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Barriers to the Collaborative Care of Patients with Orofacial Injury

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SUMMARY

Collaborative care interventions demonstrate significant promise in facilitating integrative care which addresses both the physical and mental health needs of orofacial trauma patients. Ensuring the successful implementation of collaborative care interventions depends on having an adequate understanding of the potential barriers to the provision and receipt of mental health services within specific clinical settings. The present paper reviews recent findings on patient and provider perceptions of barriers to psychosocial aftercare services in oral and maxillofacial trauma care settings. Interestingly, these findings indicate that both patients and providers recognize the need for psychosocial aftercare, but report substantial barriers to services. Among patients, structural barriers such as not knowing where to obtain services and financial cost are major obstacles. Among providers, structural barriers also serve as significant impediments to the provision of psychosocial services. Some of the most common structural barriers reported by providers include a shortage of financial resources, trained clinical staff, and space. Although collaborative care interventions may be well-suited to capitalize on both patient and provider interest in psychosocial aftercare programs, further research is needed to determine the viability of this promising aftercare model within oral and maxillofacial trauma care settings.

INTRODUCTION

Establishing collaborative care programs within oral and maxillofacial trauma settings may be an effective means to linking patients to needed psychosocial services (i.e., substance abuse, mental health treatment). Research suggests that orofacial trauma survivors may be motivated to address a range of trauma-related psychosocial problems during the period immediately following injury (Gentilello, Donovan, Dunn, & Rivara, 1995; Warburton & Shepherd, 2002). Moreover, preliminary evidence from general trauma settings indicates that collaborative care interventions show substantial promise in facilitating integrative care which addresses both the physical and mental health needs of traumatic injury patients (Zatzick, Roy-Byrne, Russo, Rivara, Koike, Jurkovich et al., 2001).

A key step in designing and implementing collaborative care programs is understanding potential barriers to the provision and receipt of mental health services within the targeted clinical setting (Katon, 2003). Until recently, knowledge concerning barriers to psychosocial care, specifically with respect to orofacial trauma patients, has been limited. The purpose of this paper is to highlight recent research findings from three interrelated studies on patient and

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health care provider perspectives on barriers to developing psychosocial services within oral and maxillofacial trauma care settings. In the first study, Wong and colleagues examine orofacial trauma patients' receptivity and perceived barriers to psychosocial services for mental health problems (Wong, Marshall, Shetty, Zhou, Belzberg, & Yamashita, 2007). In the second study, Zazzali and colleagues explore provider perceptions of patient need for psychosocial services and barriers to establishing such programs within oral and maxillofacial trauma settings (Zazzali, Marshall, Shetty, Yamashita, Sinha, & Rayburn, 2007). Finally, in the third paper, Chandra and colleagues examine the degree of concordance between provider and patient perceptions of barriers to psychosocial services (Chandra, Marshall, Shetty, Paddock, Wong, Zatzick et al., 2008). These studies were based upon interviews conducted with patients and providers at the Los Angeles County/University of Southern California (LAC+USC) Medical Center- a large Level-1 trauma center catering to a mostly indigent population. Patients were recruited while awaiting their 1-month follow-up visit at the Oral and Maxillofacial Surgery (OMS) Service for violence-related orofacial injuries. Providers included surgeons from oral and maxillofacial surgery and otolaryngology. These studies answer important questions that are relevant for future efforts at establishing collaborative care programs in OMS settings. The following are some of the questions addressed by the present review: a) To what extent are orofacial trauma patients interested in obtaining psychosocial aftercare services?; b) What are the key barriers to obtaining such services?; c) How cognizant are healthcare providers of patient need and barriers to psychosocial treatment?, and D) What are some of the challenges that healthcare providers experience with respect to establishing collaborative care programs?

PATIENT PERSPECTIVES

Objective and Perceived Need

In general trauma care settings, only a fraction of physical-injury patients with documented mental health need obtain psychosocial services (Jaycox, Marshall, & Schell, 2004; Zatzick et al., 2001). Wong et al. (2007) screened orofacial trauma patients for posttraumatic stress disorder (PTSD), major depression, and alcohol use disorder (AUD) at the LAC+USC OMS Service. A substantial proportion of patients demonstrated objective mental health need with respect to meeting criteria for probable PTSD (34%), major depression (35%), or AUD (31%). Of those meeting criteria for at least one mental health disorder, 80% met criteria for at least two disorders, whereas 50% met criteria for all three disorders. Despite significant levels of mental health need, only 8% reported currently receiving mental health treatment. Moreover, of the patients who were currently receiving treatment, all had already been involved in mental health care prior to their injury.

Patients with a positive screen on any of the mental health disorders were invited to take part in an interview that inquired about their interest in receiving psychiatric aftercare and perceived barriers to mental health treatment. Patients were asked about whether they would be interested in an aftercare program designed to help patients who were injured in the face with anxiety, depression, and alcohol problems. Patients indicated whether they were "very interested", "moderately interested" or "not at all interested" in aftercare. Contrary to what might have been expected, patients expressed high levels of interest in receiving psychosocial aftercare; 48% expressed great interest and 36% expressed moderate interest in receiving psychiatric aftercare. Only a small proportion (16%) expressed no interest in receiving psychosocial services.

Perceived Barriers

Orofacial injury patients expressing any interest in psychosocial aftercare were then asked about specific barriers that might impede their utilization of services. Patients were provided

with a list of items representing different types of barriers (e.g., financial concerns, lack of knowledge of available services, beliefs about the acceptability and effectiveness of psychosocial treatment). Items were phrased as statements, and responses were provided on a 4-point scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Wong et al. (2007) reported on the proportion of respondents who either “agreed” or “strongly agreed” that a given barrier might hinder their use of psychosocial services. On average, orofacial injury patients endorsed a total of seven different types of barriers. The two most highly endorsed barriers were lack of knowledge about where to find services (81%) and concerns about financial cost (71%). In addition, over half of those interested in psychosocial aftercare endorsed barriers related to transportation, insufficient information about counseling, wanting to handle problems on their own and having competing responsibilities that would interfere with participating in treatment. About one-third of orofacial injury patients endorsed barriers indicative of ambivalence toward obtaining professional help for psychosocial problems (e.g., not wanting to deal with problems, not needing any help). Finally, barriers that were of less concern (i.e., endorsed by fewer than 20%) included fear of family disapproval, concerns about racial/ethnic discrimination, worry about what others would think, and childcare responsibilities.

PROVIDER PERSPECTIVES

Medical providers play a pivotal role in determining whether collaborative care interventions are successfully implemented and sustained. Coordinated efforts between medical, mental health, and support specialists are essential to providing integrated services for chronic medical and psychiatric problems. To better understand medical provider views of collaborative care, Zazzali et al. (2007) conducted a Web-based survey with 20 oral and maxillofacial surgeons and 15 otolaryngology surgeons at LAC+USC Medical Center.

Perceptions of Need

Providers were asked about their opinions regarding the need for psychosocial aftercare services, the adequacy of current psychosocial programs within their departments, and the potential for aftercare programs to reduce patient non-compliance and re-injury. Providers read a series of statements concerning these topics and rated how much they agreed with the statements using a 4-point scale (1 = *strongly disagree*, 2 = *somewhat disagree*, 3 = *somewhat agree*, 4 = *strongly agree*).

With respect to the statement of whether “there is a need for an aftercare program for patients that deals with their depression, anxiety, and/or drug and alcohol abuse problems,” providers tended to somewhat to strongly agree (*mean* = 3.46; *SD* = .70). Moreover, providers somewhat disagreed with the statement that hospital departments were adequately addressing the psychosocial problems of orofacial injury patients (*mean* = 2.31; *SD* = .90). Providers also perceived positive benefits from psychosocial programs including improved compliance with medical care (*mean* = 3.51; *SD* = .66) and reduced chances for orofacial reinjury (*mean* = 3.11; *SD* = .58).

In addition, providers were presented with a variety of psychosocial issues including homelessness, depression, anxiety (e.g., posttraumatic stress), drug abuse, alcohol abuse, major psychiatric illness (e.g., schizophrenia), domestic violence, financial strain, unemployment, and legal issues. Providers were asked to rate the degree to which each psychosocial issue was seen as a problem in terms of being a consequence of orofacial injuries, a contributor to re-injury, and a factor that interferes with patient compliance. Providers responded using a 4-point Likert scale (1 = *not a problem*, 2 = *somewhat of a problem*, 3 = *moderate problem*, 4 = *significant problem*).

Providers considered most of the psychosocial issues as problematic conditions that develop as a result of orofacial trauma injury. Anxiety, depression, and legal issues were rated as the top three most problematic psychosocial issues that follow from orofacial trauma injury. Factors rated as most problematic in contributing to re-injury were alcohol abuse (mean = 3.77, S.D. = .43), drug abuse (mean = 3.74, S.D. = .51), and homelessness (mean = 3.58, S.D. = .72). Finally, providers endorsed the same set of factors, alcohol abuse (mean = 3.84, S.D. = .37), drug abuse (mean = 3.88, S.D. = .33), and homelessness (mean = 3.85, S.D. = .51), as the most problematic factors that interfere with patient compliance with medical treatment.

Provider perceptions of Barriers to Care

Providers were surveyed about various factors that may influence whether collaborative care programs can be successfully established in oral and maxillofacial trauma care settings. Specifically, providers were asked about how receptive colleagues and staff would be toward psychosocial aftercare programs, the ideal location for psychosocial aftercare services, and barriers to implementing a psychosocial aftercare program within their department (see Zazzali et al, 2007 for further details).

With respect to the establishment of an aftercare program within their department, providers were asked about the degree of receptivity to psychosocial services from three different perspectives: themselves, other clinical staff, and administrative support staff. On a 4-point scale (1 = *very unreceptive* to 4 = *very receptive*), providers rated themselves as moderately receptive to the creation of aftercare services within their hospital department (mean = 2.51; S.D. = .98). In addition, clinical colleagues (mean = 2.14; S.D. = .77) and administrative staff (mean = 2.11; S.D. = .80) expressed a similar level of openness toward aftercare programs in the department.

Providers were then asked to rate how suitable (1 = *unsuitable* to 4 = *very suitable*) the following locations were for situating an aftercare program: specialty mental health (social work and psychiatry), specialty surgical service (OMS, ENT, and plastic surgery), and community-based settings (religious institution, community agency, or free-standing independent location outside the hospital). Providers viewed specialty mental health (mean = 3.46; S.D. = .66) and community-based settings (mean = 3.29; S.D. = .52) as more suitable than surgical service settings for aftercare services (mean = 2.00; S.D. = .91; $p < .05$).

CONCORDANCE OF PROVIDER AND PATIENT PERSPECTIVES

Collaborative care programs depend in part on providers' recognition of patient barriers to psychosocial programs. Chandra et al. (2008) examined the concordance between providers' and patients' perceptions of barriers to psychosocial aftercare within oral and maxillofacial trauma care settings. Providers and patients were given a list of 24 different items that reflected reasons why patients might not attend a psychosocial aftercare program (e.g., "Worried about the cost"). Providers and patients rated the degree to which they agreed or disagreed with the statements (1 = *strongly disagree* to 4 = *strongly agree*). Patient participants answered each item according to their own perspective, whereas providers responded from the perspective of the patients they treat for violence-related orofacial injuries. In addition, two items assessing factors that would facilitate the use of psychosocial aftercare were administered. The items were phrased as statements relating to whether patients would attend an aftercare program upon a doctor's or religious leader's recommendation.

Although providers and patients agreed on a majority of the barriers, there was significant discordance in provider and patient perceptions for about a third of the barriers. In general, providers rated several structural and attitudinal factors more strongly as barriers to care than did even patients. For instance, providers believed that lost job wages (3.1 vs. 2.0) and childcare

responsibilities (3.0 vs. 1.9) would be even more of an obstacle to obtaining psychosocial services than did patients. For attitudinal barriers, providers provided significantly higher ratings than patients for the following items: problems are not a priority (2.9 vs. 2.2), believing that counseling does not work (2.9 vs. 2.1), embarrassment at discussing these problems (2.7 vs. 2.0), believing these problems cannot be helped (2.6 vs. 1.9), and not wanting to deal with these problems (3.0 vs. 2.2).

Interestingly, with respect to factors that would facilitate the use of psychosocial aftercare, providers tended to underestimate their influence on patients' treatment seeking behavior. Patients were significantly more likely than providers to believe that a doctor's recommendation would influence their participation in an aftercare program (3.1 vs. 2.3, respectively; $p < .01$).

Overall, findings suggest that providers are quite aware of patient barriers to psychosocial aftercare services. In fact, providers viewed certain barriers as even more serious than patients. It appears that patients may be more receptive to psychosocial aftercare than may be commonly believed by providers. These results suggest that increasing provider knowledge of possible misconceptions of patient receptivity and barriers to psychosocial aftercare may engender greater motivation toward the implementation of collaborative care programs. Similarly, educating providers about the potential impact of their recommending psychosocial treatment to patients may be another fruitful avenue for increasing access to needed psychosocial services.

CONCLUSIONS

Oral and maxillofacial surgeons are in a prime position to target not only the physical needs of orofacial trauma patients but also the complex psychosocial problems that often co-occur. During the immediate period following injury, patients appear to demonstrate an openness and receptivity to psychosocial aftercare services. Moreover, patients report that a provider's recommendation would significantly influence their utilization of psychosocial care. Collaborative care interventions may be well-suited to capitalize on both patient and provider interest in needed psychosocial aftercare programs. Collaborative interventions are designed to meet the physical and mental needs of patients while also addressing major structural and attitudinal barriers to care. However, important provider barriers such as the lack of financial resources and trained clinical staff will need to be addressed before collaborative care programs can be successfully established. Further research is needed to determine the viability of this promising aftercare model in facilitating access to psychosocial treatment within oral and maxillofacial trauma care settings.

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