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Primary care: contextual behavioral science

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Abstract

This article reviews the literature related to application of contextual behavioral science (CBS) to primary care medical or general practice services. After introducing the scope of need for powerful third wave behavior therapies in this setting, the article describes the Primary Care Behavioral Health (PCBH) model, a platform for delivery of CBS interventions, particularly those of Acceptance and Commitment Therapy (ACT). It then suggests adaptations to the methods of functional analysis needed to accommodate the population-based care perspective of primary care medicine. After a review of specific evidence concerning delivery of ACT in primary care, the article concludes with a discussion of the future of health and the potential support that use of ACT strategies may offer.

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Introduction

Primary care has been described as the de facto mental health system in the United States [1]. Indeed, most patients seeking care for mental health and substance abuse problems go to a family physician. The waiting rooms of primary care are also full of people with chronic diseases, most of whom struggle with making behavior changes needed to self-manage skillfully. Often, in the waiting rooms of primary care, a person with poor lifestyle habits (not yet diseased) sits between one with multiple chronic conditions and one with crippling anxiety. Most often, the anxious one is there to request help with 'chest pain' or 'sleep' or 'neck pain' and may receive orders for procedures or medications that may inadvertently further impair functioning. When a child throws tantrums often, complains of stomach pain or headaches, has excessive weight gain or does poorly in school, the parent seeks counsel from a primary care provider. For these reasons and more, the primary care setting is a gold mine for a generalist behavioral health provider who is skilled in the art of ultra-brief functional analysis!

However, the Primary Care Behavioral Health (PCBH) clinician will need additional skills to succeed in primary care and the PCBH model defines this skill set [2,3]. Systematic implementation of the PCBH model provides the groundwork for a behavioral health provider to complete 10–12 visits per day for patients of any age in need of assistance with any type of behavior change. Functional analysis provides the basic structure for the BHC's 15 and 30-min consultations with patients.

Because of their trans-diagnostic nature, third-wave behavior therapies, such as Acceptance and Commitment Therapy (ACT) offer ideal support to the BHC seeking to improve care to primary care patients. ACT can be adapted to support radical behavior change in brief treatment settings, such as primary care, and this version of ACT is often referred to as Focused Acceptance and Commitment Therapy (FACT) [4,5]. FACT may also help primary care providers develop greater resilience in managing the stress of a busy practice and greater success in using a team approach to serving patients. This brief review describes the PCBH model and the population-based care perspective characteristic of primary care. It then summarizes the evidence for using ACT with primary care patients, focusing on the handful of studies that have evaluated ACT specifically in the primary care setting. The section concludes with several suggestions for using ACT in primary care to improve health outcomes.

The PCBH model

Various studies of the PCBH approach show impressive outcomes, including improved symptoms; better quality of life and higher life satisfaction for most patients; that most patients benefit from an average of four or fewer visits; that gains made by patients are maintained for several years; and that patients and PCPs prefer this model to usual care [6–10]. The hallmark of the PCBH approach to integrating behavioral health services into primary care is its foundation in a *consultant approach*. Behavioral health providers in this model are called *behavioral health consultants* (*BHC*).

Table 1 outlines key differences between a consultant approach and a more traditional *therapist approach*. The BHC is a generalist who provides services for most problems for patients of any age, ranging from the three year old with behavior problems to the elderly patient with terminal cancer. The goal of care is to improve

Table 1

Differing dimensions of the consultant and therapist approach.

Dimension	Consultant	Therapist
Breadth of services	Wide	Narrow/specialized
Treatment focus	Improved functioning	Diagnosis and treatment to recovery
Access to care	On-demand	Scheduled
Course of care	Patient progressing toward goals, brief episodes	Patient has met goals, case closure
Primary provider (ownership of care)	Consultant to the primary care provider	Specialist role (has own caseload)
Productivity of behavioral health provider	High	Low
Care context	Team-based	Autonomous practice

patient function, as opposed to diagnose and treat to recovery. Most often, patients can access BHC services on the same-day of the medical appointment when they are referred. Typically, the BHC completes an episode of care in one to four 30-min patient visits. Once the patient begins to make gains, care is returned to the primary care provider (who 'owns' the responsibility for on-going care of the patient). BHC productivity is about twice that of specialty providers, and this allows the BHC to better meet the increased demand for care in this setting. BHCs typically need training to make the adaptation to working as a member of a team and in a consultant role.

Population-based care and functional analysis

In order to better address the needs of primary care patients, the BHC adopts the population-based care perspective characteristic of primary care. The mission of population-based care is to improve the health of all patients who come to the clinic and this is most often achieved by providing some care to many rather than a lot of care to a few. In order to improve health, the BHC works with the team to address the needs of patients with psychological problems, those with medical problems, and those with both. Preventive care is as important as acute and chronic care. The team's objective is to help patients learn skills fundamental to maintaining a state of mental, physical and social health as long as possible and to live meaningful lives with good social support free from premature development of disease and disability.

The BHC provides two basic services: brief interventions and pathway services. Brief intervention services are those delivered to patients in 15 and 30-min visits, with a focus on the primary problem of concern to the patient. The BHC uses the tools of functional assessment to target the problem and to create a powerful behavior change plan. Brief intervention services are delivered to individuals, couples, and families, as well as groups of patients.

Pathway services are those provided by the BHC according to an agreed upon protocol designed to bring evidence-based care to more patients more consistently and thereby improve clinical outcomes as well as cost. Pathway services may include better identification of patient in the target group and/or delivery of individual interventions and/or group services. An example of a preventive pathway is that of a neurodevelopmental pathway designed to improve identification of patients with social and emotional delays at the 24-month Well Child visit, delivery of BHC interventions targeting areas of concern for the parent(s), and referral for specialty services as indicated. An example of a chronic care pathway is that of a group medical visit program designed to improve social support, education to enhance self-management and end-of-life planning for patients aged 75 and over with multiple medical problems in need of monthly medical follow-up [11].

Evidence for use of ACT

ACT offers the BHC, as well as medical members of the primary care team, assessment and intervention strategies for a wide range of common problems in primary care. Specifically, a meta-analyses of ACT studies concluded that ACT is better than usual care or waiting lists and as effective as other cognitive-behavioral psychotherapies in the treatment of many traditional mental health problems seen frequently in primary care [12], including anxiety [13]. ACT is also associated with improved rates of smoking cessation [14] and improved outcomes with chronic pain and disability behavior [15,16]. ACT strategies have been shown to reduce the rate of seizures and improve quality of life in patients with uncontrolled seizure disorder [17].

Research testing ACT in brief treatment versions and specifically in the primary care setting is very limited, but the trend is toward growth. In contrast to studies of ACT just reviewed, Vowles and his colleagues employed a brief ACT intervention with chronic low back pain patients [18•] and found that patients instructed on pain acceptance performed better on a measure of physical impairment compared to patients trained on a pain control strategy and patients receiving placebo [18•].

The first study to evaluate the impact of an ACT intervention with primary care patients targeted patients being treated for Type 2 diabetes in a low-income community health clinic. Eighty-one patients were randomized to one of two conditions: a one-day workshop on medical management of diabetes alone or in combination with ACT. Patients in the ACT group learned to apply acceptance and mindfulness skills to difficult diabetes-related