Integrating Behavioral Health into Primary Care

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Tools for successful behavioral health integration: Evidenced based programs and practices.

In Issue 1 we discussed the importance of behavioral health integration into primary care (click here to read Issue 1). This issue will focus on technology, in the form of web-based programs (*e.g.* computerized cognitive behavioral therapy programs), and its use as a tool to facilitate the integration of behavioral health care into primary care settings.

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Tools for Successful Integration

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What is CBT?

Cognitive behavioral therapy (CBT) is a time-limited, goal-oriented, form of 'talk therapy' that focuses on problem-solving and building skills such as: identifying unhelpful thinking, modifying beliefs, and changing behaviors.[1] It has been proven to work for several common health problems and is, in fact, recommended by treatment guidelines as the best first option for most patients with insomnia,[2] and anxiety disorders,[3] including: obsessive compulsive disorder (OCD);[4] phobias, and panic disorder.[6] Unhelpful or problematic thinking is common to many behavioral disorders and when patients learn to evaluate their thinking in a more realistic and adaptive way, they experience improvement in their emotional state and in their behavior. Through CBT, individuals learn to recognize, evaluate, and respond to "automatic thoughts," that contribute to their health problem.[7] For example, if a man were depressed and he locked his keys in his car, he might have an automatic thought, an idea that just seemed to pop up in his mind: "I can't do anything right." This thought might then lead to a particular reaction: he might feel angry (emotion) and shout at a family member or colleague (behavior). If he then examined the validity of this idea, he might conclude that he had over-generalized and that, in fact, he actually can do many things well. Looking at his experience from this new perspective can make him feel better and lead to more functional behavior.

The use of both behavioral and cognitive techniques is important because CBT is designed to both modify unhelpful thinking and change behavior. Cognitive work is necessary to change thoughts and beliefs, and behavioral work is necessary to teach certain adaptive skills. Both are necessary for the development of changes required for improvement. Some diagnoses warrant a greater emphasis on either cognitive or behavioral work. Anxiety, for example, will almost always require behavioral work (*e.g.* exposure exercises).

Homework (self-help assignment or action plan) is really important in relating strategies covered in sessions to the real world. Homework also helps keep patients actively engaged in the therapeutic process between sessions. Patients may not be allowed to progress in therapy until homework is completed. Homework from a previous week is incorporated and built on in subsequent sessions. Homework usually consists of reading therapy notes, implementing solutions to problems (behavior change), responding to unhelpful or distorted thinking and/or practicing other cognitive and behavioral skills.[1]

What does the research say?

CBT has been found to be effective in more than 1,000 outcome studies for a myriad of psychiatric disorders, including insomnia, anxiety, depression, and substance use.[1] These research studies typically used traditional weekly sessions to deliver treatment. CBT is usually a short-term treatment, lasting from four to twenty sessions. In some cases, very brief treatment courses are used for patients with mild or moderate problems. Conversely, longer series of CBT sessions are used for those with chronic or especially complex conditions. However, the typical patient with insomnia, depression or an anxiety disorder can be treated successfully within the short-term format.

What are the principles of CBT?

The overall aim of CBT is to help patients achieve improvement of their disorder and prevent relapse by learning problem solving skills and methods to reduce and manage symptoms. Studies show this works and that the impact is long lasting. This is achieved through an empirical approach, which teaches patients to view reality more clearly through an examination of their core beliefs and problematic thinking patterns. Correcting unhelpful thinking leads to improvement in mood and functioning. A summary of the basic principles of CBT is provided below:

- *Problem-solving*: CBT focuses on the problems enumerated by the patient and removes obstacles that prevent problem resolution.
- *Goal-oriented*: CBT identifies problems and sets goals in order to maintain focus on solving problems and attaining goals.
- *Here-and-now*: CBT focuses on the present but will sometimes examine the past to help understand the present and prepare for the future.
- *Psychoeducational*: CBT aims to teach the patient about his/her disorder, about the cognitive model, and about how to set goals, evaluate thoughts and beliefs, and plan for change.
- *Time-limited*: CBT treatment is provided in a specified number of sessions.
- *Structured*: CBT sessions are structured. Standard sessions consist of agenda setting, reviewing the week and current mood, reviewing homework, focusing on the new material and/or skills to be learned that session, describing new homework, and soliciting feedback. All sessions should contain periodic summaries and a capsule summary at the conclusion of a session.
- *Directive*: CBT serves to guide the patient throughout therapy and allows the patient to arrive at his or his/her own conclusions.[1]
- *Empirically-supported*: the efficacy and effectiveness of CBT has been validated and supported in more than 1,000 clinical trials.

The bulk of CBT is devoted to working on specific problems or issues in the patient's present life. The problem-solving approach is emphasized for several reasons. First, directing the patient's attention to current problems stimulates the development of action plans. Second, data on cognitive responses to recent life events are more readily accessible and verifiable than for events that happened years in the past. Third, practical work on present problems helps to pre-vent the development of excessive dependency or regression. Finally, current problems usually provide ample opportunity to understand and explore the impact of past experiences.

What are the clinical guidelines and how can CBT be made more accessible?

The American Psychiatric Association recommends CBT as the first line of treatment for insomnia and anxiety disorders;[9]

additionally, CBT is a well-established option for depression[10] and substance use disorders.[11] However, many with these disorders do not receive recommended or validated treatment.[12] Worldwide, and in the U.S., the demand for CBT exceeds the availability of therapists. Due to a shortage of trained professionals there are long waiting lists, with the associated costs. Personal barriers, such as stigma, can also interfere with accessing CBT. As a means of overcoming such barriers, tailored, computerized CBT programs delivered over the internet[13] have been developed in recent years.

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Tools for successful behavioral health integration: Technology that saves clinician time

What is Computerized CBT?

Computerized Cognitive Behavioral Therapy (CCBT) has been described by the United Kingdom's National Institute for Health and Care Excellence (NICE) as a "generic term for delivering CBT via an interactive computer interface delivered by a personal computer, internet, or interactive voice response system,"[1] as opposed to face-to-face CBT with an in-person therapist. CCBT helps to improve access to evidence-based programs, reduce costs usually associated with seeing a CBT trained clinician for up to forty-five minutes a visit and can minimize the stigma often associated with going to therapy sessions. Research on computerized CBT (CCBT) for insomnia,[2] phobias and panic disorder,[3] OCD,[4] substance use,[5] and depression,[6] supports its efficacy. Additionally, CCBT programs have been shown to be useful for educating students and professionals[7,8] in the delivery of CBT.

Technology that saves clinicians time

CCBT programs have been shown to save clinician time. It allows clinicians to reduce face-to-face time with patients receiving psychotherapy, without jeopardizing quality of care. One study showed that self-exposure therapy for panic and phobia cuts clinician time per patient by 73% without losing efficacy when guided mainly by a computer rather than entirely by a clinician.[3] The programs allow for most of the therapeutic process to be delegated to patient-computer interactions, and no training in CBT is required for clinicians to administer the programs. CCBT also provides individualized guidance to each patient while delivering a standardized and well-studied protocol. Further-more, CCBT programs allow patients to work at their own pace, and repeat sessions as needed, without the burden of long wait times between traditional appointments.

Increasing access to evidence based programs

A number of factors impede access to CBT services, including high level of demand, limited availability of clinicians, and a "lack of clear referral criteria and path-ways."[1] Additionally, proximity to care often also stands in the way of accessing care. Generally, residents of rural areas report poorer availability and reception of mental health services.[9] Beyond issues of access, rates of utilization in rural areas are lower due to concerns around confidentiality and anonymity.[9] Given these issues, computerized therapy programs are extremely useful in serving the needs of rural populations. Research has shown that individuals in

remote and rural areas not only accepted CCBT as a tool for managing panic and phobia, but also demonstrated clear improvements in symptoms on a similar level to that of face-to-face CBT.[10]

Providing access to tools for patients with co-occurring disorders can be even more difficult and complicated. Clinical face–to-face programs addressing comorbidities are "often high-intensity, require specialist input and training, and are therefore only accessible to a minority of clients."[11] The consequences of leaving such comorbidities (*e.g.* depression, cannabis and alcohol use) untreated are significant. For example, excessive drinking alone has been found to yield a $2 per drink cost in terms of medical expenses and other externalities.[12] One study has demonstrated that access issues for these combined problems can be addressed through offering CCBT. Furthermore, the study found that CCBT is "associated with similar improvements in depression and alcohol and cannabis use as face-to-face alternatives."[11] Importantly, subjects from both rural and urban settings accepted the use of CCBT for managing co-occurring disorders, as opposed to face-to-face therapy.[11] In the face of rising health care spending, identifying and implementing proven tools that are cost-effective is of great importance.

Clinician guided CCBT

Patients receiving CCBT have been shown to have better results when they have brief support in the form of scheduled calls or abbreviated check-ups than if they were left to complete the program on their own.[13] Physicians, physician assistants, nurses, social workers, mental health clinicians, health coaches, peers, and other support staff can fill the role of a guide. This role consists of monitoring clinical symptoms (*e.g*. a risk of suicide assessment), motivating clients to do their homework, and problem solving (if a patient doesn't do homework, the guide can in-quire as to why that is and help them to overcome impediments for the next week). Most importantly, no CBT training is required to be a guide for patients completing a CCBT program.

Who is using it and what are the next steps?

There is always a need for improvement in any mode of delivering care, but already CCBT is helping broaden access to evidenced based programs and shortening the face-to-face time clinicians need to spend with their patients.[4] However, health care systems around the world face the major issues of how to fund and organize computer-aided therapy.

This is less of a problem in countries that have a national health system, For example, primary care physicians in Canada who have patients with insomnia can refer them to a web-based CBT program for insomnia called RESTORE™, which received the "Leading Edge Practice Award" from Accreditation Canada in 2010.[14] Studies have found that 90% of Canadian patients accept CCBT and have found that it is quick and easy to access. Canada is the only public health system in the world that incorporates CCBT programs for sleep into the list of tools it pays for.[15]

Australia was one of the first nations to recognize the potential and benefits of computer-guided therapy, leading to a number of e-health initiatives in the 1990s aimed at better integrating technology into practice. The CCBT program SHADE™ has been awarded the 2010 Mental Health Matters Award for Research and Evaluation[16] and the 2009 National Drug and Alcohol Industry Award for Excellence in Research[17] and is in the NSW Health Professional Practice Guidelines for Psychosocial Interventions in Drug and Alcohol Services.[1] SHADE™ has been shown to reduce hazardous drug and alcohol use by 44-58% after 6 months, as well as reduce hazardous use by 72% after 12 months.[1]

The British National Health Service has sup-ported the use of CCBT for nearly a decade, because the National Institute for Clinical Excellence (NICE), which evaluates programs offered by the NHS for both clinical efficacy and cost-effectiveness, has recommended the use of FearFighter™ for the management of anxiety as the preferred first line option. It also has described OCFighter™, a CCBT program for OCD, as having "absolute clinical efficacy". A CCBT program for depression, MoodCalmer™, is also in use throughout the UK. This program is derived from an earlier program called COPE, which was developed at the University of

London and physicians at Harvard and the University of Wisconsin. In an open, multi-site trial across two continents, COPE was shown to: (1) reduce depression severity by 41% in all participants enrolled; (2) reduce depression severity by 52% in completers; and (3) have high levels of patient satisfaction with 68% completing the program.[6]

CCBT in your region

Earlier this year clinicians at LIFE St. Francis, a Program of All-Inclusive Care for the Elderly (PACE), located in Trenton, New Jersey, began implementing CCBT programs. Participants at PACE are accessing CCBT with their clinicians from computers onsite, and from laptops in their homes, to help manage their behavioral health problems. Another implementation that is underway is a behavioral health integration project at two federally qualified health centers (FQHCs) in New Jersey – the Henry J. Austin Health Center (HJA), in Trenton, and the Center for Health Education, Medicine, & Dentistry (CHEMED), in Lakewood. Starting this Fall, primary care providers at HJA and CHEMED will use an online behavioral health screening tool in conjunction with five CCBT programs. The goal of this project will be to screen for behavioral health problems and provide proven tools (*e.g.* CCBT programs) for clinicians to offer to individuals who screen positive but do not need to be referred to a live clinician for face-to-face therapy. This project will facilitate the integration of behavioral health care, through the use of the screening tool and CCBT, with primary care services at the FQHCs in an effort to improve outcomes and demonstrate an efficient and effective approach to caring for people with multiple healthcare needs.

In summary, the use of web-based CCBT technology has proven to have great potential for facilitating behavioral health integration efforts in the United States and internationally. These tools not only help clinicians save time but can also serve to support primary care physicians in managing behavioral health problems and providing proven tools that support evidence-based, best practice guidelines.

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