PROFICIENCY IN PSYCHOLOGY

ASSESSMENT AND TREATMENT OF SERIOUS MENTAL ILLNESS

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Developed by

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and

The APA Task Force on Serious Mental Illness and Severe Emotional Disturbance

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Criterion I. Distinctiveness.

A proficiency differs from other proficiencies or similar psychological procedures in its body of knowledge and professional application relevant to one or more parameters of practice and provides evidence of these distinctions with respect to the parameters of practice specified in Principle III below.

1. Title of proficiency:

Assessment and Treatment of Serious Mental Illness

2. Provide a brief description of the proficiency (e.g., one or two sentences that would adequately describe the proficiency for the public).

The proficiency in Assessment and Treatment of Serious Mental Illness is designed to provide professional psychologists with the specialized assessment and treatment expertise to help people who have serious mental illnesses (SMI) achieve their full functional capability and live productive, satisfying lives in the community.

3. Provide a detailed description of how this proposed proficiency differs from and is similar to existing proficiency practices. The comparison and differentiation must cover the parameters of practice that are identified as defining the proficiency in Criterion III below: a) specific population(s), b) psychological, biological, or social problem, c) procedure and techniques.

Similarities to Existing Proficiencies

There are relatively few similarities between the proficiency in Assessment and Treatment of Serious Mental Illness and other, currently existing proficiencies. The two existing proficiencies where similarities can be found are the proficiency in Treatment of Alcohol and Other Psychoactive Substance Use Disorders and the proficiency in Clinical Geropsychology. However, each of these three proficiencies has distinctly different diagnostic categories, intervention strategies, and service delivery systems.

Significantly, substance use disorder is the most common co-morbid complication associated with SMI. It has been estimated that half of individuals with SMI will have a co-occurring substance abuse problem at some point in their lives. Compared with the general population, for example, people with schizophrenia are more than four times as likely to have a substance use disorder; those with bipolar disorder are more than five times as likely (Drake & Mueser, 1996). Results from the 2006 National Survey on Drug Use and Health indicate that among

adults aged 18 or older with any serious psychological disorders, 22.3 percent were dependent on or abused illicit drugs or alcohol while the rate for adults without such disorders was 7.7 percent (U.S. Department of Health and Human Services, 2007). Although awareness of co-morbidity has increased in recent years, substance use disorders are still under-diagnosed and often untreated in this population, with major consequences for patients with SMI. Substance use disorders have a high likelihood of persisting and may have deleterious effects on treatment outcome, functioning and quality of life. Accordingly, psychologists who work with individuals who have SMI need to be knowledgeable about dual diagnosis, integrated services and other resources, such as peer services and self-help groups specifically designed for those who have a dual diagnosis. However, the competencies associated with the proficiency in Assessment and Treatment of Serious Mental Illness go beyond knowledge of substance use disorders and their impact on SMI and are distinct from those associated with the proficiency in Treatment of Alcohol and Other Psychoactive Substance Use Disorders. Furthermore, when SMI and substance use co-occur, recent treatment advances suggest that effective substance abuse treatments for the SMI population require significant adaptations from intervention models effective in non-SMI populations (e.g. integrated dual disorder interventions). As will be seen in Criterion II, III, and VI, the core knowledge base and evidence based practices associated with assessment and treatment of SMI are very different and distinct.

With regard to SMI and older adults, much less is known about the life experience of older patients with SMI than is known about individuals with SMI in other age ranges (Adler et al., 1995) and as a result, available data present conflicting impressions. The reasons for this are that people with SMI have only recently begun aging in the community rather than in institutions. Additionally, some individuals with SMI recover to the extent that they can live relatively normal lives in the community and, as they age, may no longer be considered to have SMI. For instance, in 2005 and 2006, adults aged 50 to 64 were more likely to have experienced serious psychological distress over the past year than those aged 65 or older (8.8% vs. 4.5%) (U.S. Department of Health and Human Services, 2007). However, other data collected by the Department indicate that in 2003, seven million people aged 65 and older in the United States (20 percent of the older adult population) had a psychiatric illness (U.S. Department of Health and Human Services, 2004). This percentage is the same as the yearly estimated prevalence rate of all Americans who suffer from a clearly diagnosable mental disorder involving a degree of incapacity that interferes with employment, attendance at school or daily life (U.S. Department of Health and Human Services, 1999).

Despite the significant prevalence of serious psychological disorders in older adults, SMI is not often considered when psychological problems of older adults are discussed. The proficiency in Clinical Geropsychology focuses primarily on psychological and behavioral issues of normal aging and emphasizes late-onset emotional problems, whereas the proficiency in Assessment and Treatment of Serious Mental Illness is primarily concerned with assisting individuals experiencing SMI throughout the life span to regain functional capacity and live satisfying lives in the community, regardless of their age. Having said that, SMI usually strikes individuals in late adolescence or early adulthood and for this reason, most of the assessment and treatment interventions are aimed at assisting individuals in this phase of life.

It is clear that psychologists must address the challenges associated both with the normal aging process and with SMI, as the population of older adults with SMI will continue to increase. Some of the significant challenges associated with SMI and aging include the long-term side-effects of neuroleptics, the decline and death of parental caretakers, and the absence of specialized psychosocial programs for older adult clients. In addition, the SMI population experiences higher rates of aging related medical co-morbidities (cardiovascular disease, cancer) relative to the non-SMI population, and interventions designed to address these medical issues must often be tailored to account for impaired cognitive capacity and symptom issues which often are associated with the SMI. These challenges are not similar to the challenges faced by populations covered by other proficiencies and are considered within the domain of this proficiency.

Differences from Existing Proficiencies

The proficiency in Assessment and Treatment of Serious Mental Illness differs substantially from other existing proficiencies. This differentiation is associated with the identified parameters of practice as follows:

Specific Populations

SMI refers to mental disorders that carry certain diagnoses, such as schizophrenia, bipolar disorder, and major depression; that are relatively persistent (e.g., lasting at least a year); and that result in comparatively severe impairment in major areas of functioning, such as cognitive capabilities; disruption of normal developmental processes, especially in late adolescence; vocational capacity and social relationships (Federal Register, 1993). The DSM diagnoses most associated with SMI include schizophrenia, schizo-affective disorder, bipolar disorder and severe depression with or without psychotic features. Other diagnoses often co-occur in SMI populations, including post-traumatic stress disorder, substance use disorders, personality disorders, and obsessive-compulsive disorder. Depression, even in non-affective disorders such as schizophrenia, is common. In most venues, any Axis I diagnosis may meet the diagnostic criterion for SMI if functional criteria are also met. Developmental disabilities and Axis II diagnoses generally do not meet the criterion alone, but sometimes co-occur with another diagnosis that does meet it.

Most new cases of psychosis will develop in youth and these young people are likely to experience interruptions in their education and social relationships and profound disruptions in critical developmental tasks including relationship building, separation and individuation, independent living, etc. Many believe that there is a critical period which occurs soon after the manifestation of symptoms where intervention is important to change the trajectory of the illness (Birchwood, 2000; McGorry, 2002). Sometimes very serious behavioral disturbances and even psychoses develop in young children. When this occurs, the condition is referred to as serious emotional disturbance (SED). While not a DSM-IV diagnosis per se, SED refers to "diagnosable mental health disorders with extreme functional impairment that limit or interfere with one's ability to function in the family, school, and/or community" (Stroul, Blau, & Sonheimer, 2008, p. 5).

In the United States it is estimated that 3.5% of the adult U.S. civilian non-institutionalized population has a mental health disability (6.7 million people) (Jans, Stoddard, and Kraus, 2004) and many of these are young people (2.4 million or 6.5 percent) (Jans, Stoddard, and Kraus, 2004). Recently the GAO reported that about 2.4 million young adults (aged 18 through 26) with SMI were receiving disability benefits in 2006 because their severe mental illnesses prevented them from substantial employment (Government Accountability Office, 2008). Compared to young adults without SMI, these young adults completed less education and had a higher unemployment rate. Epidemiological studies suggest that, during any one-year period, 44 million Americans – approximately 20 percent - suffer from a clearly diagnosable mental disorder involving a degree of incapacity that interferes with employment, attendance at school or daily life (U.S. Department of Health and Human Services, 1999).

People with serious mental illness are uniquely vulnerable. Historically, they have been institutionalized, marginalized, segregated, victimized and subjected to seclusion, restraint and experimental treatments with significant iatrogenic effects. There are no other mental health disorders that affect such a large proportion of the population, typically strike during such a critical developmental period in middle to late adolescence, have such profound effects, and potentially remain with the individual throughout his or her lifetime. As a result, the knowledge base and core competencies that form the basis of this proficiency are distinct from the knowledge base and competencies of other proficiencies or specializations in psychology. And, it is these distinct core competencies and knowledge base that make up the unique psychological interventions required to effectively assess and treat individuals with SMI.

Psychological, Biological, or Social Problem

Serious mental illness is a problem with significant psychological, biological and social components.

A Psychological Problem

The most important direct expressions of SMI are psychological (including behavioral) in nature. Psychological symptoms such as hallucinations and delusions are the most familiar features, but research is increasingly showing that other psychological expressions, including neuropsychological impairment, emotional dysregulation, demoralization, and reduced social competence, exert at least as much impact on personal and social functioning, and produce at least as much distress. By definition, SMI involves impairment in psychological functioning of such severity that the person's ability to perform routine demands of daily life is significantly compromised. Some psychological problems are unique to SMI. Others occur in other contexts, but when they co-occur with SMI they often acquire distinctive qualities. For example, depression co-occurring with psychosis might be quite different from depression in a person with no other psychological disorder.

A Biological Problem

The biological basis of SMI has become increasingly recognized. Cognitive impairment is one of the major sequelae of the disorder and the dysregulation of psychological processes is often exacerbated by neurological deficits resulting in poor stress tolerance, poor emotional regulation, severe cognitive deficits, agitation or impulsivity, extreme anxiety, depression, and/or social withdrawal.

Research also continues to identify biological factors in the etiology of SMI, at least for some individuals. Some SMI disorders are frequently referred to as brain diseases, e.g., schizophrenia and bipolar disorder. While the medicalization of SMI has enhanced funding for these illnesses, SMI is sometimes seen as simply a biological disorder requiring only medication and institutional care, although this view is seen less and less frequently.

A Social Problem

SMI is a social problem because its consequences for a person's social functioning are severe and pervasive. People with SMI are often unable to establish or maintain interpersonal relationships, and often lack even minimal social support systems. Social isolation is commonly associated with SMI. Social support outside institutional settings is often a critical factor in successful rehabilitation. Social and community interventions should complement biological and psychological interventions to reintegrate the person into a supportive social environment.

Individuals with SMI often have serious difficulties with managing the tasks of successful instrumental and affiliative role functioning, resulting in smaller social networks (Horan, Subotnik, Snyder, & Nuechterlein (2006), higher rates of unemployment (Anthony and Blanch, 1987), and greater likelihood of homelessness relative to non-SMI populations (U.S. Conference of Mayors, 2007; U.S. Department of Health and Human Services, 1992)

Parenting is an important social role that may be especially challenged or complicated by SMI. A study of people with SMI who were receiving mental health services found that nearly one-third of those who were parents reported reluctance to seek help with child care because they were afraid their children would be removed from their care (Hearle, Plant, Jenner, Barkla, & McGrath, 1999). More recently, in a study of mothers who were eligible for Medicaid, the mothers with SMI were nearly three times as likely to have been involved in the child welfare system, or to have had children in an out-of-home placement (Park, Solomon, & Mandell, 2006). These studies highlight the social cost of SMI among parents, and point out the urgency of the need for parenting support for parents with SMI, as well as for increased planning and coordination between the child welfare and mental health systems.

SMI is also a social problem in the sense that it is a major burden on society. The costs of mental disorder and disability due to mental disorder are staggering. An economic estimate of 1990 costs shows almost $150 billion dollars of direct and indirect costs (Rice and Miller, 1998). The economic consequences of SMI rank it among the most serious health problems, including heart disease and cancer. The cost to the national economy has been estimated at

$65 billion for schizophrenia and $45 billion for bipolar disorder (Wyatt, Henter, Leary & Taylor, 1995). The cost of depression is also high (Hu & Rush, 1995; Rice & Miller, 1993). In 2008, the National Institute of Mental Health reported that serious mental illness costs Americans at least $193 billion a year in lost earnings alone (National Institute of Mental Health, 2008).

Finally, SMI is a social problem in the sense that it is highly stigmatized in our society. Social stigmatization affects people at the individual level, as they suffer discrimination and prejudice from potential friends, neighbors, employers, landlords and advocates (Crisp et al. 2000), and, more often than not, do not have access to evidence-based treatments (Drake, et al., 2001). At the community level, the stigma of mental illness makes it more difficult to get adequate funding of public services and fair insurance coverage for private services or appropriate medical care. The seriousness of stigmatization of people with SMI was recognized by the APA in 1999 when the association adopted its Resolution on Stigma and Discrimination Against People with Serious Mental Illness and Severe Emotional Disturbance (American Psychological Association, 1999), which appears at Appendix B.

Procedure and Techniques

Criterion VI presents a systematic review of the procedures and techniques that have been shown to be effective for people with SMI. Additionally, Appendix E provides a comprehensive list of the major studies and literature associated with the most widely used interventions for this population, by topic. In addition, a very useful compendium of evidence-based and best practices, largely developed by psychologists, is available on the APA web site at http://www.apa.org/practice/smi_grid-v2.pdf. The following is a short synopsis of this information.

Assessment of persons with SMI includes a focus on the individual and the person-environment interaction and deals with diagnosis, functional behavior and the biopsychosocial interaction. Treatment and rehabilitation efforts are directed at reducing symptoms, improving functional skills and capabilities, and improving quality of life. Interventions used to achieve these outcomes integrate include psychological, psychosocial, and psychopharmacological methods.

Within the past two decades, several evidence-based practices have been shown to significantly improve functional outcomes for those with SMI. It is important to note that, while many of these SMI interventions have evolved from successful treatments for other disorders (e.g. cognitive therapy for depression or social skills training for social phobia), they typically must be substantially modified to meet the needs of persons with psychosis and/or significant functioning impairments. For example, social skills training programs for person with SMI typically involve the role-play technologies and homework found in similar treatments of non-psychotic populations, but are supplemented extensively with additional techniques and information uniquely relevant to persons with SMI, such as determining the appropriate level of self-disclosure for a particular social interaction, maintaining personal hygiene, and learning to attend to subtle social cues (e.g. appropriate physical distance between speakers) (see, for example, Bellack, Mueser, Gingerich & Agresta, 2004). Thus,

more generic interventions must be tailored to become distinct interventions for SMI if they are to be effective components of a rehabilitation plan. Psychologists have taken a lead role in adapting psychosocial interventions to meet the unique needs of persons with SMI.

This expanding body of evidence has demonstrated the value of a range of psychosocial interventions that can improve the long-term outcome for people with SMI. In a review, Mueser, Bond, and Drake (2001) reported that controlled research on most of these interventions suggests specific benefits in the areas of relapse and rehospitalization, housing stability, competitive employment, social functioning, psychotic symptoms, and substance use disorders. Combined with the current focus in the SMI field on the concept of recovery, the growing arsenal of evidence-based treatments is cause for optimism.

However, a report from the U.S. Department of Health and Human Services (2007) estimated that less than half of individuals with SMI report receiving some type of treatment during the year, and even fewer were seen by a mental health specialist. Researchers have found that individuals with SMI are underserved generally, and the clinical services they do receive are seldom the evidence-based practices that have been shown to produce positive outcomes (Drake et al., 2001; Wang, Berglund, & Kessler, 2000). Thus, from the perspective of clinical practice, people with SMI represent a large and underserved population.

The absence of satisfactory, or indeed, any, treatment has devastating consequences for these individuals, for their families, and for society. People with SMI have a death rate from suicide and other causes of death that is significantly higher than the rate of the general population (Caldwell & Gottesman, 1990). In addition, as many people with mental illness reside in jails and prisons as in all of our hospitals (Torrey et al., 1992). The tragedy of this situation is emphasized by the fact that, as mentioned above, effective interventions are now available for the treatment of SMI but are not often available to those who need them. For example, the Schizophrenia Patient Outcomes Research Team (PORT) (Lehman et al., 1998a, 1998b, 2004) reported that only a minority of clients received an appropriate dose of ongoing medication (29.1%), family education and support (9.6%), supported employment (22.5%), or Assertive Community Treatment (10.1%).

When appropriate treatment, i.e., evidence-based psychosocial interventions, are provided, treatment outcomes for those with SMI compare favorably with those of people with general medical problems. Following short-term treatment, the percentage of individuals improved (as measured by reduction of symptoms) was 60% for schizophrenia, 80% for bipolar disorder, and 65% for major depression. Similarly, 1-year relapse rates were significantly different for those in active treatment versus those in placebo groups for schizophrenia (25% v. 80%), bipolar disorder (34% v. 81%), and major depression (18% v. 65%). In fact, long-term outcome studies have repeatedly demonstrated that a majority of people with SMI who receive appropriate treatment experience recovery or significant improvement (Davidson, Harding, & Spaniol, 2005; 2006; Harding, Zubin, & Strauss, 1992).

Please see Criterion VI for a more thorough discussion of the evidence-based interventions developed for this population. Criterion II also contains a listing of the didactic and

experiential components of training for the proficiency, and Criterion III contains the substantive body of knowledge that is required for the proficiency.

Criterion II. Acquisition of Knowledge and Skills.

A proficiency is defined by a core of psychological knowledge and skills, and includes specific methods for how psychologists who practice in the proficiency typically acquire its knowledge and skills.

1. For each of the parameters of practice identified above, provide a brief description of the content of the didactic experience (psychology prerequisites to the training program, course descriptions, learning objectives, teaching methods, syllabi, books, or articles) and supervised practice experiences required to assure qualification for the proficiency and how psychology's scientific substrate provides a foundation for the proposed proficiency.

SMI presents several unique challenges to the abilities and knowledge of psychological practitioners. These challenges include:

- the persistence of SMI throughout the life span,
- the profound functional disability associated with SMI,
- the lack of awareness and insight associated with SMI which may influence adherence to treatment, and
- the risk of victimization and potential criminal justice involvement.

A specialized curriculum for psychologists developing proficiency in serving people with SMI will encompass a broad array of knowledge in the areas shown below. This list is comprised of key elements that can be arranged in various ways by various educators or programs, and is organized below according to the identified parameters of practice, a) specific population, b) psychological, biological, or social problem, and c) procedure and techniques.

Specific Population

- Historical development of the concept of SMI
- Current diagnostic criteria and issues (Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), International Classification of Diseases, Tenth Edition (ICD-10))
- Epidemiology, prevalence, incidence and course of various Axis I diagnoses
- Common co-occurring disorders, both medical and psychological (e.g., substance abuse, chronic medical conditions, trauma, etc.
- Etiology:
    - Genetics
    - Family, twin, adoption and molecular genetic studies
    - Risks and benefits of genetic counseling
    - Environmental factors (e.g., birth complications, prenatal viral infections)
    - Specific neuropathophysiological findings associated with SMI

Specific postmortem findings, CT scans, Magnetic Resonance Imagery (MRI), Functional (e.g., ERP, Electroencephalogram (EEG), functional Magnetic Resonance Imaging (fMRI), Positron Emitted Tomography (PET))
The neurotransmitters believed to be involved in SMI
Cognitive precursors
Neuropsychological impairments, including executive functioning and attention
Developmental perspectives (e.g., effect of onset during late adolescence; precursors of late-onset SMI)
Integrating multiple biological and environmental etiologies; the diathesis-stress hypothesis

Psychological, Biological, or Social Problem

- Specific societal, cultural, economic, racial, ethnic, and gender issues applied to assessment and treatment of SMI

- Understanding various systems of Care for people with SMI:
  Public mental health systems
  For-profit hospital systems
  Managed behavioral healthcare
  Long term care system
  Independent or group practice
  Practice guidelines for schizophrenia and other severe mental illnesses
  Outcomes evaluation
  Evaluating and monitoring systems of care
  Intersection of mental health, social services, healthcare, and judicial/correction systems

- Prevention:
  Defining and assessing risk, including high risk populations
  Models of prevention and issues in early intervention in people with SMI
  Public education regarding SMI

- Ethics, Legal issues, and Civil Rights:
  Ethics in clinical psychology (e.g., Tarasoff/duty to warn, research ethics)
  Special issues in SMI (e.g., decisional capacity, level of autonomy)
  Competency to provide consent for research
  Involuntary commitment (inpatient and outpatient)
  Americans with Disabilities Act
  Reporting requirements (e.g. abuse and neglect)
  Advance directives
  Guardianships
  Confidentiality and family involvement in treatment
  Right to treatment, right to refuse treatment, right to be treated in the least restrictive setting
  Issues involved in forced medication

Other legal issues and civil rights (e.g., involvement in criminal justice system, custody issues, access to voting)

Procedure and Techniques

- Understanding of basic research principles and methods, and their application to assessment and treatment in SMI:
  - Experimental design
  - Statistical analytic techniques
  - Psychometric issues
  - Special issues in the study of SMI, such as ensuring informed consent
  - Measuring effects of medication
  - Selection biases and group comparisons
  - Issues in the area of large intervention trials
  - Longitudinal research issues
  - Monitoring and evaluating programs and services

- Assessment procedures:
  - Structured interviews: (e.g., Structured Clinical Interview for DSM-IV (SCID))
  - Functional assessment
  - Behavioral analysis
  - Use of symptom severity assessments (e.g., Brief Psychiatric Rating Scale (BPRS), Positive and Negative Symptom Scale (PANSS))
  - Disability assessment (e.g., International Classification of Functioning and Disability-2 (ICFD-2))
  - Neuropsychological and cognitive assessment (e.g., Wechsler Adult Intelligence Scale-IV (WAIS-IV))
  - Psychosocial assessment (e.g., Quality of Life, Social Adjustment Scale, Independent Living Skills Survey)
  - Specific symptom assessment (e.g., Peters Delusional Inventory, Beck Depression Inventory)
  - Assessment of risk of violence and risk of self-harm (e.g., HCR-20, VRAG)
  - How SMI affects results of personality assessments (e.g., MMPI-2, PAI)
  - Integrating assessment information from multiple disciplines

- Psychopharmacology
  - Names and action of medications used to treat SMI, including antipsychotics, antidepressants, and mood stabilizers
  - Potential side effects of each class of medication, including differentiation between severe and minor side effects
  - Issues related to medication adherence among people with SMI

- Psychosocial Rehabilitation techniques aimed specifically at people with SMI:
  - Validity and limitations of major interventions (e.g., token economy, cognitive-behavioral therapy, interpersonal therapy)
  - Impact of SMI on parents, spouses, siblings, offspring

Family psychoeducation and support
Respite care for family caregivers
Collaboration with families in treatment planning and interventions
Issues of confidentiality
Psychosocial Interventions (e.g., social skills training, cognitive remediation)
Overall concepts and general techniques of psychiatric rehabilitation
Neurocognitive rehabilitation
Supported education and employment
Assertive Community Treatment (ACT)
Evidence-based psychotherapies for specific disorders (e.g., cognitive therapy, interpersonal therapy)
Programmatic behavioral interventions (e.g., social learning programs, token economies)
Individual behavioral interventions (e.g., time-out from reinforcement, alternatives to restraint, seclusion and other coercive interventions; redirection and de-escalation techniques)
Hospitalization, alternatives to hospitalization, crisis intervention
Consumer-operated alternatives, peer support
Cultural, gender, economic, and familial differences in diagnoses, assessment, treatments, acceptable service providers, language, and alternative healing practices.

- Specific Attitudes and Values to be Fostered Throughout:
  - Regard people with SMI as persons with dignity and competence and engage them as collaborators in research and service planning.
  - Promote the idea that people with SMI can and do recover, when provided with appropriate treatment and rehabilitation services
  - Use person-first language and behave in a way that consistently reflects awareness of and appreciation for the dignity of individuals with mental illness
  - Foster client empowerment and consumer recovery
  - Demonstrate holistic understanding of persons with mental illness
  - Provide needed information and education to people with SMI
  - Help clients live as autonomously and independently as possible
  - Work to diminish stigma, including self-stigma, and stigma within professional and paraprofessional disciplines as well as within society.

There are two main ways in which to obtain the knowledge and skills listed above to prepare for the proficiency in the Assessment and Treatment of Serious Mental Illness. First, in many universities and professional schools, graduate students are able to shape a sub-specialty area, or track, within the general area of professional psychology that focuses in this area. Course work is accompanied by relevant experience applying skills in practicum and internship settings. Second, psychologists who are already practicing can acquire the knowledge and skills required for the proficiency on a post-doctoral basis.

Graduate Training

Most professional psychology training programs have the didactic experiences structured into several clusters. The first cluster is made up of courses required of all students at the graduate level and it is generally organized by the guidelines provided by the APA Committee on Accreditation. These courses typically cover psychological theory; basic principles of psychology (e.g., perception, cognition, group behavior); quantitative methods and research design; and professional, ethical and multicultural issues. These experiences provide the basic information that is later applied to the specific issues of assessment and treatment in SMI. The second cluster is usually comprised of courses required of all professional psychology training program students. These usually include courses in psychopathology, interventions, assessments and psychopharmacology. The number and types of courses in this clinical core cluster varies greatly from program to program, but they often include core didactic materials that are germane to SMI. The third cluster includes electives, and it is from these that special tracks are created. It is generally within this cluster that students have the opportunity to apply the information they have learned specifically to the area of assessment and treatment of SMI. Thus, it is possible for nearly all graduate training programs to offer training in basic professional psychology (what some training directors have called a generic training program) and still provide an opportunity for students to develop special knowledge and skills in a particular area such as SMI.

One of the primary ways graduate students receive exposure to SMI is through practica and internship training experiences. As with core coursework, programs vary greatly with respect to the amount and type of supervised experience graduate trainees can receive with an SMI population. However, the majority of internship programs provide at least a minor, if not major, rotation in an inpatient setting, and these afford graduate students their main opportunity to acquire the knowledge and skills relevant to assessment and treatment of SMI.

Post-Doctoral Certification

Psychologists who are already active professionally, but who did not have an opportunity, as students, to use graduate school as a preparation for the proficiency, may develop the knowledge and skills necessary as follows:

- A specified amount of time in direct contact, providing psychological services to people who have SMI. The specific time requirement will be established later as the proficiency establishes evaluation requirements (see Criterion IX and X for further information on plans to evaluate those applying for the proficiency). This experience may be gained in either inpatient or community settings or a mix of both. Supervision will be required and this must include direct observation of the psychologist's work through video or audio taping, or other observational means.

- A specified amount of time obtaining didactic experience relevant to SMI. APA Divisions 12 and 18 have offered continuing education workshops on SMI at the APA Convention, and it is expected that such workshops will continue to be offered. State and regional psychological association conventions also often provide full or half day workshops on various topics relevant to SMI.

- A comprehensive, authenticated record of these experiences will be required for certification in the proficiency.

2. In what kinds of settings are education and training for the proficiency acquired?

Professional psychology training programs are the primary source of initial training in this field. Most graduate programs in psychology provide basic information on psychopathology; diagnosis and assessment; general and specialized intervention theory and methods; quantitative methods and research design; cultural diversity, ethics, and professional issues; and psychopharmacology. Many programs also offer special courses on such topics as the community treatment of SMI, as well as arrange for practical experiences in the area of SMI.

Although a number of graduate programs now offer specialized training in working with people with SMI as a specific track or other program concentration, the comprehensive body of knowledge required to work effectively with those who have SMI is rarely available in professional psychology training programs. Surveys of clinical training directors have found a number of programs that have some components of special tracks or interest in the field of SMI (Johnson, 1992; Millet and Schwebel, 1994; Reddy and Spaulding, submitted for publication). In addition to basic clinical training, these programs may offer courses in specific diagnoses (e.g. schizophrenia), methods of assessment and treatment (e.g., social learning program), and/or settings relevant to SMI (e.g., community psychology). These programs also make it possible for students to gain experience in SMI through appropriate practicum and internship sites. In addition, there are certain internships that offer specialized training in the area of SMI.

Psychologists who are already practicing as professional psychologists may obtain the knowledge, skills and experience necessary for the proficiency through continuing education workshops, self-study, and in-service training. They must also obtain supervised experience with people with SMI in appropriate service settings.

The domain covered by the proficiency in Assessment and Treatment of Serious Mental Illness has a solid base in scientific psychology. Please see Appendix C for a list of journals that are one expression of this foundation.

Criterion III. Parameters of Practice.

A proficiency identifies the substantial, specific, and distinctive psychological knowledge and skills that provide for service with respect to at least one of the essential parameters of practice. The parameters to be considered include: a) specific population(s), b) psychological, biological, and/or social problem, c) procedure and techniques. These parameters should be described in the context of the range of settings or organizational arrangement(s) in which practice occurs.

1. Describe the distinctive knowledge and skills that define the proficiency in the following parameters of practice:

Specific Population(s):

The populations relevant to this proficiency include people with SMI, their families and other advocates, and service providers in psychology and other disciplines. Psychologists must have the specialized expertise needed to assist these populations within their individual circumstances, taking into account the environmental resources within each.

SMI is defined by a combination of functional and diagnostic characteristics. SMI is the term used in federal statutory and regulation language, but in other venues "severe and persistent mental illness" or “chronic mental illness” or "disabling mental illness" may be used. The DSM diagnoses most associated with SMI include schizophrenia, schizo-affective disorder, bipolar disorder, and severe depression with or without psychotic features. Other diagnoses often co-occur in SMI populations, including post-traumatic stress disorder, substance use disorders, personality disorders, and obsessive-compulsive disorder. Depression, even in non-affective disorders such as schizophrenia, is common.

Functional criteria for SMI generally include presence of behavioral disability sufficiently severe as to compromise the person's ability to live and work as an independent, autonomous individual. People with SMI often have difficulty successfully completing their education, obtaining and maintaining competitive employment, acquiring adequate and safe housing, and establishing ongoing supportive relationships, including romantic relationships as well as those with friends and family members. The evidence based practices designed to assist those with SMI to gain or regain these functional capabilities require specialized expertise that psychologists must learn if they are to apply these interventions with fidelity.

Family members of people with SMI are included in this proficiency's population because SMI has significant and pervasive effects on those individuals as well. They are at increased risk for the development of anxiety and depressive disorders as well and often benefit from services provided by psychologists, as they are important participants in the patient's treatment and rehabilitation. Children of people with SMI may experience custody changes or out of home placement. Although the importance of involvement of family and friends in treatment has long been understood, the size and distribution of this population has not been appreciated. As advocacy organizations have evolved, and public awareness of problems in mental health care has increased, it has become clear that SMI touches the lives of virtually everyone. The likelihood that any given person might, at some time, receive SMI-related services from a psychologist, or collaborate with a psychologist in someone else's treatment and rehabilitation, is thus surprisingly high. As advocacy and public awareness increase, this likelihood is also expected to increase.

Other advocates are included in this proficiency's population because advocacy and related social policy issues are a particularly important aspect of services for SMI. Advocacy for SMI services benefits from the input of psychologists, and there is a demand for skilled collaboration. It is necessary for psychologists to have values, attitudes, knowledge, and skills relevant to the specific characteristics of the SMI advocacy community, which includes professionals, families, consumers and peers. This makes it important to identify members of the advocacy community as a population relevant to the SMI proficiency.

Service providers in other disciplines are included in this proficiency's population because of the extent to which SMI requires interdisciplinary collaboration. Although most psychological practice involves such collaboration, the demands of SMI are so extensive, and the collaborative and consulting skills of the psychologist so critical, that it is highly appropriate to identify other providers as part of this proficiency's recipient population. For example, many people seek help with mental health problems from their medical caregiver. Analysis of nationally representative surveys reveal that primary care clinicians treat most of the people who have mental illness, including an increasing number of those with major mental health concerns (Daly, 2006; 2008). As a result, the knowledge and skills associated with this proficiency are essential for psychologists to practice effectively with all populations affected by SMI.

Problems (psychological, biological, and/or social):

The significant psychological, biological and social components that affect individuals with SMI, their families, and society require psychologists to have specialized knowledge and skills, not only as providers, but as advocates and leaders of social change.

A Psychological Problem

The hallmarks of distorted psychological expression in SMI are hallucinations and delusions but other psychological manifestations such as neuropsychological impairment, emotional dysregulation, demoralization, and reduced social competence exert at least as much impact on personal and social functioning, and produce at least as much distress.

By definition, SMI involves impairment in psychological functioning of such severity that the person's ability to perform the routine demands of daily life is significantly compromised. Some psychological problems are unique to SMI while others occur in other contexts, but when they co-occur with SMI they often acquire distinctive qualities. For example, depression co-occurring with psychosis might be quite different from depression in a person with no other psychological disorder. A broad range of psychological assessment and treatment technologies are required to address the psychological problems of SMI. Technologies used to address similar problems in other populations must often be modified, because of the special demands of the circumstances and the special needs of the recipients. Psychologists who work with people with SMI must have the skills to effectively adapt existing technologies and to intervene across a wide range of targets.

A Biological Problem

SMI is a biological problem because most disorders appear to be related to functional and structural changes in the brain. Biological factors play a role in the etiology of SMI, at least in some individuals. Psychopharmacotherapy is an accepted and potentially helpful treatment, which is almost universally advocated. At this point, medical interventions can do little to impact on etiology; pharmacotherapy has evolved primarily on the basis of practical effects, and the psychopathophysiology of mental illness has played a minor role in creating

new treatments. In addition to the skills and knowledge conventionally associated with psychopharmacotherapy, psychological assessment methods, including neuropsychological testing, observational assessment, and functional behavioral analysis, contribute importantly to the effective use of medication in treatment and rehabilitation of SMI. Use of these familiar technologies in this less familiar context requires specialized knowledge and skill.

Another sense in which SMI is a biological problem is the role of psychophysiological arousal. People with SMI often have difficulties that involve the interaction of psychological and biological factors, resulting in poor stress tolerance, poor emotional regulation, severe cognitive deficits, agitation or impulsivity, extreme anxiety, depression, and/or social withdrawal. It is increasingly recognized that cognitive impairment is one of the major sequelae of the disorder. Psychological and psychophysiological technologies have known value in addressing such problems, and are important components in psychologists' treatment repertoire.

The view of specific diagnoses, such as schizophrenia and bipolar disorder, as biological brain diseases is playing a central role in evolution of service philosophy and social policy regarding SMI. Unfortunately, this view can lead to the belief that SMI requires nothing more than medication and institutional care. A balanced perspective on the biological and non-biological aspects of SMI is prerequisite to effective functioning as a psychologist in this domain of practice. A balanced perspective requires extensive knowledge of the biological, as well as psychological and social, aspects of SMI.

A Social Problem

An individual with SMI suffers severe and pervasive social consequences and these often occur during middle to late adolescence when social relationships are critically important. People with SMI are often unable to establish or maintain interpersonal relationships, and often lack even minimal social support systems. Social isolation is commonly associated with SMI. This lack of social relationship building has devastating consequences for the development of young people with SMI. Social and community interventions should complement biological and psychological interventions to reintegrate the person into a supportive social environment.

The impact of SMI on social systems outside the individual is also readily apparent. Parents and family members of an individual with SMI are frequently bewildered and at a loss as to how to help their ill family member. At the same time, they may be reluctant to seek help due to the stigma associated with SMI or out of fear that their family member may be taken away from them. Dealing with a loved one who is actively psychotic can be frightening and challenging. Specialized skills are needed by family members who must learn how to intervene in helpful ways and at the same time maintain their own sense of balance. There is an urgent need for support for parents and other family members and, when younger children are involved, for increased planning and coordination between the child welfare and mental health systems. In order to effectively assist families of those with SMI, psychologists must have specialized education and training in the core competencies associated with this proficiency.

Many people with SMI are homeless on any given night. Estimates of the homeless population who have SMI vary between 22 and 33 percent (U.S. Conference of Mayors, 2007; U.S. Department of Health and Human Services, 1992), and many individuals with SMI who are homeless have been traumatized. Additionally, many people with SMI are incarcerated and the number is rapidly increasing. Several years ago only about 7% of the people in jails were found to be mentally ill (Torrey et al., 1992), while in 2000 it was estimated that 20% of the U.S. jail population was seriously mentally ill (American Psychiatric Association, 2000). The fact that jails and prisons have become the largest treatment venues for those with SMI is now well known. Psychological treatment of people with SMI who have also been victims of trauma and who may have been incarcerated requires the specialized skills provided in this proficiency.

Particular Procedures or Techniques

The procedures and techniques associated with this proficiency have been the subject of a number of conferences and study panels, within psychology and in other disciplines and venues, dating back to the early 1990s. The first effort that stimulated movement in the field was the 1990 NIMH conference on training psychologists to work with individuals with SMI (Johnson, 1990). More recently, reports of the Patient Outcomes Research Team (PORT) (Lehman et al., 1998a, 1998b, 2004), and critical reviews of outcome research (Cook, Leff, Blyler, et al., 2005; Mueser, Bond & Drake, 2001), along with symposia offered over the course of the past several years for CE credit by Division 18 and the CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance stimulated continued research and training in the field.

The President's New Freedom Commission on Mental Health (2003) established a new direction for mental health policy and services that is designed to transform the way the services for people with SMI are delivered. First and foremost is the notion that SMI is treatable and people do recover from SMI; thus recovery should be the expectation. It is critical to understand, however, that the use of the term "recovery", as conceptualized by the President's New Freedom Commission on Mental Health (2003), does not necessarily imply complete remission of symptoms. As stated in the Commission's report, recovery is defined as "the process by which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms… Science has shown that having hope plays an integral role in an individual's recovery" (p 5). Thus, recovery is understood to have both objective (improvement in symptoms and functioning) and subjective (inculcation of attitudes reflecting hope, self-efficacy, and empowerment) dimensions; psychologists need to possess a unique set of tools to intervene on both dimensions.

Successfully transforming the mental health service delivery system to promote recovery rests on two key principles: first, services must be consumer and family driven, and second, care must focus on increasing individuals' ability to cope successfully with life's challenges, i.e., increasing functional skills, and on building resilience, not just on reducing symptoms. The

policy direction set forth in the report of the President's New Freedom Commission on Mental Health indicates that building resilience, i.e., strengthening those factors that allow an individual to overcome adversity and gain the skills needed to live successfully in the community, must be the goal of every mental health service delivery system in the United States.

As systems move from hierarchical to shared decision-making approaches and a consumer orientation, providers need experience and familiarity with helping their clients with SMI to apply cognitive and behavioral change techniques in normative real-world settings. In order to accomplish the transformed system of care envisioned by the President's New Freedom Commission on Mental Health, a trained workforce is needed that is fully attuned to the concept of recovery and expert in delivering the evidence-based and best practices that have been shown to help individuals develop the skills and capabilities they need to regain their independence and live productive lives in the community. Furthermore, such a workforce will have to be able to provide consultation and direct services across multiple domains, including clinical, research, educational, and administrative. This proficiency is designed to specify the distinct body of knowledge and experience needed to do this work.

The body of knowledge that constitutes this proficiency, including procedures and techniques, along with their respective knowledge and skill prerequisites, can be organized into four categories: ideology and attitudes, core knowledge areas, systems and services-related knowledge and skills, and interventions:

- Ideology and Attitudes
  - Respect for people with SMI and their families.
  - Sensitivity to the experiential world of people with SMI.
  - Understanding of the burden of living with mental illness on relatives and care providers.
  - Use of "person first" language when talking with or about people with SMI.
  - A longitudinal, optimistic view of mental illness with realistic expectations in setting treatment and rehabilitation goals.
  - Recognition and acceptance of the idea that people with SMI can, and do, recover, especially when provided appropriate treatment and rehabilitation interventions.
  - Sensitivity to clients' needs to pace themselves in movement toward goals.
  - A flexible and comprehensive view of treatment and rehabilitation.
  - Interest in service provision for this population and in research on SMI.

- Core Knowledge
  - Familiarity with the psychopathology of SMI, including biological, psychological and social perspectives, especially diathesis-stress models.
  - Working knowledge of diagnostic criteria.
  - Familiarity with descriptive and developmental psychopathology, and clinical phenomenology.

Familiarity with outcome research, practice guidelines, standards and regulations pertinent to SMI, especially newer models of psychosocial rehabilitation and evidence based interventions for this population.
Familiarity with the cultural context, and issues of multicultural diversity pertinent to SMI.
Familiarity with consumer and advocacy issues.
Familiarity with consumer groups and their services.

- Systems and Service-Related Knowledge and Skills
  Ability to design, implement and evaluate service programs and models.
  Professional, administrative and clinical leadership capability in mental health systems.
  Ability to collaborate and consult with other disciplines, service recipients, advocates, families and agencies.
  Policy analysis, administrative and regulatory skills.
  Familiarity with developing system-level psycho-legal mechanisms pertinent to the needs of people with SMI (guardianship, civil commitment, advance directives, etc).
  Familiarity with issues of youth transitioning to adulthood, and knowledge of how to facilitate transition from adolescent-serving to adult-serving programs and systems
  Knowledge of social resources and benefits available to people with SMI.
  Ability to provide clinical leadership on an interdisciplinary treatment/rehabilitation team.
  Knowledge of relevant legislation and entitlements

- Clinical Assessment and Intervention Skills
  Clinical expertise in functional analysis of behavior.
  Clinical expertise in functional skill assessment and behavioral assessment, in addition to expertise in assessment of psychotic symptoms and related expressions of SMI.
  Expertise in neuropsychological assessment specialized for use with SMI.
  Clinical expertise in rehabilitative skill training (communication and social skills, disorder management skills, stress management skills, cognitive re-training, evidence based practices for this population, etc.).
  Clinical expertise in risk assessment and risk management.
  Clinical expertise in cognitive-behavioral therapy, supportive therapy and related psychotherapies applicable for use with SMI.
  Clinical expertise in neurocognitive rehabilitation.
  Clinical expertise in psychoeducational techniques specialized for use with SMI.
  Clinical expertise in Social Learning Theory - based methods, including token economy, individualized contingency management and contingency contracting, and Time Out From Reinforcement (TOFR) and related interventions.
  Clinical expertise in relapse prevention and planning.

Clinical expertise in psychopharmacology and psychopharmacotherapy, at least at the consulting level.
Clinical expertise in family psychoeducation and behavioral family therapy.
Clinical expertise in treatments for co-morbid conditions, including substance abuse, especially integrated dual diagnosis treatment.
Clinical expertise in treatment adherence technologies.
Clinical, ethical and legal expertise in behavior control interventions (restraint, seclusion, etc.).
Clinical expertise in treating victims and perpetrators of trauma.
Clinical expertise in crisis intervention techniques, specialized for use with SMI.
Clinical expertise in occupational and vocational rehabilitation and education, specialized for use with SMI.
Clinical expertise in forensic and psycho-legal assessment and related activities (court testimony, etc) sufficient for routine legal problems (civil commitment, guardianship, etc.).

Please see Criterion II for the required didactic and experiential components of training and Criterion VI for a summary, by disorder and intervention type, of the current state of the knowledge base. Additionally, Appendix E contains a listing of references for the major studies and literature for each disorder and intervention type. Lastly, a very useful compendium of evidence based and best practices, largely developed by psychologists, is available on the APA web site at http://www.apa.org/practice/smi_grid-v2.pdf.

Criterion IV. Public Need for Proficiency Practice.

A proficiency shall be clearly responsive to public need.

1. What public need does this proficiency serve?

This proficiency serves the public need for effective, humane and cost-effective treatment, rehabilitation and related services for people with SMI.

Today in the United States, hundreds of thousands of people with SMI suffer repeated relapses necessitating hospitalization, often on an involuntary basis. Thousands of others live in sordid conditions with little to do except smoke cigarettes and watch television. More thousands are less impaired by acute symptoms, but find themselves unable to work or study and are living on the margins of society. Roughly one-third to one-half recover sufficiently to return to normal functioning but these individuals often find that societal stigma and the functional deficits they have accumulated make it difficult if not impossible to return to education or employment. Reports by the President's New Freedom Commission on Mental Health, Institute of Medicine, and Surgeon-General highlight the fragmentation of public mental health services and the need to improve access to evidence–based practices (President's New Freedom Commission on Mental Health, 2003; Institute of Medicine, 2001, 2006; Surgeon General, 1999, U.S. Department of Health and Human Services, 2005).

It is increasingly clear that this gloomy state of affairs does not reflect the current state of science and technology. Government reports and reports of outcome research on services for SMI conclude that treatments of known effectiveness often do not reach the individuals that could benefit from them, and this is especially true for psychosocial rehabilitation treatments (The President's New Freedom Commission on Mental Health, 2003; Lehman et al., 1998, 2004; Cook, Leff, Blyler, et al., 2005; Mueser, Bond & Drake, 2001). As discussed above, stigmatization and poor social policy account for much of this gap (Hoge and Morris, 2002). In addition, there are too few psychologists with the clinical, administrative, and advocacy skills to make appropriate services available, even when fiscal constraints are not a problem (Gotham, 2006; Jansen, Menditto, & Pickett-Schenk, submitted for publication). The problem is perpetuated by a relative dearth of systematic and comprehensive training and experiential opportunities at the graduate and postdoctoral levels, and in many places by attitudes and mental health policies that discourage psychologists from investing their careers in SMI. Stigmatization extends not just to people with SMI, but to the professionals who serve them as well. Psychologists' professional stature and unique skills are often unrecognized in the medical model settings in which people with SMI are often served, further discouraging use of state-of-the-art psychological technology.

In institutional settings, the importance of psychologists' services has been underscored recently by the actions of the U.S. Attorney General. In state hospitals around the country, lack of appropriate psychological services, including psychosocial and behavioral interventions, has often resulted in federal litigation against states, under provisions of the Civil Rights of Institutionalized Persons Act (U. S. Department of Justice, 1997). A special litigation division of the U.S. Attorney General's office routinely includes psychologists on their expert consultant teams, in order to evaluate the adequacy of the psychological services being provided in institutions under investigation. The increasing use of jails as treatment venues coupled with the increasing use of litigation as an advocacy tool, supports the urgency of training psychologists to be fully knowledgeable about the full range of issues surrounding those with SMI.

Furthermore, even when attempts are made to provide true rehabilitative services, they tend to degenerate to "community-based custodial care" because they are insufficiently staffed and staffed and supervised by inadequately trained professionals. The absence of appropriately trained and educated psychologists for these settings is a major factor in the failure of services. Without appropriately trained professionals, attempts at providing empirically supported services often fail, leading to support for widely held beliefs that individuals with SMI cannot recover. This in turn leads to the loss of even more funding and support for services and for training, thus continuing the cycle of chronicity for this population.

Recent mandates in national mental health policy have identified critical needs to transform mental health services by including clients and families in decision-making and treatment planning; reducing disparities in access to services; integrating recovery principles, new technologies and evidence-based practices; and expanding and developing the behavioral health workforce, particularly for clients and families in greatest need (President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human

Services, 2005; Hoge & Morris, 2002). The lack of appropriate services for people with serious mental illness is increasingly recognized as a systemic problem.

This proficiency is aimed at addressing this problem by 1) identifying the skills and knowledge base required to provide effective psychological services related to SMI, 2) providing curriculum goals for training programs and personal development goals for psychologists in training, 3) providing criteria for local credentialing and privileging of psychologists, as well as hiring guidelines for potential employers and contractors. An increase in psychologists with appropriate knowledge and skills, combined with the recognition of these skills through increased awareness in hiring policies and professional credentialing, will lead to improved status of psychologists in settings where people with SMI are served, and will serve the public good by enhancing the availability of expertly trained clinicians. This will lead to better incentives to work and specialize in this area, to more psychologists developing careers relevant to the area, and, ultimately, to more and better services for the people who need them.

2. Describe any regulatory, professional privileging and/or educational statute or regulation of this proficiency of which you are aware.

There are currently no statutes or regulations that regulate this proficiency, although there is increasing but indirect pressure to develop relevant standards in some settings. Growing concern about institutional practices is driving new federal and state legislation intended to reduce use of restrictive and intrusive patient management practices such as restraint and seclusion, and this is reflected in new regulatory policy (e.g. policies of the Centers for Medicare and Medicaid) and accreditation standards (e.g., standards of the Joint Commission on Accreditation of Healthcare Facilities and the Commission on Accreditation of Rehabilitation Facilities). New standards are creating greater demands for psychological services, as such services are widely perceived as credible alternatives. However, new standards are not necessarily well informed by psychological expertise, making comprehensive training in this area even more important.

For several years, psychologists have been expanding their practice into hospital settings, and have made important gains in securing appropriate staff membership status and privileges. So far, however, these developments have been most relevant to private sector settings and recipients with problems other than SMI. State hospitals and comparable institutions are still major settings for services to people with SMI, and psychologists are just beginning to establish appropriate roles in these settings. Hospital staff membership and privileges are key to providing appropriate hospital-based services (and sometimes community-based services as well, when such services are provided by hospital-based organizations). As institutions respond to policy pressure for better services, psychologists and the services they provide will increasingly be the subject of staff membership and privileging. However, there is little precedent in these institutions for some of the privileges psychologists need (e.g. forensic and risk assessment, functional behavioral analysis, contingency management). Appropriate regulation of these areas of psychological practice will be heavily dependent on the availability of recognized skill and knowledge areas, such as represented in this proficiency, for the formulation of privileges and related regulatory mechanisms.

3. Describe how the recognition of this proficiency will increase the availability and quality of services that professional psychologists provide without reducing access to needed services.

Currently, the availability and quality of services that professional psychologists provide to people with serious mental illness are limited by the following factors:

- Graduate training programs provide only basic exposure and training relevant to serious mental illness (Johnson, 1992; Reddy and Spaulding, submitted for publication);

- Psychologists infrequently choose careers in SMI services;

- Public policy does not always encourage or fund the kinds of services psychologists are most prepared to provide; medical services and basic social support services are often the only services funded;

- In settings where people with SMI are served, especially medical settings, psychologists are often not seen as having useful knowledge and skills, and are not fully recognized as independent healthcare providers;

- Psychologists who serve people with SMI often lack a complete repertoire of necessary knowledge and skills. Even if their clinical skill repertoire is very strong, they may lack the policy-related, organizational and community skills required to create an organizational environment for effective clinical practice. In addition, training for psychologists who work in the adult mental health system may have focused on serving those in full adulthood, rather than young adulthood or older adulthood, and may have lacked attention to the developmental transitions of that age group, as well as attention to helping youth who were served in the child system make a transition to the adult system.

These factors create an illusory impression that there is too little demand for the services of psychologists. The demand is artificially suppressed by tradition and regulatory practices that devalue psychological services. However, public awareness of SMI and its attendant social problems is rapidly increasing. Developments in law and social policy point toward an acute demand for psychologists' expertise in SMI. Research increasingly shows the benefits of services based on that expertise. The true demand for psychological services relevant to SMI far exceeds the supply. This proficiency would help to close the gap between demand and supply.

It is important to note in this regard, that some of the skills, experience, and knowledge areas in this proficiency are not unique to SMI and may be covered in current professional psychology training curricula. It is the particular scope and combination of skills and knowledge that create a distinct area of proficiency, along with their particular applications to SMI and the specialized topics that are not routinely covered. The role of the proficiency is in

part to identify, among a plethora of existing training and education options, the ones to pursue to be successful in SMI-related practice. However, the proficiency will also create new training and education options by encouraging the development of SMI placements and rotations where familiar skills can be applied in a specialized context.

The proficiency will increase, rather than decrease, the number of psychologists providing services to those with SMI because it is expected that administrators in institutions and community mental health centers who seek to employ mental health professionals will choose those who have credentials showing proficiency in the SMI area. Although a result will be higher quality services from a greater number of qualified providers, this will not produce a net decrease in access. Currently, in most service delivery systems, these services are not being provided at all.

A proficiency in Assessment and Treatment of Serious Mental Illness will narrow the gap between demand and supply in the following ways:

- Enumeration of the particular knowledge and skills required for effective practice will provide a guide for curriculum development in graduate programs, so that more psychologists will be exposed to SMI and related career possibilities, and more psychologists will begin their career with a repertoire of relevant skills;

- Recognition of the particular knowledge and skills required for effective practice will encourage development of regulatory standards, hospital privileges and related mechanisms that recognize psychologists' professional status, knowledge and skills pertinent to SMI;

- Recognition by the psychological community of a special area of practice will attract psychologists to that area;

- Recognition by the healthcare community of psychologists' special skills will create incentives for psychologists to pursue careers in the area;

- Recognition and enumeration of the particular knowledge and skills required for effective practice will guide postdoctoral and continuing education curricula, so that practicing psychologists will have more opportunities to get advanced training and education in areas pertinent to SMI;

- A greater number of psychologists in the area will accelerate current trends toward greater recognition of psychologists as independent professionals in the settings where people with SMI are served;

- Inclusion of policy and advocacy knowledge and skills in the proficiency will accelerate the successes psychologists are already enjoying in gaining new stature, recognition and practice privileges in settings where people with SMI are served.

Criterion V. Administrative Organizations.

The proficiency is represented by one or more organizations of psychologists that provide systems and structures which make a significant contribution to the organized development of the proficiency.

Describe the purpose and objectives of your petitioning organization.

Division 18, Psychologists in Public Service, responds to the needs of the public in areas such as psychological practice, research, training, and policy formation. The Division is comprised of five Sections representing a variety of settings: Community and State Hospital Psychologists, Criminal Justice, Police and Public Safety, Psychologists in Indian Country, and Veterans Affairs (VA) Psychologists. The Division and its sections provide a forum for its members to discuss common professional interests, to advocate for the mental health of the public, and to promote the use of evaluation, research and evidence-based practices in public service settings and in research programs.

List other organizations that are associated with, that promote, or that certify practitioners in this psychological proficiency.

The APA CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance has assisted Division 18 in preparing this petition. The Task Force was established in 1994 by the American Psychological Association Council of Representatives. Since 1995 it has been facilitated and staffed by the APA Practice Directorate, with oversight and support by the Committee for the Advancement of Professional Practice (CAPP).

The Task Force was established as a way of insuring that issues related to severe mental illness in adults and severe emotional disturbance in children would have a voice within APA. The goals of the Task Force, as identified by the Board of Directors and approved by the Council of Representatives on August 11, 1994 are: (1) to make recommendations to Council and APA concerning practice, research, and training issues in treatment of SMI/SED, (2) to further develop coalitions with consumer groups, state mental health program directors, and others to recommend further collective action in support of the needs of SMI/SED, (3) to identify ways that psychologists can function most effectively in treating SMI/SED in organized systems of care, (4) to find ways to emphasize and publicize the fact to the public that psychologists have major contributions to make in the recovery process for individuals diagnosed with SMI/SED, and (5) to identify practical community-based alternatives to institutionalization that improve access to supported competitive employment and normalized housing in the community. The Task Force on Serious Mental Illness and Severe Emotional Disturbance is the APA's principal mechanism for advocating on behalf of those with SMI.

Since its formation, the Task Force has taken its mandate seriously and has worked to achieve the goals set forth in the resolution approved by the Council of Representatives in 1994. One of those goals is advocating for education and training of psychologists in the most up-to-date methods of working with individuals who have SMI to promote successful treatment and

recovery. As such, the Task Force is uniquely positioned to assist Division 18 with this proficiency.

The Task Force on Serious Mental Illness and Severe Emotional Disturbance reports to the Committee on Professional Practice (CAPP), which has strongly supported the Task Force over the years. For the past several years, CAPP has allocated one of its convention hours to the Task Force and the Task Force has used this hour to sponsor a symposium on SMI. For most of these years, the Task Force has been successful in garnering a second hour for the symposium, most often from Division 18. Together, Division 18 and the Task Force have worked to educate psychologists about the evidence based services available for those with SMI through these symposia, most of which have been offered for CE credit. Due to the strong support of CAPP and the original direction from the Board of Directors and the Council of Representatives, support for the work of the Task Force is strong and there are no plans to sunset it.

Please present a rationale that defends your organization as nationally representative of the practice of your proposed proficiency.

Those working in public service settings are the psychologists most likely to provide care for people with SMI in the United States. In addition, psychologists in these settings provide the majority of practical training for students, interns, and post doctoral fellows in APA-approved academic training, internship, and fellowship programs. Division 18 and its membership are the primary providers of psychological services, training and research for people with SMI.

Division 18 is uniquely suited to petition for the proficiency, because it is the home within APA for public sector psychologists, and the vast majority of people with SMI receive services through the public sector. As mentioned, the Division is comprised of five sections (Police and Public Safety, Psychologists in Indian Country, State and Community Hospital Psychologists, Criminal Justice Psychologists, and Veteran's Administration (VA) Psychologists), all of which have an interest in, and focus on, assessment and treatment of SMI. Importantly, three of the five sections of the division – State and Community Hospital Psychologists, Criminal Justice Psychologists, and Veteran's Administration (VA) Psychologists, represent the practice of psychology within the settings which overwhelmingly are responsible for providing services to persons with severe mental illness.

Criterion VI. Effectiveness.

A proficiency is characterized by a body of evidence which demonstrates its effectiveness.

1. Summarize evidence of the effectiveness of the proficiency, utilizing literature, manuscripts published in refereed journals (or equivalent), outcome studies, practice guidelines, consumer satisfaction surveys, etc., that demonstrate the efficacy of the proficiency. Where possible, relate this evidence to the parameters identified in Criterion III.

As stated in the executive summary of the President's New Freedom Commission on Mental Health, "In a transformed mental health system, consistent use of evidence-based, state-of-the art medications and psychotherapies will be standard practice throughout the mental health system. Science will inform the provision of services, and the experience of service providers will guide future research. Every time any American - whether a child or an adult, a member of a majority or a minority, from an urban or rural area - comes into contact with the mental health system, he or she will receive excellent care that is consistent with our scientific understanding of what works." (President's New Freedom Commission on Mental Health, 2003, p.19).

The scientific base supporting effective assessment and treatment interventions for individuals with serious mental illnesses has grown substantially over the past few years and there are now several evidence-based treatments that have been shown to be effective with this population. Evidence-based treatments are interventions for which there is scientific evidence consistently showing that they improve client outcomes (Drake et al., 2001). In fact, many effective and efficacious psychopharmacological and psychosocial treatments are now available for people with SMI. Psychologists have conducted much of the research that has established the evidence base for these interventions and have been at the forefront of translating research results into effective practice for treating people with SMI. Due to this burgeoning literature, there are now several recognized treatment guidelines that are based on this evidence (American Psychiatric Association, 1997; American Psychiatric Association, 2000; Dennehy, 2000; Frances, Kahn, Carpenter, Docherty, & Donovan, 1998; Hirschfeld, Bowden, Gitlin, Keck, Perlis, Suppes, et al., 2002; Lehman, Lieberman, Dixon, McGlashan, Miller, Perkins, et al. 2004; U.S. Department of Veterans Affairs, 2000; U.S. Department of Veterans Affairs, 2004). A listing of the most well known and used treatment guidelines is presented in Appendix D**.**

Assessment in SMI

Assessment practices with people who have SMI have changed greatly in the past three decades. Although conventional assessment instruments (e.g., MMPI-2, Rorschach, Thematic Apperception Test (TAT), Wechsler Adult Intelligence Scale (WAIS)) are still being used, a greater emphasis is often placed currently on observational methods, rating scales, and questionnaires designed to provide specific information about specific problem areas (e.g., Beck Depression Inventory for level of depressive mood) (Bedell, 1995; Ciarlo, Brown, Edwards, Kiresuk, & Newman, 1986; Erickson, 1994; Frisch, Cornell, Villanueva, & Retzlaff, 1992; Kay, Fiszbein, & Opler, 1987; Lukoff, et al., 1986; O'Neill, Horner, Albin, Sprague, Storey, & Newton, 1997; Paul, 1986; Wallace, 1986). There is also an increased interest in the neuropsychological aspects of assessment, such as the assessment of specific cognitive deficits and strengths (e.g., the MATRICS battery (Green & Nuechterlein, 2004).

Major Forms of Treatment and Rehabilitation

Appendix E provides a comprehensive list of the major studies and literature associated with the most widely used interventions for this population. In addition, a very useful compendium of evidence based and best practices, largely developed by psychologists, is

available on the APA web site at http://www.apa.org/practice/smi_grid-v2.pdf. The report from the Evidence Based Services Committee of the Hawaii Department of Health (Child and Adolescent Mental Health Division) summarizes evidence-based child and adolescent psychosocial interventions is available at http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs011.pdf.

A synopsis of the evidence based literature is presented below.

Pharmacotherapy

One of the most widely accepted and used interventions in SMI is medication. Pharmacological treatment of people with SMI is generally accepted as basic, and nearly all people who have these disorders are prescribed medications. It has long been accepted that medications are a cornerstone of the treatment plan. Based on their analysis of research findings, Falloon and colleagues (1998) concluded that appropriate medications can decrease symptoms in 75% of clients with schizophrenia and reduce the risk of relapse from 70% to 30-40%. Medications can also improve clients' ability to response effectively and positively to other interventions. It is also widely accepted that, while medication is essential for the management of the most troublesome symptoms, it often is not sufficient to improve the quality of life of people with SMI and to help them move on to full recovery. A short overview of the most widely prescribed medications, organized by SMI diagnosis category, follows.

Schizophrenia

Antipsychotic medications have been available for five decades, beginning with the use of Thorazine (chlorpromazine) in the 1950s. Although their effectiveness in controlling the symptoms of schizophrenia is well documented, conventional antipsychotics have limitations, including the presence of unpleasant side effects, their failure to treat negative symptoms, and a limited impact on positive symptoms in close to one-third of clients. In the past decade or so, a new generation of atypical antipsychotics has been developed, including Abilify (aripiprazole), Clozaril (clozapine), Geodon (ziprasidone HCL), Risperdal (risperidone), Seroquel (quetiapine), Zeldox (ziprasidone), and Zyprexa (olanzapine). While these newer medications do not have some of the parkinsonian and abnormal movement side-effects seen in the older medications, many of these second generation medications are associated with metabolic abnormalities and weight gain. At this point, it is unclear whether first and second-generation antipsychotic medications differ in efficacy, in part because non-adherence and medication change appear to be the norm over time (Buckley, 2008; Buckley & Correll, 2008; Weiden, Scheifler, Diamond & Ross, 1999; Wirshing, Wirshing, Marder, Saunders, Rossotto & Erhart, 1997).

Bipolar Disorder

With the recognition in the late 1950s and early 1960s that lithium carbonate could help control mood swings, medications have become a mainstay in the treatment of bipolar disorder. While lithium remains a first line agent, subsequent anticonvulsant medications

(e.g., Tegretol (carbamezepine), Depakote (valproic acid), Topamax (topiramate) and Lamictal (lamotrigine)) were found to have a significant capacity to reduce cycling. In addition, several newer antipsychotic medications, such as Abilify (aripiprazole), and Risperdal (risperidone) have been recognized as having efficacy in treating mood instability (Buckley, 2008; Sachs & Thase, 2000; Scherk, Pajonk & Leucht, 2007). However, side effects for some individuals range from bothersome (nausea, diarrhea, tremors, fatigue, sedation) to dangerous (heart or kidney problems). Similar to the information presented on schizophrenia above, medication non-adherence is a significant impediment to recovery in bipolar illness.

Depression

The wide range of medications for the treatment of depression is well-known, including tricyclics such as Elavil (amitryptyline) and Anafranil (clomipramine); monoamine oxidase inhibitors such as Nardil (phenelzine); and selective serotonin reuptake inhibitors such as Prozac (fluoxetine), Zoloft (sertraline HCL), and Paxil (paroxetine). Also well-known is the ongoing controversy about their relative effectiveness, especially compared to psychological interventions such as cognitive therapy, cognitive-behavioral therapy (including such components as affective education, activity scheduling, social skills training, self instructional training, and cognitive restructuring), and interpersonal therapy (Kirsch & Saperstein, 1998; Moncrieff, Wessely & Hardy, 1998; Moncrieff, Wessely & Hardy, 2001).

Psychologists and Pharmacotherapy

Psychologists often have a major role to play in the psychopharmacologic area, in some instances because they have prescription privileges, but more often because they can serve as effective consultants to physicians on medication-related matters. Developing programs to enhance shared decision-making to promote treatment adherence is an area where psychologists can play a particularly useful role and psychologists trained in issues related to SMI would be especially useful (Corrigan, 2002; Deegan & Drake, 2006; Kane, 2006; Pampallona, Bollini, Tibaldi, Kupelnick & Munizza, 2004; Pettit, Voelz & Joiner, 2001; Spaulding, Johnson & Coursey, 2001).

Psychosocial Treatment and Rehabilitation Methods

While medications play a key role in symptom reduction with SMI, it is widely acknowledged that, in most cases, medications alone do not assure that individuals with these illnesses live full, satisfying lives. To overcome negative symptoms, to support treatment adherence, and to move beyond symptom relief to recovery, psychosocial interventions have been shown to be key. In many cases psychosocial methods have an effectiveness that is at least as great as those demonstrated for medications, without unpleasant or even intolerable pharmacological side effects. Furthermore, in as many of one-third of cases, medications do not provide complete symptom relief. Here psychosocial interventions may play an especially critical role in recovery.

Over the past two decades, an expanding body of evidence has demonstrated the value of a range of psychosocial interventions that can improve the long-term outcome for people with SMI. In a review, Mueser, Bond, and Drake (2001) reported that controlled research on most of these interventions suggests specific benefits in the areas of relapse and rehospitalization, housing stability, competitive employment, social functioning, psychotic symptoms, and substance use disorders. Combined with the current focus in the SMI field on the concept of recovery, the growing arsenal of evidence-based treatments is cause for optimism.

The most widely researched psychosocial interventions for SMI include:

- Assertive Community Treatment
- Family psychoeducation
- Psychotherapy, especially Cognitive Behavioral Therapy
- Training in social skills and illness management
- Cognitive remediation
- Supported employment
- Comprehensive Social Learning Programs (including token economies)
- Integrated treatment for co-occurring substance use disorders
- Treatment for co-occurring trauma

A short overview of these interventions follows.

Program in Assertive Community Treatment (PACT)

The PACT model was designed to meet the needs of clients with a history of high service utilization or severe functional impairment. Designed to provide services to clients in their natural living environments, the model incorporates 24-hour coverage by multidisciplinary treatment teams, integration of treatment and rehabilitation, small caseloads and frequent client contact, and close attention to illness management and daily living problems. Case management services assure the assessment, coordination, and provision of different and varied treatment components. There is strong evidence that ACT decreases hospitalizations and improves housing stability. Some studies also point to higher rates of client satisfaction, improved quality of life, and decreased symptoms (Burns, Catty, Dash, Roberts, Lockwood, & Marshall, 2007; Mueser, Bond, Drake, & Resnick, 1998).

In addition to the PACT program, people with SMI living in the community often need assistance in managing medications, keeping appointments, dealing with housing problems, dealing with familial, legal, and/or custodial issues, and the like. Case management, which provides for coordination of care in an increasingly complex and fragmented community system, is designed to provide this assistance (Manion & Granger, 2007; Mueser, Bond, Drake & Resnick, 1998).

Family Interventions

Many factors have influenced the proliferation of family interventions for schizophrenia in recent years (Marsh, 1998; 2001). Important factors include:

- New evidence for the role of biological factors in the etiology of serious mental illness;
- The necessity for families to assume caretaking roles in the wake of deinstitutionalization;
- Robust evidence for the catastrophic impact of schizophrenia on families;
- Absence of empirical support for earlier theories of family dysfunction or pathogenesis, such as the double-bind hypothesis;
- Evidence that high levels of family stress increase the risk of relapse for recently-discharged clients;
- Recognition that families of persons with serious psychiatric illnesses are at increased risks themselves for anxiety and depressive disorders;
- The family advocacy movement (e.g., NAMI) which has moved families into more informed and assertive roles;
- Recognition that lack of future planning by family caregivers may lead to premature institutionalization for older adults with SMI.

In response to these developments, there has been an historical shift from a view of the family as a cause of schizophrenia to the family as a source of support. Namely, the family is now seen as part of the solution rather than the part of the problem. Several family interventions for SMI are available, although the most extensive evaluations have been of family psychoeducation, which is among the most empirically-validated evidence-based treatments for schizophrenia and bipolar disorder (Dixon, McFarlane, Lefley, Lucksted, Cohen, Falloon, et al., 2001; Fristad, Goldberg Arnold & Gavazzi, 2002; Glynn, Cohen, Dixon & Niv, 2006; Miklowitz, George, Richards, Simoneau & Suddath, 2003; Miklowitz & Goldstein, 1997; Miklowitz, Simoneau, George, Richards, Kalbag, Sachs-Ericsson, et al., 2000; Mueser & Glynn, 2000; Sikich, 2005).

Psychoeducational programs generally include education and skills training with both client and family involvement lasting at least 9 months, while educational programs tend to be shorter, emphasize provision of information, and are typically not related to improvements in patient clinical outcomes. The most widely disseminated family education program is a peer-led program (The Family-to-Family program) offered through local chapters of the Alliance for the Mentally Ill (Dixon, Lucksted, Stewart, Burland, Brown, Postrado, et al., 2004; Dixon, Stewart, Burland, Delahanty, Lucksted & Hoffman, 2001; Sherman, 2003).

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Psychotherapy, Especially Cognitive and Cognitive-Behavioral

Cognitive behavioral psychotherapy for depression and the anxiety disorders has been accepted as effective and useful for many years. Research demonstrating effectiveness for bipolar disorder and schizophrenia is more recent, but the results are persuasive (Beck, Rush, Shaw & Emery, 1987; Chadwick & Trower, 1996; Dickerson, 2000; Dickerson & Lehman, 2006; Garety, Fowler & Kuipers, 2000; Kingdon & Turkington, 1994; Lam, Jones, Hayward & Bright, 1999; Scott, 2001; Wykes, Steel, Everitt & Tarrier, 2008). Newer treatments which have had promising results include acceptance and commitment therapy for psychosis (Bach and Hayes, 2002) and for depression (Forman, Herbert, Moitra, Yeomans & Geller, 2007), and social rhythm therapy for bipolar disorder (Frank, Swartz, & Kupfer, 2000).

Training in Social Skills

Because SMI is typically characterized by significant impairments in social functioning, practitioner/researchers have developed programs designed to help clients improve their conversational, conflict management, assertiveness, community living, and friendship and dating skills. Researchers have repeatedly found that social skills training is effective at teaching specific skills to clients and that these skills are maintained over time; promoting generalization of skills to the community continues to be the critical challenge (Bellack, Mueser, Gingerich & Agresta, 2004; Heinssen, Liberman & Kopelowicz, 2000; Kopelowicz, Liberman & Zarate, 2006; Kurtz & Mueser, 2008; Mueser, Bond & Drake, 2001).

Illness Management

Effective programs have also been developed to help clients to manage their illnesses. Such programs generally include education about SMI and treatment, as well as strategies for preventing relapse and for coping with stress or persistent symptoms. Based on research findings, Mueser and his colleagues (2001) concluded that training in illness management is a core ingredient of effective intervention programs for clients with SMI (Merinder, 2000; Mueser, Corrigan, Hilton, Tanzman, Schaub, Gingerich, et al., 2002).

Cognitive Remediation

Although especially true of schizophrenia, neurocognitive deficits exist in all forms of SMI. These deficits interfere with vocational and social rehabilitation. Important recent research has shown that these deficits can, to some extent, be remediated through targeted interventions and these improvements can be associated with improved community functioning. Psychologists have played a particularly prominent role in this field of research (Kurtz, Moberg, Gur & Gur, 2001; McGurk, Twamley, Sitzer, McHugo & Mueser, 2007; Silverstein, Hatashita-Wong, Solak, Uhlhaas, Landa & Wilkniss, 2005; Spaulding, Reed, Sullivan, Richardson & Weiler, 1999).

Supported Employment

Psychologists have been at the forefront of the development of methods for vocational rehabilitation. Although most people with SMI want competitive employment in normal work settings, traditional approaches have been notably unsuccessful in helping them achieve their vocational goals. Supported employment is a recent approach that features rapid job search rather than extensive prevocational assessment, competitive wages for jobs in integrated settings, ongoing support once a job has been obtained, integrated vocational and mental health services, and client preference driving the job search. Strong outcome data exist to support the efficacy of supported employment for persons with SMI. Research findings from studies of supported employment provide clear and consistent evidence of improved employment outcomes across many different types of settings and populations (Becker & Drake, 2003; Bond, Becker, Drake, Rapp, Meisler, Lehman, Bell & Blyer, 2001; Bond, Drake & Becker, 2008; Twamley, Jeste & Lehman, 2003). Additionally, research has found that

when supported employment is combined with other mental health services, i.e., in a highly integrated model of service delivery, employment rates for those with SMI can be more than double that of those who receive supported employment without additional integrated services, and individuals achieve significantly higher earnings and remain employed for longer periods (Cook, Lehman, Drake, et al., 2005; Cook, Leff, Blyler, et al., 2005).

Social Learning Programs

Some people with SMI may not respond well or fully to psychopharmacological treatment, and may have significant areas of disability that prevent them from receiving full benefits from psychosocial treatments. Social Learning Programs, including token economies and intensive staff observation and training, have been shown to be very effective with this group, and have enabled them to make substantial progress towards their goals for recovery (Paul & Lentz, 1977; Dickerson, Tenhula & Green-Paden, 2005).

Integrated Treatment for Comorbid Substance Use Disorders

It has been estimated that half of the individuals with SMI will have a co-occurring substance abuse problem at some point in their lives; the incidence of such co-morbidity is approximately 25% at any given time (Regier et al., 1990). As Mueser and his colleagues (2001) note, this "dual diagnosis" is associated with a wide range of negative outcomes that include relapse and re-hospitalization, housing instability, financial problems, violence, increased risk of self-harm, increased service utilization, family conflict, and legal problems. Traditional approaches to treatment are largely ineffective, including the "sequential" approach in which one disorder (e.g., schizophrenia) is treated before initiating treatment for the second disorder (e.g., substance use disorder); and the "parallel" treatment approach in which both disorders are treated simultaneously but by different providers. In contrast, research has suggested that integrated mental health and substance abuse treatment programs may be more successful than traditional programs in reducing substance abuse (Drake, Mercer-McFadden, McHugo & Bond, 1998; Tiet & Mausbach, 2007).

Treating traumatic stress in persons with SMI

Surveys indicate that upwards of 70% of patients with SMI have been exposed to at least one DSM-IV criterion A stressor (Resnick, Bond & Mueser, 2003), with approximately half of these individuals meeting current diagnostic criterion for PTSD (Mueser, Salyers, et al., 2004). Comorbid PTSD diagnoses are related to poorer clinical (Mueser, Salyers, et al., 2004) and vocational outcomes (Mueser, Essock, Haines, Wolfe, & Xie, 2004), and thus have been more recently targeted with focal cognitive-behavioral treatments in an effort to improve overall treatment outcomes (Mueser, Rosenberg, Xie, Jankowski, Bolton, Lu, et al., 2008).

SMI Interventions and Developmental Stage

It has become increasingly clear that treatments for SMI are enhanced when they take into account the individual's developmental phase. Over the last ten years, there has been increasing interest in improving the illness trajectory of persons in a prodrome or first episode

of a schizophrenia or bipolar illness, as well as targeted treatments to older individuals with serious psychiatric illnesses.

First episode of psychosis

Most new cases of psychosis will develop in youth and young adults (Chapman, 1966; Jablensky, Sartorius, Ernberg, et al, 1992; Owens, Miller, Lawrie & Johnstone, 2005; Sartorius, Jablensky, Korten, et al, 1986; Tandon, Keshavan & Nasrallah, 2008). For these young people, it is likely that their education and social relationships will be interrupted and the learning that would normally take place around developmental issues such as relationship building, separation and individuation, independent living, etc., may also be disrupted. The earlier that psychological interventions can assist these young people to resume their normal developmental trajectory and resume their social, educational, and vocational maturation, the easier their accomplishment of these milestones will be. In recent years, there has been increasing recognition of the need to intervene as early as possible with both pharmacologic and psychosocial interventions whenever symptoms of psychosis or other SMI become apparent. Although there are many factors that influence functional outcomes, there is growing evidence that early intervention with pharmacologic and psychosocial treatments during the first episode of psychosis may lead to improved outcomes (Bryden, Carrey & Kutcher, 2001). Many believe that there is a critical period which occurs soon after the manifestation of symptoms where intervention is important to minimize the effects of the illness (Birchwood, 2000; McGorry, 2002). It is during this time that psychosocial interventions should be provided along with pharmacologic treatments.

Older individuals with SMI

With the aging of the overall population, more and more individuals are living into their older years with SMI. Many of these individuals need assistance to manage both social needs and the physical and cognitive disabilities often associated with aging. In addition, there are issues related to housing and placement for older individuals with SMI. It is estimated that over 9% of nursing home residents have SMI (Becker & Mehra, 2005). Much concern has been expressed regarding placement of older adults with schizophrenia in nursing homes, as this has been shown to lead to a decline in cognitive status and overall functioning, as well as an increase in mortality (Harvey, 2005). A number of psychologists are now developing and testing interventions programs tailored to the unique needs of these individuals (Bartels, Forester, Mueser, Miles, Dums, Pratt, et al., 2004; Granholm, McQuaid, McClure, Pedrelli & Jeste, 2002).

Young People in Transition to Adulthood

Compared to their peers without disabilities, youth with SED/SMI are 44% less likely to complete secondary school, have higher unemployment rates, and are less likely to live independently (Clark, Deschenes, Sieler, Green, White & Sondheimer, 2008). The Transition to Independence Process (TIP) model is a practice model that addresses the domains of employment/career, education, living situation, and community-life functioning (http://tip.fmhi.usf.edu). Evaluation of federally supported initiatives in five communities

showed that participants were more likely to pursue high school or post secondary education and to be employed. Their mental health conditions were less likely to interfere in their lives, and they had less interference from using alcohol or drugs.

Training Issues and the Impact on Implementation of Evidence Based Services

The provision of quality services requires the efforts of staff members who have been trained to understand which methods and procedures are most effective, and how to implement them. Some of the most effective interventions are extremely complex and require specialized intensive training. For example, the Program in Assertive Community Treatment (PACT), discussed above, has been demonstrated to reduce relapse in frequently hospitalized individuals and help them remain in the community. This program has become widely disseminated, but it is clear that many practical adaptations of the program fail to include elements that are essential to obtaining optimal results. The same is true of supported employment programs, even those where manual fidelity is associated with better outcomes (Becker, Smith, Tanzman, Drake & Tremblay, 2001). There are many psychosocial interventions with demonstrated efficacy and effectiveness and there are subgroups of people with SMI who can benefit greatly from the programs, but for effective implementation they require staff who are highly trained and who receive ongoing consultation to assure continued success. Appropriately trained psychologists are uniquely capable of providing this training and consultation.

Combined with the current national focus in the SMI field on the concept of recovery, the growing arsenal of evidence-based treatments is cause for optimism. As noted earlier, however, mental health programs do not routinely provide evidence-based treatments to the great majority of clients with SMI (Drake et al., 2001). This lack of satisfactory, or indeed any, treatment has devastating consequences for these clients, for their families, and for society.

The reasons for this lack of access are many and were detailed earlier in this document. One critical reason however, is the lack of adequately trained and supported mental health professionals, especially psychologists, to lead the transformation needed to ensure that every person receives the services needed. This proficiency is designed to assist in the effort to overcome this deficiency by enlarging the cadre of psychologists trained and available to carry out this work.

Criterion VII. Quality Improvement.

A proficiency promotes ongoing investigations and procedures to develop further the quality and utility of its knowledge, skills, and services.

1. Provide a description of the types of investigations that are designed to evaluate and increase the usefulness of the skills and services of this proficiency. Estimate the number of researchers conducting these types of studies, the scope of their efforts, and how your organization and/or other organizations associated with the proficiency will act to foster

these developments. It also is appropriate to provide evidence of current efforts in these areas.

Randomized clinical trials (RCT) are the gold standard for determining the effectiveness of interventions to assist those with SMI gain the skills they need to achieve their full potential. RCTs are costly and difficult to do, especially in community settings where most individuals with SMI now reside. When funding has been provided, psychologists have frequently led these studies (Cook, Leff, Blyler, et al., 2005; Mueser, Rosenberg, Xie, Jankowski, Bolton, Lu, et al., 2008; Miklowitz, George, Richards, Simoneau & Suddath, 2003). Another approach is the meta-analytic evaluation of previously conducted rigorous studies, and psychologists have been at the forefront of this research method (Kurtz & Mueser, 2008; Kurtz, Moberg, Gur & Gur, 2001; McGurk, Twamley, Sitzer, McHugo & Mueser, 2007; Twamley, Jeste & Lehman, 2003). Research reviews are also useful in this regard. Original research is used to determine efficacy of newly developed interventions and to assess the relative usefulness of interventions used alone or in combination. As noted in Criterion VI, psychologists have led the field in the majority of these efforts.

The number of psychologists doing research in the SMI area is not known. However, it is possible to estimate from reviews of journal authorship for reports in the SMI area that the number is great indeed. Psychologists are involved in virtually all aspects of research on SMI. They have the lead in research on treatment, especially in the area of psychosocial rehabilitation (Silverstein, 2000; Silverstein & Bellack, 2008), in empirically validated community-based interventions (Bellack, Mueser, Gingerich & Agresta, 2004; Cook, Leff, Blyler, et al., 2005; Glynn, Cohen, Dixon & Niv, 2006; Mueser & Glynn, 2000; Mueser, Bond & Drake, 2001; Mueser, Bond, Drake & Resnick, 1998; Spaulding, Reed, Sullivan, Richardson & Weiler, 1999), and in evidence-based practices in inpatient and residential facilities (Paul & Lentz, 1977) where nearly all effective methods have been developed by psychologists. They are also part of new medication development and evaluation efforts and have a vital role in the psychobiology of SMI working in conjunction with brain imaging methods. Psychologists have led the way in research on longitudinal studies of the course of SMI, have examined the early development of the disorders in infancy and childhood, and have used the methods of neuropsychology to map out the behaviors associated with areas of brain function. Psychologists have had a key role in efforts to improve classification in this area and have gone beyond diagnosis in developing cognitive assessment methods and cognitive rehabilitation strategies that are some of the most promising new treatment strategies. Research on the genetics of SMI has also benefitted from input of psychologists on defining the phenotype. And, importantly, psychologists have had a central role in almost all research in this area as research methodologists and statisticians.

Division 18 does not have funding to support research but many of its members are employed in settings where research is carried out and indeed many of the leading SMI researchers are Division 18 members.

In this regard, psychologists obtain funding from a wide array of sources including those that are the major sources of research funding in this area including the National Institute of Mental Health, National Alliance for the Mentally Ill (NAMI), Veterans Administration,

Health Care Financing Administration, Rehabilitation Services Administration, Social Security Administration, Agency for Health Care Policy and Research, and CMHS (SAMHSA). There are also several smaller foundations such as the Stanley Foundation, National Alliance for Research on Schizophrenia and Depression (NARSAD), Scottish Rite and the Hogg Foundation. In addition, some states support research in the area and a substantial amount of small project research is supported by universities and pharmaceutical companies.

2. Describe how the proficiency seeks ways to improve the quality and usefulness of its practitioners' services beyond its original determinations of effectiveness.

Continuing education programs, sponsored by APA and by other organizations, are a major source of new information for practitioners and researchers in this field. Professional journals, of which there are many, are also an important source of information. In addition, several newsletters provide information of interest. These provide news on recent research developments (e.g., new discoveries in the area of genetics), discussions between investigators on such topics as the possible heterogeneity of schizophrenia, and provide data sources of interest to epidemiologically-oriented psychologists. An increasingly important source of information is the World Wide Web with its vast amount of information and data, allowing most everyone to obtain up-to-date information easily and quickly.

3. Describe how the research and practice literature are regularly reviewed for developments that are relevant to the proficiency's skills and services, and how this information is publicly disseminated.

Developments in the field of SMI are frequently reviewed in journals such as Psychological Bulletin, Psychological Services, Psychiatric Rehabilitation Journal, Schizophrenia Bulletin, Clinical Psychology Review, Psychiatric Rehabilitation Skills and electronically in Medscape and many other websites. The Annual Review of Psychology includes reviews pertinent to this area nearly every year. In addition, the American Psychiatric Press produces a large number of books on severe mental illness and contemporary issues in the treatment of schizophrenia. Both APAs issue monthly digests (Clinician's Research Digest and Journal Watch Psychiatry) that monitor recent articles relevant to SMI. Convention presentations also provide a forum for review of new developments in the field. The major conventions are the American Psychological Association, National Alliance for the Mentally Ill (NAMI), United States Psychiatric Rehabilitation Association (USPRA), World Association for Psychosocial Rehabilitation (WAPR), Federation of Families for Children's Mental Health, and Institute on Psychiatric Services. Recent APA conventions have offered several CE sessions offering updates on evidence based treatments in SMI. Finally, there is an increasing number of large national conferences on SMI, and psychologists both attend and present regularly at these events.

Criterion VIII. Standards for Proficiency Service Delivery.

Proficiency practitioners conform their professional activities, not only to the profession's general practice standards and ethical principles but also to appropriate proficiency standards.

1. Describe how the proficiency's practitioners assume effective and ongoing communication to members of the discipline and the public as to the proficiency's practices, practice enhancements, and/or new applications.

There are several ways that this is accomplished, as follows:

A major form of communication is the professional journal.

In the area of SMI there are many journals that reflect a substantial interest in the topic. Some focus only on research reports and others include research and practice-oriented materials. The international literature is also extensive. Please see Appendix C for this list.

Newsletters are also used to promote communication.

Typical of these is the newsletter of Division 18, "Public Service Psychology". Other excellent sources of up to date newsletters are the National Alliance of the Mentally Ill (NAMI) at the national level and NAMI affiliates at the state level, and the World Association for Psychosocial Rehabilitation (WAPR). Increasingly the web is used for information, e.g., Medscape reviews and articles and the Substance Abuse and Mental Health Services Administration (SAMHSA) website has an extensive section on the use of several evidence based practices, and the website is accessed often as a resource for clinicians wishing to implement these services for persons with SMI.

Presentations are another means of conveying information and promoting communication and training.

Members and observers of the CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance, as well as those from Divisions 12 and 18 often present at the APA convention and at state psychological association meetings, as well as at conferences of other organizations. As mentioned above, psychologists also meet at other conferences solely devoted to SMI, such as those sponsored by NAMI, U.S. Psychiatric Rehabilitation Association (USPRA), World Association for Psychiatric Rehabilitation (WAPR), and SAMHSA's Center for Mental Health Services (CMHS). In addition, presentations and workshops on SMI are often offered as specialized tracks or programs within more general meetings and conventions (such as the Schizophrenia And Other Severe Mental Illnesses Special Interest Group within the Association for Cognitive and Behavioral Therapies). These offer the opportunity to communicate with members of the discipline and the public about the proficiency's practices, enhancements, and new applications.

Lastly, several listservs operate to foster communication among psychologists and between psychologists and members of the public.

Two worth mentioning are the CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance whose listserv connects members with consumers and other interested parties. The Community and State Hospital Section of Division 18 is primarily concerned with SMI, and also has a listserv that enables Section and Division members to communicate about the topic.

2) How does your proficiency encourage the development of standards of practice?

Members of the APA CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance, along with members of Division 18, have collaborated with many other organizations in developing standards of practice for people with SMI. Some examples of such collaborative efforts include:

- Substance Abuse and Mental Health Services Administration Toolkits for Implementing Evidence Based Practices;
- U.S. Department of Veterans Affairs Management of Psychosis Clinical Practice Guideline;
- U.S. Department of Veterans Affairs Uniform Package of Mental Health Services;
- U.S. Department of Veterans Affairs Management of Major Depressive Disorders Clinical Practice Guideline;
- HCFA National Standards for Use of Restraints;
- Certification Examination of Psychiatric Rehabilitation Practitioners (CPRP) of USPRA;
- American Psychiatric Association, Practice Guidelines on Schizophrenia;
- Implementation and monitoring of Assertive Community Treatment services for veterans provided nationwide by the U.S. Department of Veterans Affairs.

Psychological research, more than any other discipline, has contributed to the practices outlined in the many clinical practice guidelines already developed. This work will no doubt continue, and as the proficiency gains momentum and professional training programs adopt core courses, infuse this content into existing courses, and encourage greater research, the number of psychologists desiring certification in the proficiency is expected to grow. This should stimulate further empirical research on evidence-based practices for individuals with SMI and further contribute to the continuing refinement of standards of practice.

Criterion IX. Provider Identification and Evaluation.

A proficiency recognizes the public benefits of developing sound methods for permitting individual practitioners to secure an evaluation of their knowledge and skill and to be identified as meeting the qualifications for competent practice in the proficiency.

1. Describe how and by whom the proficiency identifies those who are qualified to practice in the proficiency.

Division 18 and the APA CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance are collaborating on the development of curriculum models and evaluation mechanisms for the proficiency. For those who meet the criteria, a Certificate of Proficiency in the Assessment and Treatment of Serious Mental Illness will be awarded.

2. Describe how and by whom the proficiency assesses the actual knowledge and skills of individuals who wish to be identified as practitioners in this proficiency.

Once the evaluation system is operational, the knowledge and skills of individuals who want to be identified as practitioners of the proficiency will be assessed by an examination administered by Division 18. The examination will include an evaluation of content knowledge as well as scenarios which require skill in translating knowledge into practice.

The competencies identified in Criterion III as the body of knowledge that constitutes this proficiency are those that are needed for proficient practice in the area. It is these competencies that will form the basis of the certification examination. The four major headings provided in Criterion III are: Ideology and Attitudes, Core Knowledge, Systems and Service-related Knowledge and Skills, Clinical Assessment and Intervention Skills. Please see Criterion III for a complete list of the competencies under each of these headings.

3. Describe how and by whom the proficiency educates the public and the profession concerning those who are identified as a practitioner of this proficiency.

Availability of the proficiency will be announced in the APA Monitor and in newsletters of appropriate APA divisions. In addition, State and Territorial Psychological Associations will receive notification of the proficiency and will be invited to announce the proficiency in their newsletters, and ultimately to provide a list of certified psychologists as a referral source for the public. We intend to follow-up on this with a series of mailings and direct contact by members of the CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance with state officials to show that it is to their advantage to use the proficiency as a way of identifying highly qualified psychologists for service in public mental health positions.

In addition, to ensure that the proficiency is known to as many educational venues as possible, the proficiency will be marketed to the Council of Graduate Departments of Psychology, the Council of University Directors of Clinical Psychology, the Council of Clinical Health Psychology Training Programs, the National Association of Schools of Professional

Psychology, APA accredited programs in professional psychology, and APA accredited internship and postdoctoral programs.

Division 18 will maintain the master list of those who are credentialed (certified) as practitioners of the proficiency and will make the information available to those who request it.

4. Estimate how many practitioners there are in this proficiency (e.g., spend 25% or more of their time in services characteristic of this proficiency) and provide whatever demographic information is available.

The most recent APA employment survey of 22,502 psychologists in full-time clinical practice showed that 30% of full-time employed psychologists who identified themselves as practicing clinicians and who responded to the survey were employed in organized health care centers such as general hospitals, VA medical centers, and community mental health centers/clinics. This represents an increase from approximately 21% in 1995 (Kohout, Li & Wicherski, 1996; 2007). It is these public hospitals and clinics where the majority of persons with SMI are seen for services and thus it can be assumed that a large percentage of these psychologists work extensively with individuals with SMI.

Data from the 2005 Doctorate Employment Survey indicate that almost 14% of all respondents were employed in hospitals, more often public than private. Given that respondents to this survey are *all* psychologists, not just clinical psychologists, this is a significant percentage of the total. It is important to note that it is generally in public hospitals that individuals with SMI receive treatment. An additional 7% of all psychologist responders to the survey reported working in managed care settings, most of which were community mental health centers (Wicherski and Kohout, 2007). If these percentages are added together, 21%, or more than one-fifth, of psychologists are employed in settings where they will provide services for people with SMI.

Taken together, these data indicate a need for the core body of knowledge, provided comprehensively in professional psychology training programs, that will constitute this proficiency. While there are a large number of psychologists working in the SMI field now, many, if not most, have not received adequate education and training in how to appropriately assess and treat individuals with SMI. For this reason, it is anticipated that a large number of psychologists currently working in the area will seek additional educational experiences and apply to become certified in the proficiency.

Criterion X. Continuing Professional Development and Education.

A proficiency provides its practitioners a broad range of regularly offered opportunities for continuing professional development in the proficiency practice and mechanisms to assess the acquisition of knowledge and skills.

1. Describe the opportunities for continuing professional development in the proficiency practice.

Many opportunities for continuing professional development are available. These include continuing education (CE) programs offered directly by APA as well as by APA-approved sponsors and state associations, and by programs sponsored by national organizations such as NAMI, and USPSRS, as well as by universities and provider organizations.

Other strategies are also available for enhancing professional development. These include:

- Attending relevant programs at the annual APA convention, some of which have been sponsored by the CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance and offered for CE credit;

- Participating in APA divisions that focus on SMI, such as Divisions 12 and 18;

- Becoming familiar with the extensive literature concerned with SMI, especially the evidence-based practices literature, and with local services and resources;

- Contacting advocacy organizations such as NAMI and USPRS and attending their state and national conventions, and subscribing to their newsletters;

- Participating in educational opportunities of related organizations and universities, such as USPRS and the Boston University Center for Psychiatric Rehabilitation, to name just two, which offer specialized training and certification programs in the area of psychosocial rehabilitation;

- Obtaining consultation or supervision from a psychologist who has expertise in the area of SMI. State associations can usually provide a referral to knowledgeable colleagues;

- Networking with professionals who have specialized knowledge concerned with SMI. Many opportunities are available at interdisciplinary conferences and through collaborative activities on local, state, and national levels. Additionally, the CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance has a listserv of psychologists who are proficient and work in this area and there is frequent communication about relevant topics by members of the listserv.

2. Describe the formal requirements, if any, for continuing professional development in the proficiency. What credits are required?

There are no formal requirements for continuing professional development in the proficiency at this time. As the evaluation and certification program of Division 18 mentioned above under Criterion IX is finalized, requirements for continuing professional development will be included.

3. Describe how the assessment of an individual's professional development is accomplished in the proficiency.

Presently, this occurs through evaluation of university coursework and experiential training in practica, internships and post doctoral fellows programs. As the proficiency matures, and certification with requirements for continuing professional development comes on line, professional development will be assessed through the evaluation and certification processes of Division 18.

Appendix A

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Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive behavior therapy for schizophrenia: effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin*, 34, 3, 523-537.

Appendix B

APA Resolution on Stigma and Discrimination in SMI

American Psychological Association, February, 1999

Resolution on Stigma and Discrimination Against People with Serious Mental Illness and Severe Emotional Disturbance

WHEREAS "Serious mental illness" (SMI) has been defined by the Center for Mental Health Services (CMHS) in accordance with PL 102 321 (1992) to help identify those people who may receive mental health services from states under federal block grants; and that they are people who "have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified by DSM IV, and that has resulted in functional impairments which substantially interfere with or limit one or more major life activities"; and whereas "severe emotional disturbance" refers to those mental illnesses with similar impact on children and adolescents;

WHEREAS the CMHS definition includes any mental disorders in DSM III or IV with exception of the "T codes, substance use disorders and developmental disorders, unless they co occur with another diagnosable SMI; and that all SMIs have episodic, recurrent or persistent features but vary in terms of severity and disabling effects; and that functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one ore more major life activities including basic daily living skills (e.g., eating, bathing, dressing), instrumental living skills (e.g., managing money, maintaining a household, taking prescribed medication, or functioning in social, family, and vocational/educational contexts) and that adults who would have met the functional impairment criteria during the year without the benefit of treatment or other support services are considered to have a serious mental illness;

WHEREAS the Center for Mental Health Services reports that 5.4 million or 2.7 percent of the adult population have a "severe and persistent" mental illness, such as schizophrenia, bipolar disorder or major depression; and that more than 3 million children and adolescents have a severe emotional disturbance that undermines their present functioning and imperils their future (National Advisory Mental Health Council, 1990)

WHEREAS recovery from serious mental illness, once thought impossible, is being documented in research and demonstrated by the productive lives of an increasing number of recovered and recovering people who are open about their experience (Jamison, 1995; DeSisto, Harding, McCormack, Ashikaga, & Brooks, 1995); and there are many diverse paths through recovery (Bassman, 1997; Frese & Davis, 1997; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987); and no one should be excluded from the possibility of a positive outcome or from services or education which would maximize recovery;

WHEREAS stigma and discrimination are most damaging to recovery and can unjustifiably foreclose opportunities for employment, housing, education, and other services;

WHEREAS the tendency of the lay public as well as some mental health professionals to define individuals as an illness or diagnosis and to use pejorative and dehumanizing terms contribute to the loss of hope, dignity, and self respect;

WHEREAS to be effective facilitators of recovery, it is essential for psychologists to understand how stereotypic and stigmatizing language, attitudes, and behaviors can demean and devalue people with mental illness and have an adverse impart on multiple aspects of functioning, such as self concept, relationships, self esteem, self efficacy, and performance;

WHEREAS the Americans with Disabilities Act (ADA) protects people with mental disabilities and covers psychological training and employment; whereas in selecting applicants to psychology training programs and in hiring psychologists with a mental disability, the issue should be whether individuals can perform the work with reasonable accommodation; and whereas psychology training programs should be careful not to discriminate solely based on the fact or suspicion that students carry a diagnosis of mental illness, but rather to consider their potential to become proficient professionals and their possible future contributions to the field, taking note of the special insight, understanding, and practical experience they bring to their work;

THEREFORE BE IT RESOLVED

1) That APA support efforts to eliminate stigma and discrimination against people with serious mental illness and children and adolescents with severe emotional disturbance, and to counter the negative attitudes and expectations that are often internalized by clients;

2) That APA, as stipulated in its Publication Manual, encourage psychologists to maintain the integrity of individuals as human beings by avoiding language that equates persons with their conditions (e.g., "the schizophrenics") and by using person first language in their publications (e.g., "people with schizophrenia");

3) That APA, in accordance with the spirit and requirements of the ADA, encourage state psychology boards to examine their state licensing requirements for the mental health disciplines to ensure that candidates for licensure are not disqualified solely on the basis of a diagnosis of mental illness;

4) That APA draft appropriate recommendations to assist psychology programs in screening, training, providing reasonable accommodation as needed, and when necessary, dismissing undergraduate and graduate students with mental disabilities in accord with the spirit and requirements of the ADA.

Appendix C

Listing of Journals for SMI Literature

Journals that are primarily psychological:

Affective Disorders
American Journal of Community Psychology
American Journal of Psychiatric Rehabilitation
Behavior Modification
Behavior Therapy
Behavior Research and Therapy
Clinical Psychology Review
Cognitive Therapy and Research
Community Mental Health Journal
Current Directions in Psychological Science
Journal of Abnormal Psychology
Journal of Anxiety Disorders
Journal of Behavior Therapy and Experimental Psychiatry
Journal of Clinical Psychology
Journal of Consulting and Clinical Psychology
Journal of Psychopathology and Behavioral Assessment
Psychiatric Rehabilitation Journal
Psychological Services
Rehabilitation Psychology
Schizophrenia Bulletin
Schizophrenia Research

Other, largely psychiatric journals that report scientific findings related to the area:

Acta Psychiatric Scandinavica
American Journal of Psychiatry
Archives of General Psychiatry
Australian/New Zealand Journal of Psychiatry
British Journal of Psychiatry
Canadian Journal of Psychiatry
Journal of Clinical Psychiatry
Journal of Nervous and Mental Disease
Psychological Medicine
Psychiatric Services
Social Psychiatry and Psychiatric Epidemiology

Appendix D

List of Evidence Based Treatment Guidelines

General

Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology*, 66, 53-88.

DeRubeis, R. J., & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting and Clinical Psychology*, 66, 37-52.

Drake, R. E., Goldman, H.H., Lehman, A. F., Dixon, L., Mueser, K. T., & Torrey, W. C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, 52, 179-182.

Kendall, P. C. (1998). Empirically supported psychological therapies. *Journal of Consulting and Clinical Psychology*, 66, 3-6.

Mueser, K. T., Bond, G. R., & Drake, R. E. (2001). Community-based treatment of schizophrenia and other severe mental disorders: treatment outcomes? *Medscape Mental Health*, 6 (1/13/2001).

Disorder Specific

Schizophrenia

American Psychiatric Association (1997). Practice guidelines for the treatment of patients with schizophrenia. *American Journal of Psychiatry*, 154 (Suppl. April), 1-63.

Lehman, A. F., Lieberman J.A., Dixon, L. B., McGlashan, T. H., Miller, A. I., Perkins, D. O., et al. (2004). *Practice Guideline for the Treatment of Patients with Schizophrenia*, 2nd edition. Retrieved February 5, 2006, from www.psych.org/psyc_pract/treat//pg/SchizPG-Complete-Feb04.pdf

U.S. Department of Veterans Affairs. (2004). *Management of Psychoses*. Washington, DC: Veterans Health Administration.

Affective Disorders

American Psychiatric Association. (2000). Practice guideline for the treatment of patients with major depressive disorder (revision). *American Journal of Psychiatry*, 157, (4 Suppl), 1-45.

Dennehy, E. B. (2000). Guidelines for treatment of bipolar disorder. *Current Psychiatry Reports*, 2, 316-321.

DeRubeis, R. J., & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting and Clinical Psychology*, 66, 17-52.

Frances, A. J., Kahn, D. A., Carpenter, D., Docherty, J. P., & Donovan, S. L. (1998). The expert consensus guidelines for treating depression in bipolar disorder. *Journal of Clinical Psychiatry*, 59, (Suppl. 4), 73-79.

Fristad, M.A., Goldberg Arnold, J.S., & Gavazzi, S. M. (2002). Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder. *Bipolar Disorders*, 4, 254-262.

Hirschfeld, R. M. A., Bowden, C. L., Gitlin, M. J., Keck, P. E., Perlis, R. H., Suppes, T., et al. (2002). *Practice Guidelines for the Treatment of Patients with Bipolar Disorder*, 2nd edition. Retrieved February 5, 2006, from http://www.psych.org/psych_pract/treatg/pg/bipolar_revisebook_index.cfm

Sikich, L. (2005). Psychotherapy and school interventions. In R. L. Findling & S. C. Schultz (Eds.) *Juvenile-onset Schizophrenia* (pp. 257-287). Baltimore, MD: Johns Hopkins University Press.

U.S. Department of Veterans Affairs. (2000). *Management of Major Depressive Disorders*. Washington, DC: Veterans Health Administration.

U.S. Department of Veterans Affairs. (2008). *Uniform Package of Mental Health Services*. Washington, DC: Veterans Health Administration Office of Mental Health Services.

Appendix E

List of Evidence Based Practice Literature by Topic

A very useful compendium of evidence based and best practices, largely developed by psychologists is available on the APA web site at http://www.apa.org/practice/smi_grid-v2.pdf

Assessment Methods

Bedell. J. R. (Ed.) (1995). *Psychological Assessment and Treatment of Persons with Severe Mental Disorders*. Baltimore: Taylor & Francis.

Ciarlo, J. A., Brown, T. R., Edwards, D. W., Kiresuk, T. J., & Newman, F. L. (1986). *Assessing Mental Health Treatment Outcome Measurement Techniques*. Series FN No. 9. DHHS Pub. No. (ADM)86-1301. Washington, DC: U.S. Government Printing Office.

Erickson, R.(1994). Neuropsychological assessment and consultation in psychiatric rehabilitation. In W. Spaulding (Eds.), *Cognitive Technology in Psychiatric Rehabilitation* (pp. 27-48). Lincoln, NE: University of Nebraska Press.

Frisch, M. B., Cornell, J., Villanueva, M., & Retzlaff, P. J. (1992). Clinical validation of the Quality of Life Inventory: A measure of life satisfaction for use in treatment planning and outcome assessment. *Psychological Assessment*, 4, 92-101.

Green, M. F., & Nuechterlein, K. H. (2004). The MATRICS initiative: Developing a consensus cognitive battery for cognitive trials. *Schizophrenia Research*, 72, 1-3.

Kay, S. R., Fiszbein, A., & Opler, L. A. (1987). The Positive and Negative Symptom Scale for Schizophrenia (PANSS). *Schizophrenia Bulletin*, 13, 261-276.

Lukoff, D., et al.(1986). Appendix A. Manual for Expanded Brief Rating Scale (BPRS). Schizophrenia Bulletin, 12, 594-602.

O'Neill, R.E., Horner, R.H., Albin, R.W., Sprague, J.R., Storey, K., & Newton, J.S. (1997). *Functional Assessment and Program Development for Problem Behavior: A Practical Handbook* (2nd Ed.). New York: Brooks/Cole.

Paul, G. L. (Ed.). (1986). *Assessment in Residential Treatment Settings: Principles and Methods to Support Cost-effective Quality Operations*. Champaign, IL: Research Press.

Wallace, C. J. (1986). Functional assessment in rehabilitation. *Schizophrenia Bulletin*, 12, 604-624.

Pharmacology

Schizophrenia

Buckley, P. F. (2008). Update on the treatment and management of schizophrenia and bipolar disorder. *CNS Spectrums*, 13, 2 (Suppl 1), 1-10; quiz 11-12.

Buckley, P. F., & Correll, C. U. (2008). Strategies for dosing and switching antipsychotics for optimal clinical management. *Journal of Clinical Psychiatry*, 69 Suppl 1, 4-17.

Weiden, P. J., Scheifler, P. L., Diamond, R. J., & Ross, R. (1999). *Breakthroughs in Antipsychotic Medications: A Guide for Consumers, Families, and Clinicians*. New York: Norton.

Wirshing, D. A., Wirshing, W. C., Marder, S. R., Saunders, S., Rossotto, E. H., & Erhart, S. M. (1997). Atypical antipsychotics: a practical review. *Medscape Mental Health*, 2, 10, 1-23.

Bipolar Disorder

Buckley, P. F. (2008). Update on the treatment and management of schizophrenia and bipolar disorder. *CNS Spectrums*, 13, 2 (Suppl 1), 1-10.

Sachs, G. S., & Thase, M. E. (2000). Bipolar disorder therapeutics: maintenance treatment. *Biological Psychiatry*, 48, 573-581.

Scherk, H., Pajonk, F. G., & Leucht, S. (2007). Second-generation antipsychotic agents in the treatment of acute mania: a systematic review and meta-analysis of randomized controlled trials. *Archives of General Psychiatry*, 64, 4, 442-455.

Depression

Kirsch, I., & Saperstein, G. (1998). Listening to Prozac but hearing placebo: a meta-analysis of antidepressant medication. *Prevention and Treatment*, 1, 1-17.

Moncrieff, J., Wessely, S., & Hardy, R. (1998). Meta-analysis of trials comparing antidepressants with active placebos. *British Journal of Psychiatry*, 172, 227-231; discussion 232-224.

Moncrieff, J., Wessely, S., & Hardy, R. (2001). Antidepressants using active placebos. *Cochrane Database Systematic Review* (2), CD003012.

Psychologists and medications

Corrigan, P. W. (2002). Adherence to anti-psychotic medications and health behavior theories. *Journal of Mental Health*, 11, 243-254.

Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services*, 57, 11, 1636-1639.

Kane, J. M. (2006). Review of treatments that can ameliorate nonadherence in patients with schizophrenia. *Journal of Clinical Psychiatry*, 67 Suppl 5, 9-14.

Pampallona, S., Bollini, P., Tibaldi, G., Kupelnick, B., & Munizza, C. (2004). Combined pharmacotherapy and psychological treatment for depression: a systematic review. Arch Gen Psychiatry, 61(7), 714-719.

Pettit, J. W., Voelz, Z. R., & Joiner, T. E., (2001). Combined treatments for depression. In M. Sammons & Schmidt (Eds.) *Psychology and Psychopharmacology* (pp. 131-160). Washington, DC: American Psychological Association Press.

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Psychosocial Treatment and Rehabilitation Methods

Program in Assertive Community Treatment (PACT)

Burns, T., Catty, J., Dash, M., Roberts, C., Lockwood, A., & Marshall, M. (2007). Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *British Medical Journal*, 335(7615), 336.

Mueser, K. T., Bond, G. R., Drake, R. E., & Resnick, S. G. (1998). Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin*, 24, 37-74.

Case Management

Manion, E., & Granger, B. (2007). *Helping Behavioral Health Clients With Parenting & Child Custody Issues. Guidebook and Training Materials for Half-Day Training For Case Managers and Other Service Providers.* Developed by the UPenn Collaborative on Community Integration of Individuals with Psychiatric Disabilities, www.upennrrtc.org

Mueser, K., Bond, G., Drake, R., & Resnick, S. (1998). Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin*, 24, 37-73.

Family Psychoeducation

Dixon, L., McFarlane, W., Lefley, H., Lucksted, A., Cohen, C., Falloon, I., et al. (2001). Evidence-based practices for services to family members of people with psychiatric disabilities. *Psychiatric Services*, 52, 903-910.

Glynn, S. M., Cohen, A. N., Dixon, L. B., & Niv, N. (2006). The potential impact of the recovery movement on family interventions for schizophrenia: opportunities and obstacles. *Schizophrenia Bulletin*, 32(3), 451-463.

Miklowitz, D. J., George, E. L., Richards, J. A., Simoneau, T. L., & Suddath, R. L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry*, 60, 904-912.

Miklowitz, D. J., & Goldstein, M. J. (1997). *Bipolar Disorder: A Family-Focused Treatment Approach*. New York: Guilford.

Miklowitz, D. J., Simoneau, T. L., George, E. L., Richards, J. A., Kalbag, A., Sachs-Ericsson, N., et al. (2000). Family-focused treatment of bipolar disorder: One-year effects of a psychoeducational program in conjunction with pharmacotherapy. *Biological Psychiatry*, 48, 582-592.

Mueser, K. T., & Glynn, S. M. (2000). *Behavioral Family Therapy for Psychiatric Disorders* (2nd ed.). Oakland, CA: New Harbinger.

Family Education

Dixon, L., Lucksted, A., Stewart, B., Burland, J., Brown, C. H., Postrado, L., et al. (2004). Outcomes of the peer-taught 12-week family-to-family education program for severe mental illness. *Acta Psychiatrica Scandinavica*, 109(3), 207-215.

Dixon, L., Stewart, B., Burland, J., Delahanty, J., Lucksted, A., & Hoffman, M. (2001). Pilot study of the effectiveness of the family-to-family education program. *Psychiatric Services*, 52, 7, 965-967.

Fristad, M.A., Goldberg Arnold, J.S., & Gavazzi, S. M. (2002). Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder. *Bipolar Disorders*, 4, 254-262.

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Sikich, L. (2005). Psychotherapy and school interventions. In R. L. Findling & S. C. Schultz (Eds.), *Juvenile-onset Schizophrenia* (pp. 257-287). Baltimore, MD: Johns Hopkins University Press.

Psychotherapy Especially Cognitive Behavior Therapy

Schizophrenia

Bach, P., & Hayes, S. C. (2002). The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 70, 1129-1139.

Chadwick, P., & Trower, P. (1996). Cognitive Therapy for Hallucinations, *Delusions and Paranoia*. Chichester: Wiley.

Dickerson, F. B. (2000). Cognitive behavioral psychotherapy for schizophrenia: a review of recent empirical studies. *Schizophrenia Research*, 43, 71-90.

Dickerson, F. B., & Lehman, A. F. (2006). Evidence-based psychotherapy for schizophrenia. *Journal of Nervous and Mental Disease*, 194, 1, 3-9.

Garety, P. A., Fowler, D., & Kuipers, E. (2000). Cognitive-behavior therapy for medication-resistant symptoms. *Schizophrenia Bulletin*, 26, 73-86.

Kingdon, D.G., & Turkington, D. (1994). *Cognitive-Behavioral Therapy of Schizophrenia*. New York: The Guilford Press. p. 212.

Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive behavior therapy for schizophrenia: effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin*, 34, 3, 523-537.

Depression

Beck, A. T., Rush, J., Shaw, B. F. & Emery, G. (1987). *Cognitive Therapy of Depression*. New York: Guilford.

Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D., & Geller, P. A. (2007). A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. *Behavior Modification*, 31, 6, 772-799.

Pampallona, S., Bollini, P., Tibaldi, G., Kupelnick, B., & Munizza, C. (2004). Combined pharmacotherapy and psychological treatment for depression: a systematic review. *Archives of General Psychiatry*, 61, 7, 714-719.

Bipolar Disorder

Frank, E., Swartz, H. A., & Kupfer, D. J. (2000). Interpersonal and social rhythm therapy: Managing the chaos of bipolar disorder. *Biological Psychiatry*, 48, 593-604.

Lam, D. H., Jones, S. H., Hayward, P., & Bright, J. A. (1999). *Cognitive Therapy for Bipolar Disorder: A Therapist's Guide to Concepts, Methods and Practice*. New York: John Wiley & Sons.

Scott, J. (2001). Cognitive therapy as an adjunct to medication in bipolar disorder. *British Journal of Psychiatry*, 178 (Suppl.41), 164-168.

Interpersonal Psychotherapy

Weissman, M. M., Markowitz, J. C. (1994). Interpersonal psychotherapy: Current status. *Archives of General Psychiatry*, 51, 599-606.

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