Barriers to the Collaborative Care of Patients with Orofacial Injury

Eunice C. Wong, PhD*, Grant N. Marshall, PhD

KEYWORDS

• Posttraumatic stress • Collaborative care
• Barriers • Orofacial

Establishing collaborative care programs within oral and maxillofacial trauma settings may be an effective means of linking patients to the psychosocial services (ie, substance abuse, mental health treatment) that they need. Research suggests that orofacial trauma survivors may be motivated to address a range of trauma-related psychosocial problems during the period immediately after injury.[1,2] Moreover, preliminary evidence from general trauma settings indicates that collaborative care interventions show substantial promise in facilitating integrative care, which addresses the physical and mental health needs of patients with traumatic injury.[3]

A key step in designing and implementing collaborative care programs is to understand the potential barriers to the provision and receipt of mental health services within the targeted clinical setting.[4] Until recently, knowledge concerning barriers to psychosocial care, specifically with respect to patients with orofacial trauma, has been limited. This article highlights recent research findings from 3 interrelated studies on the patients' and health care providers' perspectives of the barriers in developing psychosocial services within oral and maxillofacial trauma care settings. In the first study, Wong and colleagues[5] examined orofacial trauma patients' receptivity and perceived barriers to psychosocial services for mental health problems. In the second, Zazzali and colleagues[6] explored provider perceptions of patient need for psychosocial services, and the barriers to establishing such programs within oral and maxillofacial trauma settings. In the third article, Chandra and colleagues[7] examined the degree of concordance between providers' and patients' perceptions of barriers to psychosocial services. These studies were based on the interviews conducted with patients and providers at the Los Angeles County and University of Southern California (LAC+USC) Medical Center—a large level-1 trauma center catering to a mostly indigent population. Patients who were awaiting their 1-month follow-up visit at the oral and maxillofacial surgery (OMS) service for violence-related orofacial injuries were recruited. Providers included surgeons from OMS and otolaryngology. These studies answered important questions that are relevant for future efforts at establishing collaborative care programs in OMS settings. The following questions are addressed in this article: (1) To what extent are orofacial trauma patients interested in obtaining psychosocial aftercare services? (2) What are the key barriers to obtaining such services? (3) How cognizant are health care providers to patients' needs and barriers to psychosocial treatment? (4) What are some of the challenges that health care providers experience with respect to establishing collaborative care programs?

PATIENT PERSPECTIVES

Objective and Perceived Need

In general trauma care settings, only a fraction of patients with physical injury and documented mental health need obtain psychosocial

RAND Corporation, 1776 Main Street, PO Box 2138, Santa Monica, CA 90407-2138, USA
* Corresponding author.
E-mail address: ewong@rand.org

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services.[3,8] Wong and colleagues[5] 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 showed objective mental health need with respect to meeting criteria for probable PTSD (34%), major depression (35%), or AUD (31%). Of those who met the criteria for at least 1 mental health disorder, 80% met criteria for at least 2 disorders and 50% met criteria for all 3 disorders. Despite significant levels of mental health need, only 8% reported that they were 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 psychosocial services.

Perceived Barriers

Patients with orofacial injury expressing any interest in psychosocial aftercare were then asked about specific barriers that might impede their use of services. Patients were provided with a list of items representing different types of barriers (eg, 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 and colleagues[5] 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, patients with orofacial injury endorsed a total of 7 different types of barriers. The 2 most highly endorsed barriers were lack of knowledge about where to find services (81%) and concerns about financial cost (71%). In addition, more than half of those who were 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 the patients with orofacial injury endorsed barriers that indicated ambivalence toward obtaining professional help for psychosocial problems (eg, not wanting to deal with problems, not needing any help). Barriers that were of less concern (ie, those that were endorsed by fewer than 20%) included fear of family disapproval, concerns about racial and ethnic discrimination, worry about what others would think, and child care 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 for the provision of integrated services for chronic medical and psychiatric problems. To better understand the views of medical providers for collaborative care, Zazzali and colleagues[6] 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 noncompliance and reinjury. 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; and 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, or drug and alcohol abuse problems, providers tended to somewhat strongly agree (mean, 3.46; SD, 0.70). Moreover, providers somewhat disagreed with the statement that hospital departments were adequately addressing the psychosocial problems of patients with orofacial injury (mean, 2.31; SD, 0.90). Providers also perceived benefits from psychosocial programs, including improved compliance with medical care (mean, 3.51; SD,