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Primary Care Prescribing Psychologists in the Indian Health Service

Earl Sutherland Jr. · Steven R. Tulkin

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Abstract Some of the largest health care disparities are those related to services for American Indians and Alaska Natives (AI/ANs), who show significantly greater prevalence for diabetes, coronary heart disease, smoking, obesity, heavy alcohol use, depression, and PTSD than the general population. Given the recognition of the behavioral components of all of these conditions, the Indian Health Service, the federal agency responsible for providing comprehensive health care services to AI/ANs, has been focusing on increasing the integration of behavior health and primary care. One innovation has been to hire prescribing psychologists on primary care teams. This paper describes the role of a prescribing psychologist on three treatment teams at an IHS facility in Montana. Prescribing psychologists in the Indian Health Service can serve as valuable members of comprehensive care teams, providing exceptional wrap-around care for some of our most vulnerable and underserved citizens. This model could be an example of how a prescribing psychologist could contribute to primary care clinics in a variety of other settings.

Keywords Prescribing psychologist · Primary care · Co-morbidities · Indian Health Service · Behavioral health · Integrated care

E. Sutherland Jr.
Crow/N. Cheyenne Hospital, Crow Agency, MT 59022, USA
e-mail: Earl.SutherandJr@ihs.gov

S. R. Tulkin (✉)
California School of Professional Psychology at Alliant International University, One Beach Street, San Francisco, CA 94133, USA
e-mail: stulkin@alliant.edu

Research and practice in health psychology have yielded effective interventions for a multitude of medical problems that are seen in primary care (Gatchel & Oordt, 2003). More recent research has emphasized that integrating mental and behavioral health into primary care produces better patient care, improved efficiency, and potential cost savings (Hunter, Goodie, Oordt, & Dobmeyer, 2009; Vogel, Kirkpatrick, Collings, Cederna-Meko, & Grey, 2012). Medical comorbidities are higher among patients with mental health diagnoses, e.g., 2–3 times higher for diabetes and cardiovascular diseases and over 5 times higher for hepatitis (De Hert et al., 2011), and the impact of the comorbidities is bi-directional: Depression makes it less likely that patients will follow medical recommendations (for example diet, exercise and medication adherence), and feelings of powerlessness over a chronic medical condition can increase depression. These comorbidities demonstrate that effective treatment plans need to include both medical and psychological interventions, and that interventions are more successful when done in a primary care setting. Druss and Walker (2011) found that psychological interventions in medical settings were highly cost effective, particularly for the most complex patients with comorbid medical and mental health conditions. Katon et al. (2010) found that, for patients with comorbid depression and chronic disease (including diabetes and coronary heart disease), integrated care interventions led to significantly improved control of both the medical condition and depression, compared to usual care.

One of the barriers to implementing integrated care is the shortage of mental health providers, especially in public mental health services (Cunningham, 2009). A specific finding is that 96 % of the counties across the United States estimate a shortage of prescribers trained in psychological and behavioral disorders (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Shortages in both prescribing and

non-prescribing mental health professionals are continually reported for rural areas of the United States, and have been especially serious in areas serving Native American populations (Gone & Trimble, 2012). American Indians/Alaska Natives (AI/ANs) experience serious psychological distress 1.5 times more frequently than the general population (National Center for Health Statistics, DHHS, 2007), with the most significant concerns being the high prevalence of depression, substance use disorders, suicide, and anxiety (Beals et al., 2005). Specifically, AI/ANs experience PTSD more than twice as often as the general population (Surgeon General, 2001), and suicide is the second leading cause of death among 10–34 year old AI/ANs (Centers for Disease Control and Prevention, 2009). The Indian Health Service (IHS) is the federal agency responsible for providing comprehensive health care services to AI/ANs. Per person expenditures for the IHS user population were just $2,741 in comparison to $6,909 for the general population (Indian Health Service, 2011a), and less than 10 % of the funds allocated for clinical services was dedicated to mental health and substance abuse treatment in 2010 (Indian Health Service, 2011b). In his review of disparities in health services for AI/ANs, Gone and Trimble (2012) concluded that because of the dearth of mental health resources, "primary care physicians may well be the primary source of mental health treatment in the IHS, raising concerns that AI/AN mental health issues may be regularly overlooked or ignored" (p. 145). This is also true for the general population (Kessler & Stafford, 2008), but is "especially severe for low-income uninsured people…as public mental health services are seriously underfunded in many areas" (Cunningham, 2009, p. 490).

In recent years, IHS recognized the need for primary care providers trained in both psychopharmacology and behavioral health, and has recruited prescribing psychologists to meet the need in primary care clinics. All IHS health care providers are required to maintain an active state license or professional license. Health care providers must also be credentialed by their respective facilities in order to practice at an IHS facility. A provider's scope of practice is defined by their license and Service Unit credentials. Prescribing psychologists are licensed and credentialed members of their facilities' medical staffs. The first author is a licensed prescribing psychologist in New Mexico, and is credentialed by his Indian Health Service Medical Facility.

The Crow/N. Cheyenne Hospital in Crow Agency Montana is an IHS facility that provides services to members of the Crow and Northern Cheyenne tribes, as well as the urban Indian populations of Billings Montana and Sheridan Wyoming. The hospital is a 24-bed critical access facility that also provides out-patient medical, dental, optometric, physical therapy and behavioral health services. There are two additional outpatient satellite clinics affiliated with the hospital. Together these facilities comprise the Crow Service Unit (CSU). Approximately 18,000 people are served by the CSU. The Crow reservation is located in Big Horn County, which has a population density of less than three people per square mile. The reservation is approximately 85 miles east to west and 70 miles north to south. The rural nature of the community creates challenges in terms of access to specialized and ancillary health care services for tribal members and their families.

In 2009, CSU set a goal of fully integrating behavioral health with primary care in order to address challenges associated with access to comprehensive services. Although there is a consulting adult psychiatrist available in the Behavior Health department 3 days a month, there is generally a 12–16 week waiting list for an appointment. As part of the CSU initiative to improve access to comprehensive services, staff members are developing patient care teams. Patient care teams have been created for chronic pain, family practice, obstetrics/gynecology, pediatric, and podiatry services. A basic team typically consists of a physician, nurse practioner, nurse, and consulting pharmacist.

Patient Needs

Currently there is one prescribing psychologist employed at the CSU. This psychologist (the first author) provides direct patient care and consultation services through participation in three treatment teams as well as traditional out-patient psychotherapy appointments. The prescribing psychologist is a member of an outpatient family practice team, pediatrics/child behavior team and chronic pain team. Team participation involves seeing patients together with the primary care provider, having the patients see other team members at other times, or consulting with other team members regarding case formulations or treatment recommendations. Assessment and brief treatment may be provided by the prescribing psychologist as part of a patient's team appointment. Follow up treatment services are scheduled as needed. The prescribing psychologist is also available to assist other teams and departments, including the emergency room, inpatient and women's health services.

The work of the prescribing psychologist will be described by presenting three cases that are illustrative of the needs in this population group, but also likely reflect more general primary care needs in rural areas throughout the country.

Family Practice Team

The Family Practice Team (FPT) focuses on providing family medicine services to patients across their life span.

Diabetes is one of the most frequently diagnosed chronic diseases at CSU and diabetic patients make up a large proportion of the FPT's case load. At nearly 16.1 %, AI/ANs have the highest age-adjusted prevalence of diabetes among all US racial and ethnic groups (Barnes, Adams, & Powell-Griner, 2010). Depression is a commonly occurring co-morbid disorder for individuals with diabetes. This makes involvement of a psychologist particularly valuable from the earliest stages of disease identification and treatment planning. Depression has been found to interfere with adequate self-management of diabetes (Gonder-Frederick, Cox, & Ritterband, 2001), and has been noted as a major risk factor for patients with diabetes (Williams, Clouse, & Lustman, 2006). Individuals recently discharged from inpatient psychiatric treatment are seen by the FPT for medication reviews and refills until they can become established with the consulting psychiatrist.

Mr. Abel, a 39 year old male, was having trouble controlling his diabetes. He had recently been given a promotion and reported increased stress associated with his new work responsibilities. He previously had good control of his diabetes, but now was struggling to keep his sugar levels stable and was experiencing increasing feelings of anxiety. Over time he had seen a variety of health care providers and was only recently assigned to the family practice team. A review of his records showed that he had been started on buspirone, but never had the dose increased to a therapeutic level. Brief psychotherapy helped him identify better ways to cope with his new job demands and he responded well to an increase in his buspirone. An adjustment was made to his diabetes medications and his sugar levels soon returned to good control. Mr. Abel had never talked with a health care provider about his anxious feelings after being put on buspirone. He believed that it was appropriate to speak with his doctor only about medical issues.

Chronic Pain Team

Rural areas have very high rates of traumatic injuries. Rodeo, ranching and farming all have high accident rates. In areas of high substance abuse there are also frequent motor vehicle accidents. Injuries related to these circumstances result in large numbers of chronic pain patients at CSU.

The chronic pain team treats patients who have been diagnosed with chronic pain disorders. These patients tend to be older adults frequently diagnosed with co-morbid depression. Forlich, Jacobi, & Wittchen (2006) found that 30 % of chronic pain patients met criteria for a depressive disorder, and also that substance abuse disorders were more frequent among those with DSM-IV pain disorder. These co-morbidities make it difficult for primary care physicians to treat chronic pain, and, therefore, provide unique opportunities for prescribing psychologists. The prescribing psychologist plays an important role in identifying mental health issues that contribute to chronic pain, assessing potential substance abuse problems, and providing patients with alternative methods for managing long-term pain.

Ms. Beta, a 46 year old woman whose chronic pain had been effectively managed for chronic pain for the past year, now reported increased and diffuse pain with no apparent cause. Given the level of narcotic addictions in reservation communities, the chronic pain team is always concerned about possible drug diversion. The patient's physical exam did not reveal any new condition to account for her increased experience of pain. The team was, therefore, reluctant to increase medication. The prescribing psychologist was able to spend additional time with the patient to explore any mental health concerns that might contribute to increased pain levels. The psychologist learned that the increased sense of pain was stemming from a severe major depressive disorder, resulting from the recent loss of six close relatives in an 8 month time span. Ms. Beta responded well to an anti-depressant and brief psychotherapy and again became stable on her previous level of pain medication.

Pediatric/Child Behavior Team

There are no child psychiatry services available to the CSU. The pediatric/child behavior team provides diagnostic and treatment services for a full range of child and adolescent mental illnesses. The prescribing psychologist has had specialty training in clinical child and adolescent psychology.

Braden, a 6 year old male, had been treated effectively by the CSU pediatric/child behavior team for ADHD. Subsequently, his family moved to a non-reservation community. Through a series of false reports by an angry extended family member, the child was removed from his parents' custody by state social services. He resided with a non-Indian family for 3 months, during which time he had no contact with his biological family. During the family separation, Braden was seen by a pediatrician who continued his Ritalin and added an atypical antipsychotic and an anti-convulsant medication. When the child was returned to his family, an evaluation by the CSU pediatric/child behavior team was requested. Braden's parents were concerned about the numerous medications their son was taking, and what they saw as a dramatic change in his behavior. They described him as very lethargic and tired. The team gradually eliminated the antipsychotic and anti-convulsant

medications. At a 2-month follow up he was doing well at school and exhibiting normal behavior at home.

Olfson, Blanco, Linxu, Moreno, and Laje (2006) reported that in the United States, the estimated number of office-based visits by youth that included antipsychotic treatment increased from approximately 201,000 in 1993 to 1,224,000 in 2002. Most interesting is that the vast majority of prescriptions for antipsychotic medication in children were not for psychotic disorders. Instead, "visits with prescription of an antipsychotic included patients with diagnoses of disruptive behavior disorders (37.8 %), mood disorders (31.8 %), pervasive developmental disorders or mental retardation (17.3 %)" (p. 679). Only 14.2 % were for psychotic disorders. Further, Olfson et al. reported that fewer than one-half of antipsychotic-treated young children received a mental health assessment (40.8 %), a psychotherapy visit (41.4 %), or a visit with a psychiatrist (42.6 %) during the year of antipsychotic use. Clearly, a psychologist trained in psychopharmacology would be an asset in primary care settings, and would likely contribute to a change in these trends.

Prescribing Patterns

A full range of psychotropic medications is utilized by the prescribing psychologist. Prescription of antidepressants is most common, including adjusting doses, working with patients regarding side effects, and coordinating the medications with behavioral/psychological treatments, mostly Cognitive Behavioral Therapy. The prescribing psychologist also reduces or discontinues medications, such as benzodiazepines prescribed chronically for anxiety and depression, antipsychotics prescribed for anxiety and insomnia, and escalating doses of narcotics that were given in response to demands of chronic pain patients. With the high rate of obesity and diabetes in the CSU patient population (see Holm, Vogeltanz, Poltavski & McDonald, 2010), the use of atypical anti-psychotic medications is also very carefully monitored. The CSU utilizes an electronic health record (EHR). The EHR greatly enhances the prescribing psychologist's ability to collaborate with primary care providers regarding relevant laboratory tests, patient medications and treatment plans.

System Response to a Prescribing Psychologist

The medical providers of the CSU have been overwhelmingly supportive of the prescribing psychologist. Medical staff members are unanimous in their support for recruiting additional prescribing psychologists. Requests for medication consultations have quadrupled over the year that a prescribing psychologist has been available. The prescribing psychologist has been asked to aid in the differential diagnosis of inpatient cases and to provide medication recommendations to emergency room providers on an on-going basis. The position of Director of Behavior Health for the CSU was revised to specifically include duties related to the provision of psychotropic medication consultations and the advancement of mental health service integration with primary care services.

The problems of distance and weather often make it difficult for patients to keep appointments. The consulting psychiatrist considers the prescribing psychologist to be a valuable resource in providing medication refills for his patients and in providing follow up for laboratory orders. The continuous availability of an on-site prescribing psychologist also fosters timely and effective communication with psychiatry patients regarding medication interactions and side effects.

Future Plans and Conclusion

As funding becomes available, additional prescribing psychologists will be recruited at CSU to meet the goal of having a full time prescribing psychologist available to every primary care team. The Indian Health Service is also recruiting prescribing psychologists to work in other IHS facilities. With more personnel, we look forward to initiating outcome research that would document the increased effectiveness and cost savings related to utilizing prescribing psychologists. Until that point, anecdotal evidence of both clinical effectiveness and organizational acceptance is the best we can offer.

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