



He's Too Sick to Be Here: Challenges of Providing Hospice and Palliative Care in the Setting of Serious Mental Illness



Jordana L. Meyerson, MD, MSc^{1,2,3}, Kate L.M. Hinrichs, PhD^{1,2}

1. Veterans Affairs Boston Healthcare System, Boston, MA, 2. Harvard Medical School, Boston, MA, 3. Boston University School of Medicine, Boston, MA

Learning Objectives

- Identify at least three contributing factors to shortened life expectancy for patients with serious mental illness.
- Discuss challenges in palliative care delivery to the population with serious mental illness.
- Describe two specific benefits of palliative care for patients with serious mental illness.

Shortened Life Expectancy in Schizophrenia¹

Medical comorbidities

- Higher rates of diabetes and cardiac and pulmonary diseases
- Our Veteran had chronic obstructive pulmonary disease and hyperglycemia

Deleterious lifestyle habits

- Increased substance use disorders and tobacco dependence
- Our Veteran had tobacco dependence and an alcohol use disorder in remission

Delays in diagnosis and treatment

- Patients present with more advanced disease states
- Our Veteran's cancer was incurable due to inability to cooperate with diagnostics

Barriers to Accessing Palliative Care^{1,2,4}

Communication

- Patients with schizophrenia might have a withdrawn or bizarre affect making it difficult to build a therapeutic alliance

Lack of social supports

- Patients might not have designated agents to advocate for them, despite facing challenges in decision making

Care setting

- There might be division in mental and physical health services

Clinician factors

- Providers might not feel they have the skills to care for patients with serious mental illness

Background

- People with serious mental illness (SMI) have an estimated 13 to 30-year shortened life expectancy.¹
- In particular, people with schizophrenia have higher mortality and face barriers to accessing care.^{1,2}
- It has been found that those with schizophrenia are less likely to be referred to palliative care.²
- There is conflicting evidence on place of death for people with SMI, though they might be more likely to die in a care home setting.³

Our Veteran's Story

Mr. M was a 73 year-old veteran with schizophrenia diagnosed in his early 20s during his time in military service. His schizophrenia was brittle and marked by visual and auditory hallucinations that significantly impacted his functioning. He was incapable of making medical decisions and his sister was his activated healthcare proxy (HCP). Due to his impaired function, he was a long-term resident of a psychiatry ward within the Veterans Affairs (VA) system.

Our palliative care team was consulted to assist with clarifying the goals of Mr. M's care. He had been experiencing significant dysphagia and choking episodes of unclear etiology. These episodes often necessitated the Heimlich maneuver and ambulance trips to the hospital. He had declined work-up of the dysphagia, becoming combative with attempts at investigation. Our Ethics team was consulted for assistance, as his HCP was amenable to further diagnostics and was determined that he could undergo any procedures necessary. During a prolonged acute care hospitalization he was diagnosed with a large anaplastic thyroid cancer that was considered incurable.

Our Veteran in Hospice

Though Mr. M had resided in a long-stay psychiatry unit, it was felt that his symptoms could not be managed in that setting at end-of-life. Upon discharge from the hospital, he was admitted to our inpatient hospice unit. Fortunately this was housed on the same campus as his psychiatry unit and staff who knew him would come often to visit. He passed away peacefully two weeks later.

Myths and Truths About SMI and Dying^{2,5,6}

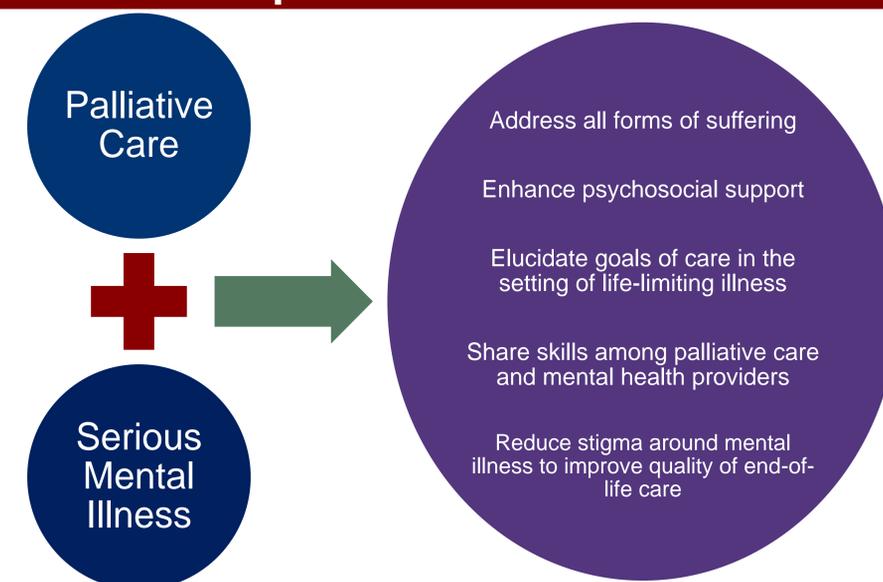
Myth

- People with SMI do not have capacity for end-of-life decision making.
- People with SMI are less likely to go to the hospital toward end-of-life.
- There is a clear place for people with SMI to receive end-of-life care.
- Stigma around SMI disappears as patients face end-of life.
- Communication with patients who have SMI is similar to communicating with other patients.

Truth

- Individuals with schizophrenia are interested in conversations around end-of-life care.
- In the last month of life, people with SMI are more likely to visit the emergency department.
- End-of-life in SMI requires collaboration with mental health not available in all care settings.
- Physical symptoms at end-of-life are often attributed to mental illness and overlooked.
- Providers should encourage patients to discuss delusions or hallucinations to better understand their experiences.

Relationship of Palliative Care and SMI^{1,2}



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Contact: Jordana.Meyerson@va.gov