirements for appointment as outlined in VA Handbook 5005 Staffing, Part II, Section B. Appointment Requirements and Determinations. https://www.va.gov/vapubs/viewPublication.asp?Pub_ID=646&FTtype=2
- Selective Service website where the requirements, benefits and penalties of registering vs. not registering are outlined: <https://www.sss.gov/Registration/Why-Register/Benefits-and-Penalties>

Additional information specific suitability information from Title 5 (referenced in VHA Handbook 5005 – hyperlinks included):

(b) Specific factors. In determining whether a person is suitable for Federal employment, only the following factors will be considered a basis for finding a person unsuitable and taking a suitability action:

- (1) Misconduct or negligence in employment;
- (2) Criminal or dishonest conduct;
- (3) Material, intentional false statement, or deception or fraud in examination or appointment;
- (4) Refusal to furnish testimony as required by § 5.4 of this chapter;
- (5) Alcohol abuse, without evidence of substantial rehabilitation, of a nature and duration that suggests that the applicant or appointee would be prevented from performing the duties of the position in question, or would constitute a direct threat to the property or safety of the applicant or appointee or others;
- (6) Illegal use of narcotics, drugs, or other controlled substances without evidence of substantial rehabilitation;
- (7) Knowing and willful engagement in acts or activities designed to overthrow the U.S. Government by force; and
- (8) Any statutory or regulatory bar which prevents the lawful employment of the person involved in the position in question.

(c) Additional considerations. OPM and agencies must consider any of the following additional considerations to the extent OPM or the relevant agency, in its sole discretion, deems any of them pertinent to the individual case:

- (1) The nature of the position for which the person is applying or in which the person is employed;
- (2) The nature and seriousness of the conduct;
- (3) The circumstances surrounding the conduct;
- (4) The recency of the conduct;
- (5) The age of the person involved at the time of the conduct;
- (6) Contributing societal conditions; and

The absence or presence of rehabilitation or efforts toward rehabilitation.

END OF PETITION FORM