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SPECIAL SERIES: CBT in Medical Settings

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Integrating Cognitive Behavioral Therapy Into Primary Care Settings

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This article serves as an introduction to the first issue of the Cognitive and Behavioral Practice special series on cognitive-behavioral practice in medical settings. This first issue of our two-part series focuses on strategies and recommendations for integrating cognitive behavioral therapy (CBT) into primary care settings and the unique challenges primary care in particular presents. Our subsequent issue will focus on the implementation of CBT in other, more specialized forms of medical care, including cancer treatment and HIV care.

Why Focus on Behavioral Health in Primary Care?

In recent years, the movement to integrate behavioral health into primary care has been rapidly growing. The passing of the Affordable Care Act in 2010, the wide adoption of a patient-centered medical home model in primary care, and the advent of the Accountable Care Organization (ACO) Medicare Shared Savings Program have led primary care sites throughout the U.S. to further consider comprehensive, "whole person" (American Academy of Family Physicians, 2008) care of their patients, including a focus on behavioral health. This policy focus on behavioral health care in primary care settings reflects the current needs of primary care patients and providers. Data shows that the majority of individuals seeking mental health services turn to primary care as their first or only source of treatment (Cauce et al., 2002; Wang et al., 2005; Wang et al., 2006). As a result, more than half of common mental health problems are treated exclusively in primary care (Bea & Tesar, 2002). In 2007, in the U.S., nearly half of all prescriptions for antidepressants and anxiolytics were written in primary care settings (Schappert & Rechtsteiner, 2011).

However, these estimates do not include the proportion of patients who present in need of behavioral modification of health risk lifestyle factors, or who might benefit from the assistance of a behavioral health provider in learning how to adjust to and manage chronic physical illness. As readers of *Cognitive and Behavioral Practice* know well, there are numerous empirically supported cognitive and behavioral interventions for chronic disease management and lifestyle modification, including programs targeting chronic pain (e.g., Allen et al., 2012; Hoffman et al., 2007; Thorn, Boothby, & Sullivan, 2002), diabetes (e.g., Amsberg et al., 2009; Safren et al., 2014), insomnia (e.g., Bélanger, LeBlanc, & Morin, 2012; Espie, et al., 2012), obesity (e.g., DiLillo, Siegfried, & Smith West, 2003; Unick et al., 2013), smoking cessation (e.g., Stanton & Grimshaw, 2013), and adherence to treatment regimens (e.g., Demonceau et al., 2013; Newcomb et al., 2014). Traditionally, mental health treatment in primary care settings has focused on provision of psychopharmacotherapy and psychosocial treatments have been managed via referrals to providers in the community. However, research shows that one-third to one-half of primary care patients referred to mental health specialists do not attend even a first visit (Fisher & Ransom, 1997). Primary care patients cite inaccessible offices, inconvenient office hours, difficulty finding providers who take their insurance, and/or the fact they do not have insurance, as some of the key barriers for not following up on these referrals (Fisher & Ransom). As a result, many patients who may benefit from psychosocial treatments do not receive this care.

For example, one of us (R.W.) found that nearly half (47%) of a sample of primary care patients in New England who had a current anxiety disorder diagnosis were not receiving any mental health treatment. Only 32% had received any form of psychotherapy in the past 3 months (Weisberg et al., 2007). Further, only 14% had received psychotherapy that reportedly contained key

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components of CBT such as exposure and/or cognitive restructuring (Weisberg et al., 2013). When we followed the primary care patients for up to 5 years, we found that under 37% ever, at any time during the follow-period, received psychotherapy containing CBT elements (Weisberg et al., 2013). Thus, though efficacious CBT treatments have existed for many years for the treatment of anxiety disorders, approximately two-thirds of primary care patients with anxiety disorders in our sample did not receive this type of care at any time over a 5-year period.

Embedding mental health services within the primary care site may help foster receipt of behavioral health treatment. There are a number of models for bringing behavioral health into primary care settings. In co-location, the behavioral health provider functions as an independent professional, but is geographically located within the same service as the primary care team and may have basic or close consultation and collaboration with the primary care providers. In integration, the behavioral health provider is part of the primary care team. There is close collaboration within an integrated system. All providers are part of the business of the practice, attend team meetings, and use the same medical record system. As noted below, the articles in this series present treatments that primarily are co-located, in that the treatment research team brought in services from their home organizations and performed them on-site in collaboration with the primary care team. In a few of these papers, the work approached integration, in that the behavioral health staff was part of the same organization and a collaborative treatment team (e.g., Bryan, Corso, & Macalanda, 2014-this issue; Gomez et al., 2014-this issue; Goodie & Hunter, 2014-this issue) and/or used a shared electronic medical records (Pigeon & Funderburk, 2014-this issue).

Whether co-located or more fully integrated, a growing body of research indicates that collaborative behavioral–primary care results in improved patient outcomes (e.g., Archer et al., 2012; Bower et al., 2006; Craske et al., 2011; Gilbody et al., 2006, Rollman et al., 2005; Roy-Byrne et al., 2010). However, collaborative care does not always include the provision of psychotherapy. The key defining elements of collaborative care are that health professionals work with primary care providers to serve as care managers and/or behavioral health clinicians, and that these professionals monitor patient treatment adherence and outcomes over time in a systematic manner, and provide feedback to the primary care provider. The health professional may be a nurse who monitors adherence to hypertension medications and home blood pressure checks and reports problems to the provider, or they may be a psychologist who provides brief psychotherapy to primary care patients with depression, while also monitoring outcomes and reporting these to the primary care providers. This is important to note, because recent meta-analyses of collaborative care for depression—the disorder/problem with the largest primary care collaboration research base—found that while collaborative care was overall associated with decreased depressive symptoms, and care managers with a mental health background were associated with better outcomes than those without such education, whether or not the collaboration included psychotherapy services was *not* predictive of outcomes (Bower et al., 2006; Gilbody et al., 2006).

As cognitive-behavioral therapy researchers, we find this information troubling. A wealth of data from controlled trials in tertiary care shows that we have efficacious psychotherapies for the treatment of depression, so it is puzzling that the addition of psychotherapy to other collaborative care (primarily care management) was not associated with improved outcomes for depressed patients. However, further examination of the meta-analyses cited above (Bower et al., 2006; Gilbody et al., 2006) shows that psychotherapy was considered as one broad variable in these analyses. That is, there was no differentiation between cognitive behavioral therapy and other therapies with less of an evidence base. Similarly, Funderburk and colleagues (2011) examined the chart notes of primary care patients who had received behavioral health services as part of an integrated behavioral health–primary care program in the Veteran's Administration Medical Centers in upstate New York. A random sample of 10% of the 1,870 patients who had at least one visit with a behavioral health provider was reviewed. Although the behavioral health providers were all trained in the functions of their role and in the idea of providing brief, co-located interventions, the BHPs did not receive training or guidance as to the specific interventions to use during these brief therapy sessions. The authors found that chart notes made infrequent mention of the use of CBT techniques. Within the VA medical centers under study, only 18% of primary care patients seen by a behavioral health provider (BHP) for depression received psychotherapy that included cognitive therapy techniques, and only approximately 25% received behavioral activation. Patient education and supportive treatments were commonly used. Thus, it is possible that the provision of psychotherapy has not been found to predict outcomes in meta-analyses of collaborative care, in part because the specific interventions used in the psychotherapy are not always those with an evidence base. Improving the integration of CBT into primary care settings may therefore be crucial for improving patient outcomes and demonstrating the important role of brief psychotherapies in this context.

Providing CBT in primary care settings is challenging. As Blount and Miller (2009) point out, there are a great number of differences between working as a psychotherapist in a specialty mental health setting and being a BHP in primary care. As a BHP, you are the ancillary, rather