

Training Guidelines for Post-Doctoral Psychology Residency Programs in Serious Mental Illness (SMI) Psychology

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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.

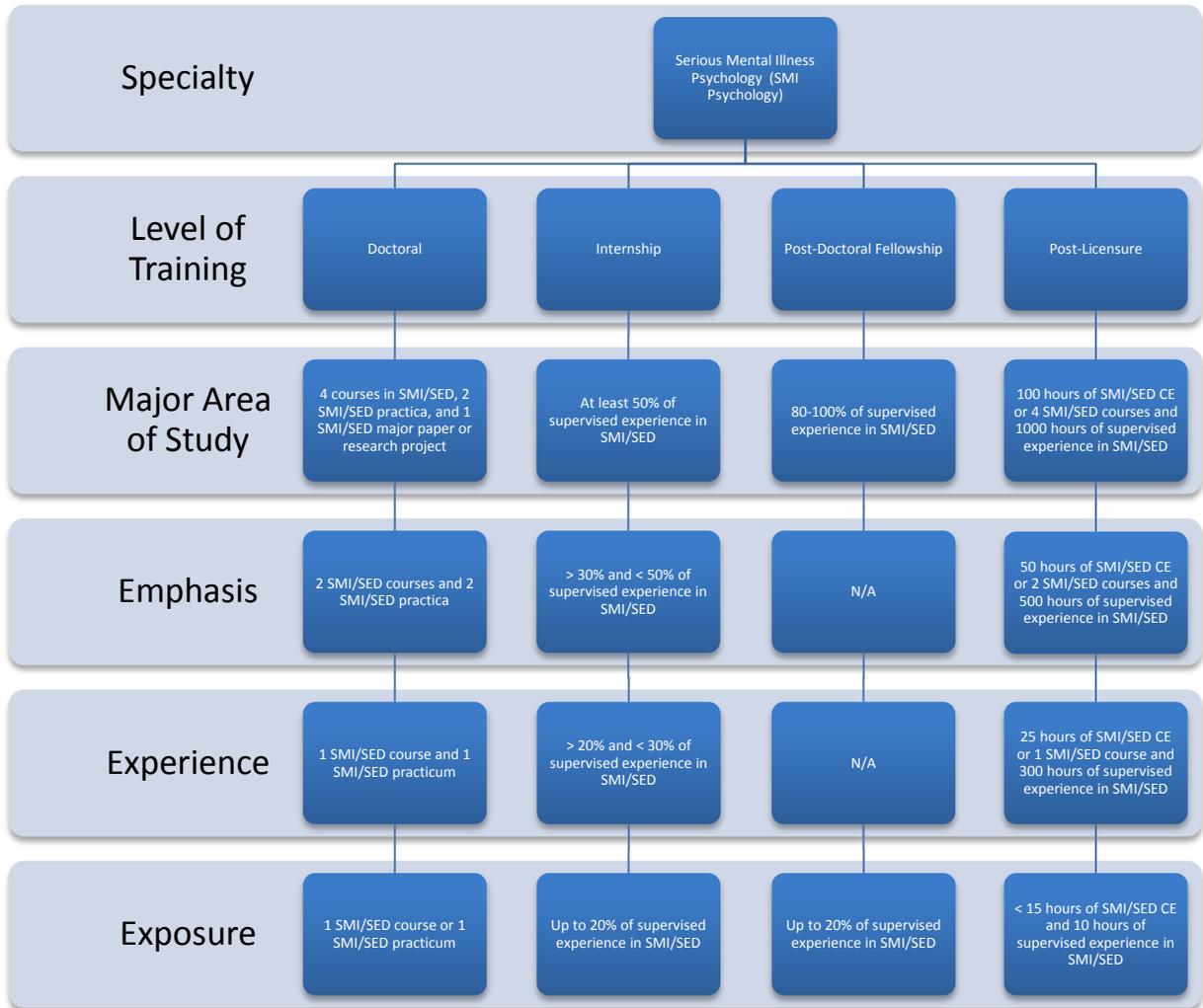
In accordance with relevant state laws and administrative regulations, the establishment and recognition of specialties in professional psychology does not constrain the general practice of psychology or require specialty credentialing of licensed psychologists practicing within their areas of competence 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) Psychosis and Schizophrenia Spectrum Special Interest Group (SIG), 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 programing 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

In addition to the important foundational and functional competencies required in doctoral level training, post-doctoral training programs in SMI Psychology should ensure that residents develop competence in the following competencies. This 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:

Integration of science and practice related to work with persons with SMI/SED

Ethical and legal standards, both generally related to the practice of psychology and specifically related to practice with persons who have SMI/SED

Awareness of and respect for all manifestations of individual and cultural diversity

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

Consultation for staff, family members, and organizations working with persons with SMI/SED

Supervision for psychology and non-psychology trainees and staff

Research methods adapted for populations such as this

Continuing professional development, and

Advocacy and systems transformation methods specific to mental health systems that serve this population.

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 in-depth 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):

Integration of Science and Practice

Competence and Expected Outcomes in Integration of Science and Practice

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

- Residents demonstrate the ability to locate, cite, and use scientific evidence related to SMI/SED to support professional activities in clinical and research settings
- Residents are able to incorporate knowledge into their practice with persons with SMI/SED in clinical and research settings
- Residents demonstrate the ability to recognize strengths and limitations in the scientific and practice literature about persons with SMI/SED

Ethical and Legal Standards

Competence and Expected Outcomes Related to Ethical and Legal Standards

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 and the high rates of health problems and early mortality in adults diagnosed with schizophrenia and bipolar illness, SMI Psychologists often collaborate with internists and general medical practitioners who are managing the medical care of individuals diagnosed with SMI/SED. Thus, recognition of boundary issues and the legal and ethical practices of psychology and related health disciplines is important for work with this population.

- Residents demonstrate good knowledge of and act in accordance with the APA Ethical Principles of Psychologists and Code of Conduct in all professional endeavors (e.g., assessment, intervention, research, consultation, communication, teaching, supervision, etc.)
- Residents demonstrate knowledgeable of and act in accordance with relevant laws, regulations, rules, and policies governing health service psychology at the organizational, local, state, regional, and federal levels
- Residents demonstrate ability to identify barriers (psychological, legal, financial, etc.) to community re-integration after hospitalization, jail, or residential placement
- Residents demonstrate knowledge related to issues of competency, capacity, and ability to provide informed consent for both research and for clinical practice
- Residents demonstrate knowledge of and respect for individuals' legal rights and be willing to provide information to help individuals exercise such rights as attempting to vote or register to vote
- Residents demonstrate the ability to balance the need for competent decision making with self-autonomy in light of risks to self and others
- Residents demonstrate 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

Individual and Cultural Diversity

Competence and Expected Outcomes in Individual and Cultural Diversity

Understanding of and respect for diversity are crucial for faculty, staff and residents and must be demonstrated toward those with SMI/SED, their family members and support systems and in a manner that reflects psychology's ethical principles and professional standards.

Competence in individual and cultural diversity is especially important when working with the SMI/SED 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 colors the

experience of illnesses such as schizophrenia. This includes utilizing assessment and intervention methods based on knowledge of the full range of diversity-related characteristics including recognition of the importance of environmental, social, health disparity, and developmental factors that may account for illness and functioning in persons with SMI/SED.

- Residents demonstrate recognition of the human worth of people with SMI/SED and the importance of their integration into the society at large
- Residents are able to describe barriers faced by individuals with SMI/SED and the prejudices and discrimination that they may experience along with recognition of the impact of such prejudice and discrimination on persons with SMI/SED
- Residents demonstrate ability to articulate conceptualizations of diversity factors that influence clients of all ages, ethnicities, races, cultural backgrounds, genders, gender identities, religions, socioeconomic strata, and other potential diversity factors, and integrate these into clinical care
- Residents demonstrate understanding of issues of social justice and equity as they affect persons with SMI/SED
- Residents demonstrate ability to provide clinical, research, and education services that are culturally centered, i.e., guided by a conceptualization of behavior as influenced by culture and life experiences

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.

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

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)

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 via 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

Continuing Professional Development

Competence in Recognizing the Importance of, and in Participating in On-going Professional Development that Leads to Life Long Learning:

- Residents demonstrate awareness of personal biases, assumptions, stereotypes, and potential discomfort in working with persons with SMI/SED, their families and supporting team members, particularly those of backgrounds divergent from the psychologist
- Residents are open and responsive to feedback and supervision.
- Residents affiliate with professional organizations whose mission it is to advance knowledge and practice in PSR theory and practice
- Residents 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
- Residents 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

Advocacy and Public Interest

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 understanding the scientific underpinnings related to the distinctiveness of SMI and on 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, consultation for staff, family members, and organizations working with persons with SMI/SED, supervision for psychology and non-psychology trainees and staff, research methods adapted for populations such as this, continuing professional development, and advocacy and systems transformation methods specific to mental health systems that serve this population. These are in addition to the ethical, legal, and diversity issues and concerns that impact this population specifically, and 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 Post-doctoral 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.

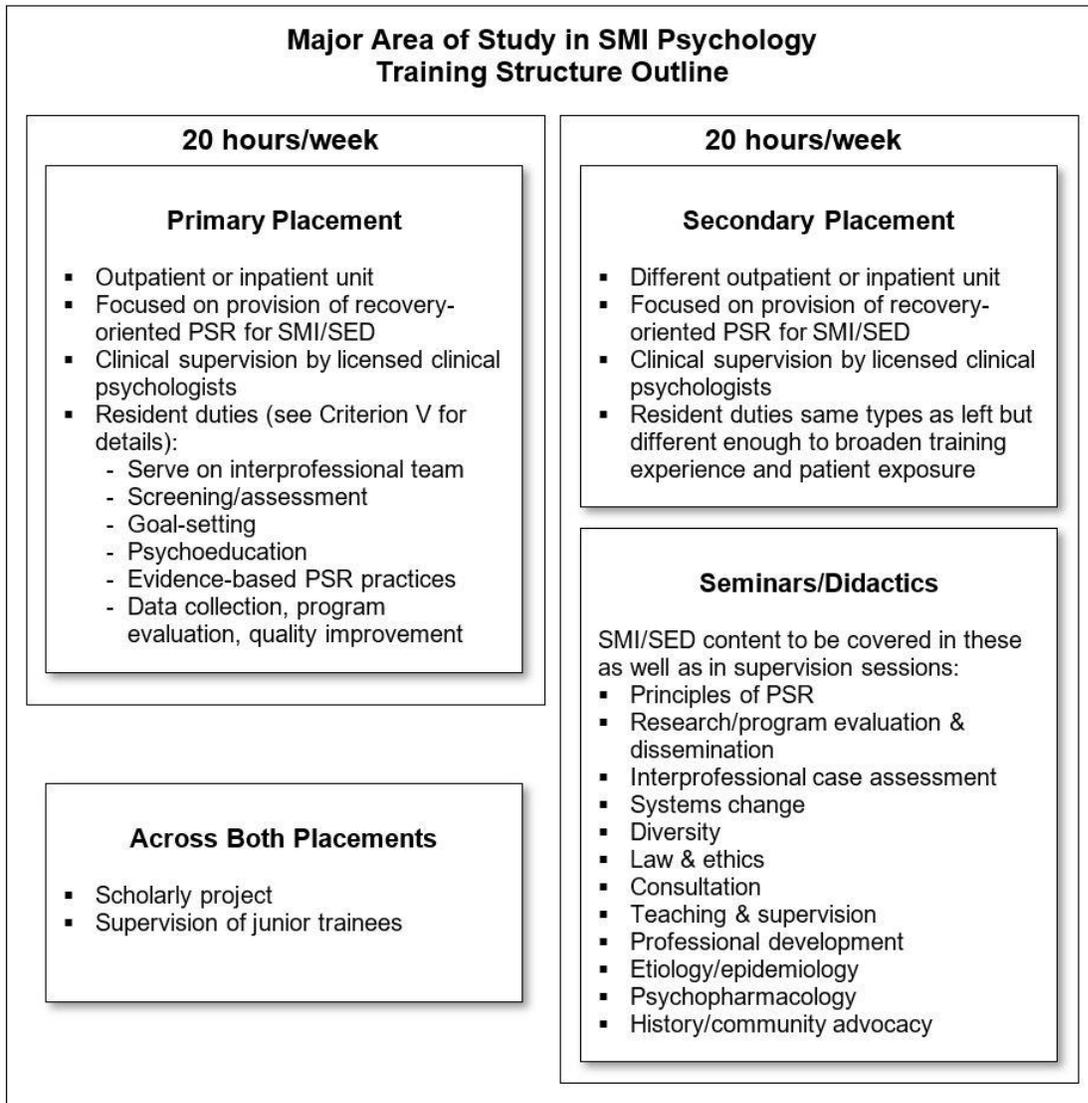
Individual Supervision with Training Faculty: Residents should have the opportunity to meet with a faculty member to discuss program matters including administrative needs, educational plans, professional development, systems issues, and other matters of individual interest.

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) (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 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, Dorman, & 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.

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