PROFESSIONAL SOLDIERS
A VOLUNTEER ARMY
OR A DRAFT:
WHO CAN AND SHOULD PROVIDE BSM
SERVICES AND CBT-I?

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THE CONTENTS OF THIS TALK SIMPLY REPRESENT ONE POINT OF VIEW
THE OLD PROBLEM

IS CBT-I REALLY EFFICACIOUS AND EFFECTIVE?

IS CBT-I REALLY COMPARABLE TO MEDICAL THERAPY?
THE OLD PROBLEM

ANSWER:

YES.

YES.

YES.
THE NEW PROBLEM

HOW DO WE GET CBT-I TO BE READILY AVAILABLE?

ANSWER: MORE QUESTIONS.

- WHAT IS THE TIME FRAME FOR “UNIVERSAL” ACCESS?
- WHERE SHOULD SERVICES BE PROVIDED?
- WHO SHOULD PROVIDE BSM AND CBT-I SERVICES?
- HOW SHOULD PROVIDERS BE CREDENTIALED?
- HOW CAN WE PROVIDE FOR QA FOR NON CBSM THERAPISTS?
- **HOW DO WE RECRUIT/TRAIN NEW THERAPISTS?**
GOOD NEWS

ALL THESE QUESTIONS HAVE ANSWERS !
WHAT IS THE TIME FRAME FOR “UNIVERSAL” ACCESS?

A: BEST GUESS NEXT 5 YEARS
WHERE SHOULD SERVICES BE PROVIDED?

A: IDEALLY AT SDCS OR IN AFFILIATED CLINICS
WHO SHOULD PROVIDE BSM & CBT-I SERVICES?
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A: HOW ABOUT LICENSED MENTAL HEALTH PROVIDERS
HOW SHOULD PROVIDERS BE CREDENTIALED?

A1: IDEALLY, PHDS (MDS?) SHOULD BE “BOARD” CERTIFIED VIA THE CBSM

A2: NOTE: THERE IS ALSO DISCUSSION ABOUT SEEKING CERTIFICATION VIA ABPP
HOW CAN WE PROVIDE FOR QA FOR NON-CBSM AND/OR MA LEVEL THERAPISTS

A1: REQUIRE / RECOMMEND THE ESTABLISHMENT OF COLLABORATIVE ARRANGEMENTS WITH CBSM “DIPLOMATES”

A2: FORMALLY / INFORMALLY ESTABLISH A NETWORK OF PEER SUPERVISORS
HOW DO WE RECRUIT/TRAIN NEW THERAPISTS?

HOW DO WE FIELD AN ARMY OF CLINICIANS IN 5 YEARS?
THIS IS THE HARD QUESTION!
HERE’S WHAT APPEARS TO BE THE OPTIONS

GRADUATE PROGRAMS
PSYCHOLOGY INTERNSHIPS
ACCREDITED/INFORMAL BSM FELLOWSHIPS
ACCREDITED/INFORMAL MINI FELLOWSHIPS
CONTINUING EDUCATION PROGRAMS
TREATMENT MANUALS
BSM SERIES WEBINARS FOR CBT-I
GRADUATE PROGRAMS

THERE ARE 6-10 PROGRAMS

STRENGTHS: THESE INDIVIDUALS, UPON COMPLETION OF TRAINING, TEND TO BE “DYED IN THE WOOL” EXPERTS

WEAKNESSES: TOO FEW PROGRAMS
THE PROGRAMS ARE SMALL (1-5 TRAINEES PER PROGRAM)
PROGRAMS TEND TO PRODUCE RESEARCHERS (VS. CLINICIANS)
PSYCHOLOGY INTERNSHIPS

THERE ARE 6-10 PROGRAMS

STRENGTH: MOST PROGRAMS ALLOW FOR AN INTENSIVE TRAINING EXPERIENCE FOR 3-6 MONTHS

WEAKNESS: TOO FEW PROGRAMS
PROGRAMS ARE SMALL (1-3 TRAINEES / YEAR)
BSM FELLOWSHIPS

THERE ARE 9 PROGRAMS

**STRENGTHS:** ALLOWS FOR AN INTENSIVE TRAINING EXPERIENCE FOR 1-2 YEARS

**WEAKNESS:** TOO FEW PROGRAMS
PROGRAMS ARE SMALL (USUALLY 1 TRAINEE / YEAR)
PROGRAMS REQUIRE DEDICATED FINANCIAL RESOURCES
BSM MINI-FELLOWSHIPS

THE NUMBER OF INFORMAL AND FORMAL PROGRAMS IS UNKNOWN
BEST GUESS: 6-10

STRENGTHS: ALLOWS FOR AN INTENSIVE TRAINING EXPERIENCE
OVER A SHORT TIME INTERVAL (1-2 WEEKS)
PROGRAMS HAVE MANAGEABLE COSTS

WEAKNESSES: TOO FEW PROGRAMS
PROGRAMS ARE SMALL (1-5 TRAINEES / YEAR)
Behavioral Sleep Medicine: Evidence-Based Treatments for Sleep Disorders (Workshop Code: #108)

Workshop Description
An overwhelming number of patients have sleep problems, which can be disconcerting to clinicians without the training to treat these disorders. An abundance of evidence supports several psychological treatments of sleep disorders such as insomnia, parasomnias, and circadian rhythm disorders. There is a growing need for practitioners with expertise in these techniques. The main goal of this INTRODUCTORY workshop is to educate clinicians about how to provide and be reimbursed for, empirically validated treatments for common sleep disorders (e.g., Insomnia).

This workshop is designed to help you:
1. Discuss the prevalence of sleep disorders treatable with behavioral and cognitive interventions,
2. Apply the theoretical etiology of these disorders in developing a treatment plan,
3. Provide empirically validated treatments for these disorders in adults,
4. Provide empirically validated treatments for these disorders in children,
5. Develop a practice specialty in behavioral sleep medicine through collaboration with local sleep disorders centers,
6. Apply effective billing methods for behavioral sleep medicine services,
7. Prepare to become certified in behavioral sleep medicine.

Leader: Daniel J. Taylor, PhD, University of North Texas, Denton, TX

Thursday, August 6, 2009
AASM BSM/INSOMNIA COURSE (2 DAYS)

**STRENGTH:**
- ALLOWS FOR AN INTENSIVE TRAINING EXPERIENCE OVER A WEEKEND SEMINAR LED BY LEADING BSM EXPERTS
- IS SPONSORED BY, AND UNDERWRITTEN BY, THE AASM
- ALLOWS FOR A LARGE NUMBER OF TRAINEES (100-200 PEOPLE / COURSE)

**WEAKNESS:**
- TRAINING IS AN OVERVIEW OF BSM AND NOT DEDICATED TO CBT-I TRAINING
- TARGET AUDIENCE IS FROM WITHIN THE SLEEP COMMUNITY
- A MODERATE TO LARGE PERCENTAGE DO NOT GO ON TO PRACTICE CBT-I
UR/UPENN CBT-I WEEKEND SEMINAR (3 DAYS)

STRENGTHS:
- ALLOWS FOR AN INTENSIVE TRAINING DEDICATED TO CBT-I
- COURSE IS BASED ON A PUBLISHED TRAINING MANUAL
- THE TARGET AUDIENCE IS NON-SLEEP MENTAL HEALTH CLINICIANS
- ALLOWS FOR 50-100 PEOPLE / COURSE
- COURSE IS SET OUT AS “STEP 1 EXPERIENCE” WITH A CLEAR PATH TOWARDS PRACTICE AND CERTIFICATION

WEAKNESSES:
- THE PERCENTAGE OF CLINICIANS THAT GO ON TO FOLLOW THE “PRESCRIBED PATH” TO FULL TRAINING IS UNKNOWN
- THE PERCENTAGE OF CLINICIANS THAT GO ON TO PRACTICE CBT-I PART OR FULL TIME IS UNKNOWN
- SOME MAY CONSIDER THE CBT-I TRAINING TOO NARROW AND TOO FOCUSED ON A SINGLE APPROACH
APA BSM/INSOMNIA COURSE (1 DAY)

STRENGTH:  ALLOWS FOR AN EXCELLENT OVERVIEW OF BSM AND IS LEAD BY BSM EXPERTS

TARGETS A NON-SLEEP AUDIENCE

ALLOWS FOR A LARGE NUMBER OF TRAINEES (50 PEOPLE / COURSE)

WEAKNESS:  TRAINING IS AN OVERVIEW OF BSM AND NOT DEDICATED TO CBT-I TRAINING

A MODERATE TO LARGE PERCENTAGE DO NOT GO ON TO PRACTICE CBT-I
PUBLISHED TREATMENT MANUALS

- Insomnia: A Clinical Guide to Assessment and Treatment
  - Charles M. Morin and Colin A. Espie

- Cognitive Behavioral Treatment of Insomnia: A Session-by-Session Guide
  - Michael E. Manber, Carla J. Jurgens, Michael T. Smith, Donna Poster

- Overcoming Insomnia: A Cognitive-Behavioral Therapy Approach
  - Treating Insomnia: Therapist Guide
  - Jack D. Edinger, Colleen E. Carsley
PUBLISHED TREATMENT MANUALS

STRENGTHS: ALLOW FOR AN UNLIMITED ACCESS TO THE TECHNIQUES
ALLOW FOR HIGHLY DETAILED AND REFINED PRESENTATION OF METHODS.

WEAKNESS: OFTEN DO NOT EMPHASIZE THE NEED FOR TRAINING BEYOND “BOOK LEARNING”
THE PERCENTAGE OF CLINICIANS THAT GO ON TO PRACTICE CBT-I PART OR FULL TIME IS UNKNOWN
DO NOT ALLOW FOR QUALITY CONTROL.
STRENGTHS:
CREATED BY BSM EXPERTS
ALLOWS FOR AN UNLIMITED ACCESS
ALLOWS FOR HIGHLY DETAILED & Refined PRESENTATIONS
ALLOWS FOR SELF-PACED LEARNING

WEAKNESSES:
DOES NOT TARGET A NON-SLEEP AUDIENCE
DOES NOT EMPHASIZE THE NEED FOR TRAINING BEYOND "BOOK LEARNING"
THE PERCENTAGE OF CLINICIANS THAT GO ON TO PRACTICE CBT-I FTE/PTe IS UNKNOWN
DOES NOT ALLOW FOR QUALITY CONTROL.
RECOMMENDATIONS

WORK TOWARDS A POLICY WHERE ALL FULLY ACCREDITED SDCs HAVE A FTE/PTE CBSM ON STAFF WITHIN 5 YEARS

ESTABLISH GUIDELINES FOR PRACTICE AND PRACTICE AGREEMENTS FOR ALL MA LEVEL CLINICIANS

ESTABLISH FORMAL OR AN INFORMAL NETWORK OF PEER SUPERVISORS FOR BSM NOVITIATES AND/OR MA LEVEL CLINICIANS

EXPAND NUMBER OF INTERNSHIPS, FELLOWSHIPS, MINI-FELLOWSHIPS. PERHAPS VIA INCENTIVES

EXPAND TARGET AUDIENCE FOR THE AASM BSM COURSE TO APA & ABCT

EXPLORE THE PROVISION OF AASM ACREDITATION FOR NON-AASM TRAININGS

PARTNER WITH INDUSTRY TO DISTRIBUTE THE 3 TX MANUALS TO ALL SDCs
FINALLY,
MANY OF THE IDEAS COVERED HERE
ARE DISCUSSED IN
How can we make CBT-I and other BSM services widely available?

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Following several presentations and discussion panels regarding cognitive-behavioral therapy for insomnia (CBT-I) during the 2007 annual meeting of the Associated Professional Sleep Societies in Minneapolis, it seems to many of us that the budding field of behavioral sleep medicine (BSM) is at a critical juncture. Six events have occurred that bring us to the present crossroads. First, as a result of the vision and generosity of the American Academy of Sleep Medicine (AASM), there is (as of 2004), a credentialing board for BSM that is underwritten and administered by the Academy. Second, the research literature regarding CBT-I has matured to a point where the 2005 NICE State of the Science Panel acknowledged that this form of BSM is to be considered a first-line therapy for chronic insomnia. Third, sleep medicine (with the change in the board-certification process from the American Board of Sleep Medicine to the American Board of Medical Specialties) has recently been redefined as a medical subspecialty and, as a result, BSM is now formally a part of sleep medicine. Fourth, with the rebranding of AASM sections to be aligned with disease states (vs areas of specialty), BSM is no longer identified as a section within the Academy. Fifth, the recent AASM Comprehensive Academic Sleep Programs of Distinction initiative does not reference BSM nor require that centers within this program have BSM services. Sixth, and finally, it now appears that there is a substantial push to alter the Joint Commission to require CBT-I (and more BSM “physician extender” vs BSM specialties) as a hospital requirement. Although each of these last six events is relevant for the continued growth of BSM as an allied field and an interdisciplinary component of sleep medicine, the last six months have been eagerly needed to be addressed.

The push to make CBT-I more available by diversifying who can provide it and how it is provided is largely based on the following beliefs: (1) There are not enough credentialled BSM specialists to provide treatment for the millions of patients with insomnia, (2) reimbursement for BSM services is complicated and patients too low a level of reimbursement, (3) CBT-I can be conducted by anyone with a minimal amount of training, and (4) BSM specialists have little to offer sleep disorders centers beyond the treatment of insomnia (which can hardly keep one busy enough to justify a part-time equivalent or full-time equivalent salary).

Before addressing these issues specifically (and providing a series of recommendations), it is worth addressing the global perspective. Twenty to 30 years ago, sleep medicine itself was faced with many of the same daunting issues (e.g., too few specialists, problems with reimbursement, and a lack of evidence that sleep medicine alone could contain a dedicated clinical enterprise). Yet, at that time, there was no call to populate the field with non-MDs to conduct polysomnography studies and evaluations (although this was allowed via the American Board of Sleep Medicine) nor was there a call to make polysomnography assessment studies half an hour-long studies to reduce the burden of the assessment process. Instead it was suggested that these issues required time and work to resolve and that only in this way could a clinical specialty be established.

What has changed? Who is there now a sense of urgency and a rush toward solutions that can only diminish the effect to establish BSM as a subspeciality of sleep medicine (and behavioral medicine). Whatever the answer, it cannot be one that accepts that sleep medicine is, and should continue to be, a multidisciplinary field.

THERE ARE NOT ENOUGH CREDENTIALED BSM SPECIALISTS TO PROVIDE TREATMENT FOR THE MILLIONS OF PATIENTS WITH INSOMNIA.

First, while it is estimated that 10% to 15% of the population suffers from chronic insomnia, it is unclear what proportion of this population is actively seeking help. Thus, the assumptions that the demand far exceeds the supply remains to be formally documented. What is clear is that most accredited sleep disorders centers do not have full-time or part-time clinicians who specialise...
THANKS FOR LISTENING
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