

# Disparities in End-of-Life Care for Individuals with Severe Mental Illness



Kelly Park, MD,<sup>1</sup> Cybèle Arsan, MD,<sup>2</sup> Charles Manchee, MD,<sup>3</sup> Christine Annibali, MD,<sup>3</sup> Stephanie Cho, MD, MS<sup>3</sup>

<sup>1</sup>LAC+USC Medical Center; <sup>2</sup>Kaiser Permanente Medical Center, Oakland, CA; <sup>3</sup>Keck School of Medicine of USC



## Background

- Severe mental illness (SMI) is characterized by behavioral/psychiatric symptoms that cause significant functional impairment.<sup>1</sup>
- Individuals with SMI experience marginalization in many societal domains – including healthcare.<sup>2</sup>
- Inequities can obstruct access to palliative care during life-limiting or disabling medical illness.<sup>3,4</sup>

## Objectives

- Describe common disparities in end-of-life care for individuals with SMI.
- Discuss medical, ethical, and legal complexities in caring for SMI patients with life-limiting or disabling conditions.
- Identify opportunities for CL psychiatrists to advocate for improved palliative care in SMI.

## Factors Contributing to Disparities in SMI

### Lack of Knowledge



- Distinguishing between psychiatric and non-psychiatric etiologies of symptoms
- Inexperience with behavioral management
- Complex capacity considerations

### Stigma



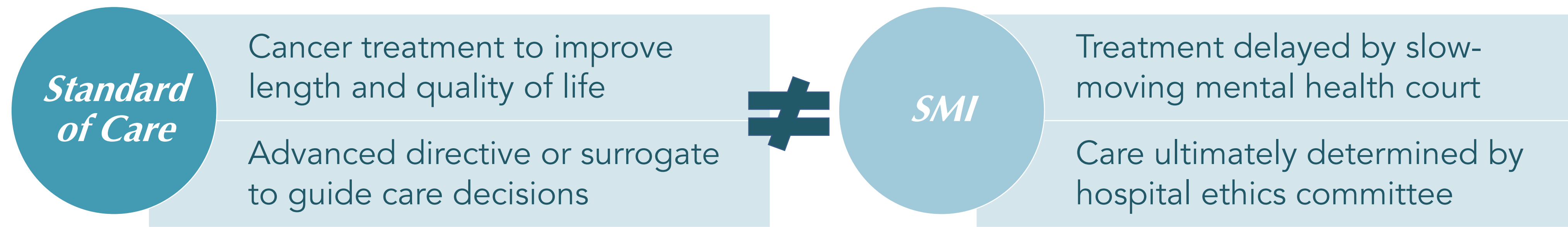
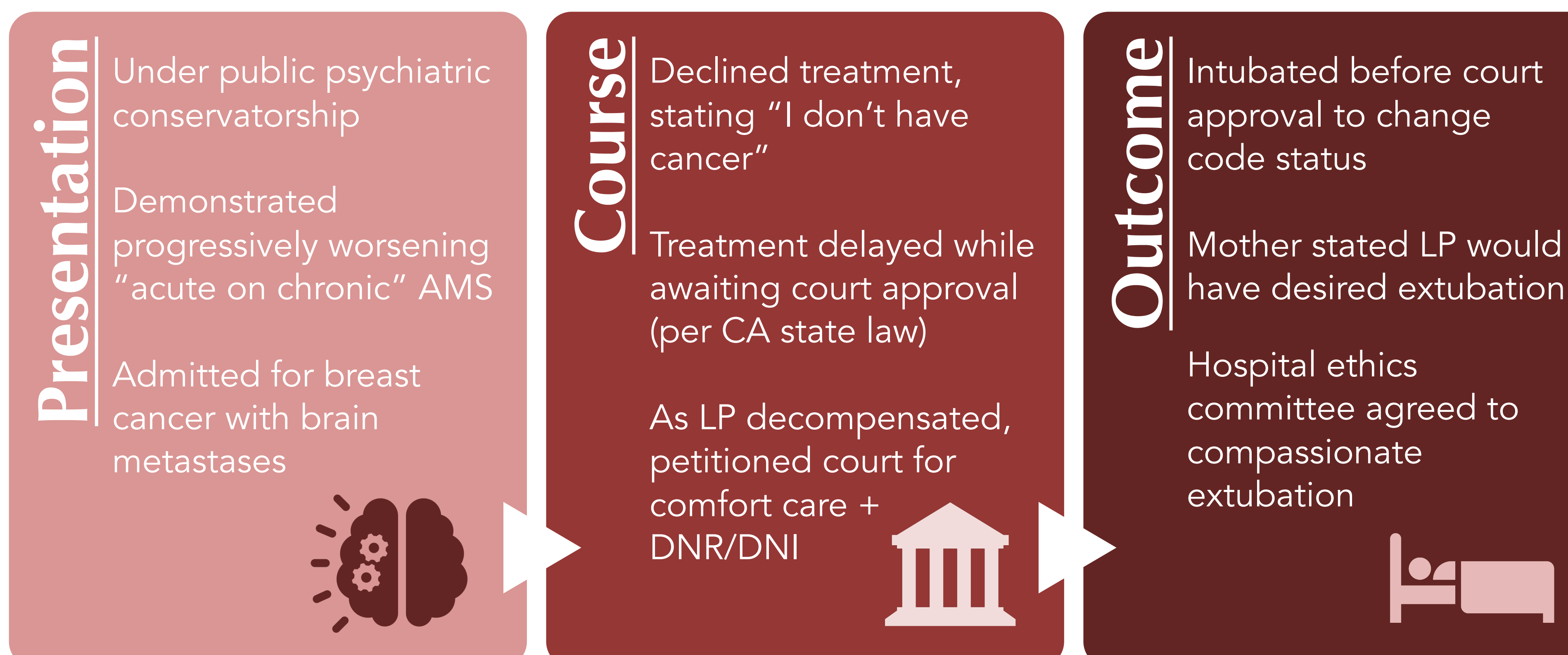
- Affective/automatic discomfort with neurodivergence<sup>5</sup>
- Constructed hierarchies of “acceptability” among mental disorders<sup>6</sup>

### Structural Factors

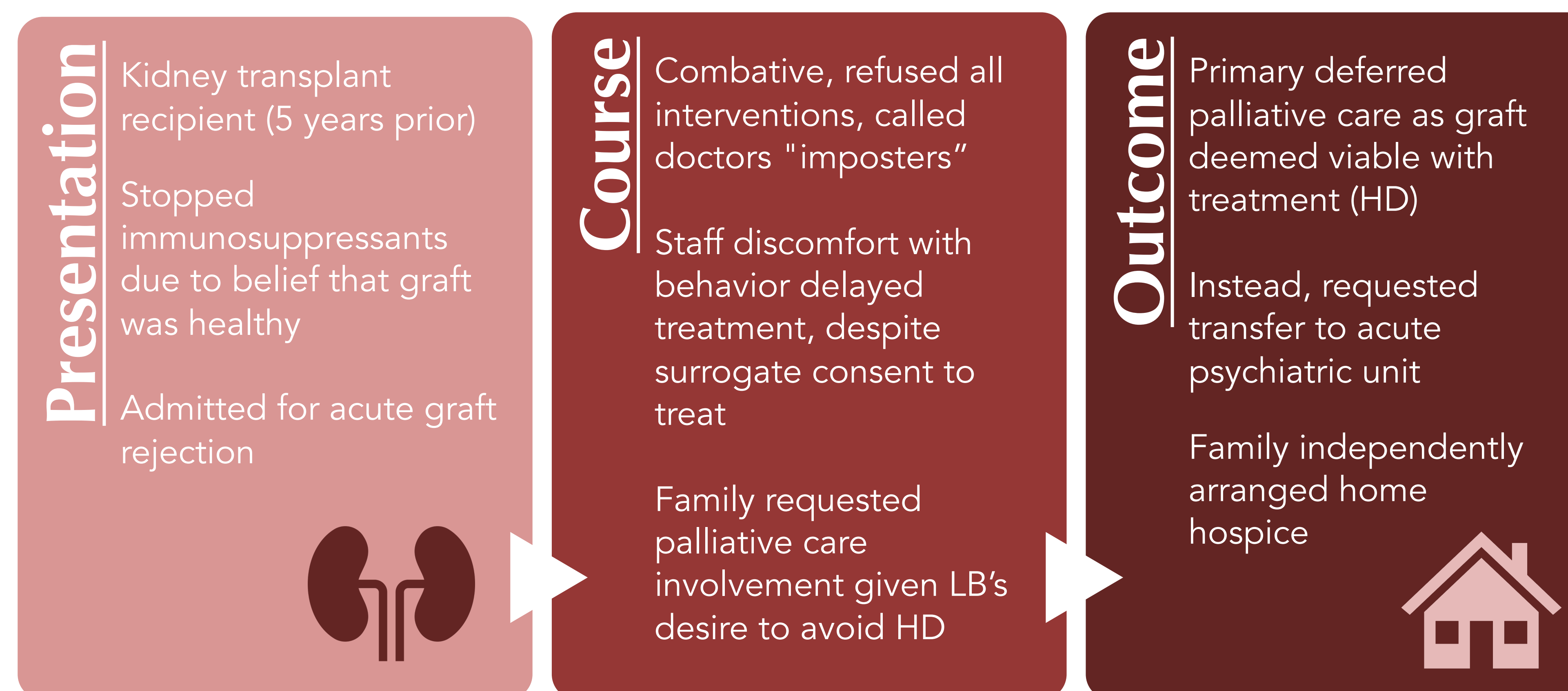


- Separation of psychiatric and medical hospitalization
- Forensic/legal limitations

## Case 1: LP, a 51 y/o with schizoaffective disorder



## Case 2: LB, a 60 y/o with no psychiatric history



## Discussion

- Despite varying presentations, these cases demonstrate common disparities in end-of-life care for individuals with SMI:

- Decreased access to & quality of palliative care
- Misattribution of symptoms to psychiatric illness
- Non-engagement of surrogate decision-makers
- Limited management of severe behavioral symptoms in non-psychiatric settings

- In both, disparities delayed appropriate treatments beyond meaningful benefit.
- While advocating for standard of care was necessary, it could not overcome treatment barriers, particularly when over objection.
- Early involvement of palliative care and goals-of-care discussions may have prevented non-beneficial interventions and suffering.

## Conclusions

- Healthcare disparities, particularly in end-of-life care, impact all individuals with SMI, regardless of etiology, care setting, or legal autonomy.
- Effective advocacy must navigate these barriers while prioritizing the individual’s specific needs.
- CL psychiatry must advocate for health equity given the field’s unique role in mediating broader medical, legal, and ethical conflicts.

## References

- SAMHSA, 2019 National Survey on Drug Use and Health (2020).
- De Hert et al, World Psychiatry. 10(2011).
- Relyea et al, Journal of Palliative Care. 34:1(2019).
- Baruth et al, International Psychogeriatrics. 33:2(2021).
- Boysen et al, J Soc Psychol. 160:3(2020).
- Choe et al, J Ment Health Policy Econ. 23:2(2020).

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