Session #B3

Psychology, Medical Family Therapy, Social Work, Psychiatric Nursing, Counseling, and Others:

Effective Collaborators, or Sibling Disciplines at-War?

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CFHA 20th Annual Conference
October 18-20, 2018 • Rochester, New York

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosures

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Overall Learning Objective

At the conclusion of this session, the participant will be able to:

- Articulate ways that we all – across a myriad of guild-memberships, license-types, and field/practice orientations – can do better work when we work together

Specific Learning Objectives

At the conclusion of this session, the participant will be able to:

- Articulate key findings from empirical comparisons of behavioral health sibling disciplines in terms of care outcomes, drop-out rates, and cost effectiveness
- Describe key findings from empirical research regarding common therapeutic factors that overlap sibling disciplines in behavioral health
- Identify ways to include, coordinate, and integrate sibling disciplines in collaborative care teams

Bibliography / References

Crane, D., & Christenson, J. (2014). A summary report of cost-effectiveness: Recognizing the value of family therapy in health care. In J. Hodgson, A. Lamson, T. Mendenhall, and D. Crane (Eds.), *Medical family therapy: Advanced applications*. New York, NY: Springer.

Hamilton, S., Moore, A., Crane, D., Payne, S. (2011). Psychotherapy dropouts: Differences by modality, license, and DSM-IV diagnosis. *Journal of Marital and Family Therapy*, *37*, 333-343. doi: 10.1111/j.1752-0606.2010.00204.x

Mendenhall, T., Lamson, A., Hodgson, J., & Baird, M. (Eds.) (2018). *Clinical methods in medical family therapy*. New York, NY: Springer.

Bibliography / References (continued)

Moore, A., Hamilton, S., Crane, D. & Fawcett, D. (2011). The influence of professional license type of the outcome of family therapy. *American Journal of Family Therapy*, *39*, 149-161. doi: 10.1080/01926187.2010.530186

Swift, J., Tompkins, K., & Parkin, S. (2017). Understanding the client's perspective of helpful and hindering events in psychotherapy sessions: A micro-process approach. *Journal of Clinical Psychology*, *73*, 1543-1555. doi: 10.1002/jclp.22531

Learning Assessment

A learning assessment is required for CE credit

A question and answer period will be conducted at the end of this presentation

Contemporary Fields & Specializations in Behavioral Health

Distinctions that were once limited and relatively clear (e.g., Psychiatry, Psychology, Social Work) are now extensive and oftentimes complex / ambiguous

Students aspiring to work in Behavioral Health, alongside patients / families seeking services, have a lot of choices

- This can be a good thing (e.g., matching need/want to specialized focus)
- But it can also be confusing and frustrating (e.g., navigating payers and politics)

Biomedical providers can also find these distinctions confusing

Fields & Specializations (continued)

Current-day “sibling disciplines” in Behavioral Health vary by credentialing

- Certificate (additional credentialing over-and-above a baseline degree)
- Master’s-degree (e.g., MA, MS, MSW)
- Doctoral-degree (e.g., Ph.D., PsyD, EdD, MD)
- Licensure (e.g., LP, LICSW, LP, LMFT)

Fields & Specializations (continued)

Current-day “sibling disciplines” in Behavioral Health vary by disciplinary “home” (guild) and identity

- Psychiatry
- Psychology
- Counseling
- Marriage and Family Therapy
- Medical Family Therapy
- Social Work
- Others…

Fields & Specializations (continued)

Regulation (licensure)
Ethical Codes
Diversification of Technology/Approach
Specialized Skill Sets

Inflexible Professional Identity
Guild-Preservation Over Collaboration
Culture of Self-Protection

Collaborators or Competitors?

Sibling discipline tensions are not unique to Behavioral Health

Questions re: Collaboration vs. Competition exist throughout healthcare

- *Family Medicine versus….*
- *Pediatrics versus…*
- *Nursing versus…*
- *Hospitalists versus…*
- *Internal Medicine versus…*
- *Endocrinology versus…*
- *Dieticians versus…*
- *Others…*

The Pie Analogy

The pie is a fixed size

Everyone needs to protect the size of their slice

Your guild can get more of the pie by stealing some of others' slices

The Pie Analogy

Actually, the pie has grown

There is plenty to go around

Contemporary Demands for Behavioral Health in Integrated Care

Current-day demands for integrated care are outweighing current-day supply(ies) of available and competent Behavioral Health clinicians

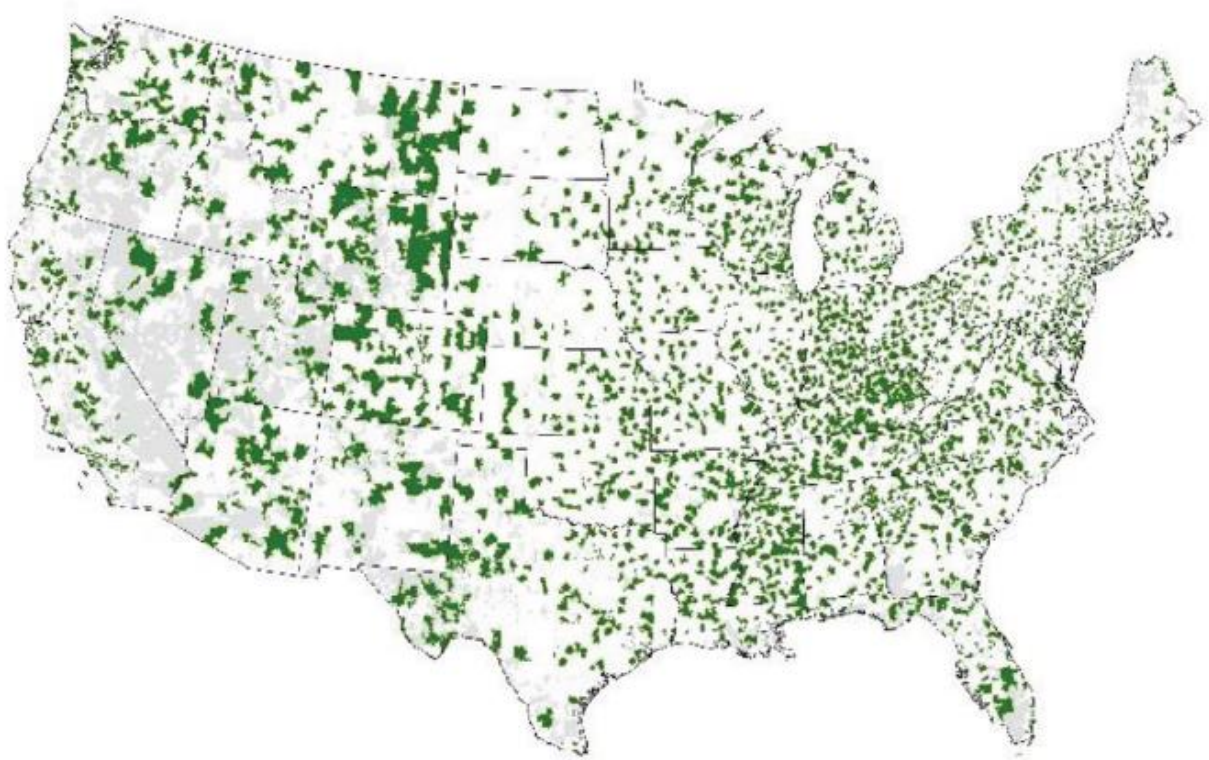
Biomedical providers do not tend to understand (or care about) guild-driven tensions and/or turf battles between Behavioral Health “siblings” – i.e., they just want BH in their teams

National Supply and Demand
All Behavioral Health Practitioner Categories, 2013 and 2025

	2013 Estimates Scenario Two (Alternative)			2025 Projections Scenario Two (Alternative)		
Practitioner	**Supply**	**Demand**	**Difference**	**Supply**	**Demand**	**Difference**
Psychiatrists	45,580	56,980	-11,400	45,210	60,610	-15,400
Behavioral Health NP	7,670	9,590	-1,920	12,960	10,160	2,800
Behavioral Health PA	1,280	1,600	-320	1,800	1,690	110
Clinical, Counseling, and School Psychologists	186,710	233,390	-46,680	188,930	246,420	-57,490
Substance Abuse and Behavioral Disorder Counselors	85,120	106,380	-21,260	105,970	122,510	-16,540
Mental Health and Substance Abuse Social Workers	110,880	138,630	-27,750	109,220	157,760	-48,540
Mental Health Counselors	120,010	150,000	-29,990	145,700	172,630	-26,930
School Counselors	246,480	308,130	-61,650	243,450	321,500	-78,050
Marriage and Family Therapists	30,560	38,250	-7,690	29,780	40,250	-10,470

Health Resources and Services Administration/National Center for Health Workforce Analysis; Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation. (2015). *National projections of supply and demand for behavioral health practitioners*: 2013-2025. Rockville, Maryland

Socioeconomic Discrepancies



42%

high income communities have services

vs

23%

low income communities have services

Cummings, J.R., Allen, L., Clennon, J. et al. (2017). Geographic access to specialty mental health care across high and low income US communities. *JAMA Psychiatry, 74*, 476-484.

Resources

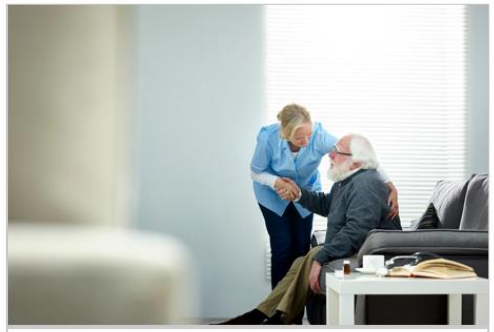
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER

ABOUT US | PROJECTS | PUBLICATIONS | DATA | CONTACT US

Research to produce a workforce to meet the nation's behavioral health needs

Minimum Data Set (MDS) Research

Characteristics and Practice Settings Studies



Scopes of Practice (SOPs)

Collaborators or Competitors?

Sibling disciplines in Behavioral Health overlap a great deal in what they are able to contribute to team-based care

- Acute and long-term therapy / care services
- Psychoeducation
- Team coordination

They also bring unique and/or specialized skillsets to the table.

- Diagnostics (by presenting problem, age-group, etc.)
- Individual/Couple/Family/Group care formats
- Primary/Secondary/Tertiary/Other care formats

Collaborators or Competitors? (continued)

Sibling disciplines differ considerably in foci outside of on-the-ground care arenas, including:

- Guild-power (e.g., APA vs. AAMFT)
- Competitive lobbying efforts for third-party payer coverage
- Visibility (and preference) in hiring practices
- Institutional perceptions regarding practice rigor, care outcomes, and cost-effectiveness

Consequently, many like-minded colleagues who could otherwise work well together find themselves at-odds with – or even in direct conflict with – each other

Sibling Discipline Comparisons

Most literature comparing sibling disciplines focuses on side-by-side disclosures regarding training, credentials, and finances

- Years of education (2, 3, 4, 5, 8+, etc.)
- Degree type (MA, MS, Ph.D., PsyD, MD, etc.)
- Clinical hours / supervision for licensure (internship, residency)
- Costs for services (e.g., MA/MS = cheapest; MD = most expensive)
- Expected / Average salaries (e.g., MSW = lowest; MD = highest)

Comparisons (continued)

Most literature comparing sibling disciplines against each other is archival (not experimental or quasi-experimental)

- Cost effectiveness
- Treatment duration / frequency
- Drop-out rates

Comparisons (continued)

Most literature comparing different therapy modalities against each other (i.e., manualized, experimental or quasi-experimental) stays within one care discipline

- CBT vs. BT vs. control(s)
- NET vs. TIFT vs. control(s)
- Integrative FT vs. mono-modal FT

Comparisons (continued)

Most literature regarding therapy processes / outcomes shows that

- Something is better than nothing
- Degree type (e.g., MA vs. MS vs. Ph.D.) makes no difference
- Common therapeutic factors are more influential than therapy type, provider degree / credential, and/or disciplinary identity / type

Where does Therapeutic Change come from?

Common factors / tx relationships (30%)

Expectancy (15%)

Extra-therapeutic factors / events (40%)

Counseling techniques (15%)

Common Factors

Therapeutic Relationship
- empathy, encouragement
- patient/client thinks/knows that the clinician cares

Shared World View
- by race/ethnicity, SES, life-experiences, etc.

Patient/Client Expectations
- client sees clinician as expert
- placebo (and nocebo) effects

Rituals and Interventions
- directive, non-directive

Core Competencies for Integrated Care (SAMHSA-HRSA)

1. Interpersonal Communication
2. Collaboration & Teamwork
3. Screening & Assessment
4. Care Planning & Care Coordination
5. Intervention
6. Cultural Competence & Adaptation
7. Systems Oriented Practice
8. Practice Based Learning & Quality Improvement
9. Informatics

SAMHSA-HRSA Center for Integrated Health Solutions (2014). *Core competencies for integrated care*. Retried from https://www.integration.samhsa.gov/workforce/core-competencies-for-integrated-care

Where is the Conflict?

Educational Worlds

- Disciplinary disciple-ship and socialization-processes in graduate school

Clinical Worlds

- Siblings generally work well together (when they have the opportunities to do so)

Operational Worlds

- Hiring practices favor Psychology and Social Work

Financial Worlds

- Policy / Guild-battles for payment-preference range from tense (at best) to viscous (at worst)

Examples of Sibling Discipline Collaboration

Primary Care

School Mental Health

Military Installation

Activity…

On the post-it note(s) provided to you, write down something that you have seen or heard that you believe keeps Behavioral Health guilds from working together (i.e., collaborating).

Activity… (continued)

What are some of the common themes (generally)?

What are some of the common themes related to policy? education / training? payment? hiring practices? other?

Call-to-Action

What can we do to better-advance collaboration between our Behavioral Health siblings? *What is next*?

Call-to-Action (continued)

Recognize that we need each other

- Nationwide shortage of Behavioral Health services and access
- Our shared (overlapping) and respective/distinct strengths contribute to a whole more than the sum of its parts
- Create space / opportunities to train and work together
- Curriculum that extends beyond disciplinary home-base / departments
- Interdisciplinary training sites
- Interdisciplinary supervision and practicum sequences
- Interdisciplinary presentation / writing / advocacy sequences

Discussion / Q & A

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Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session

Thank you!

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