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



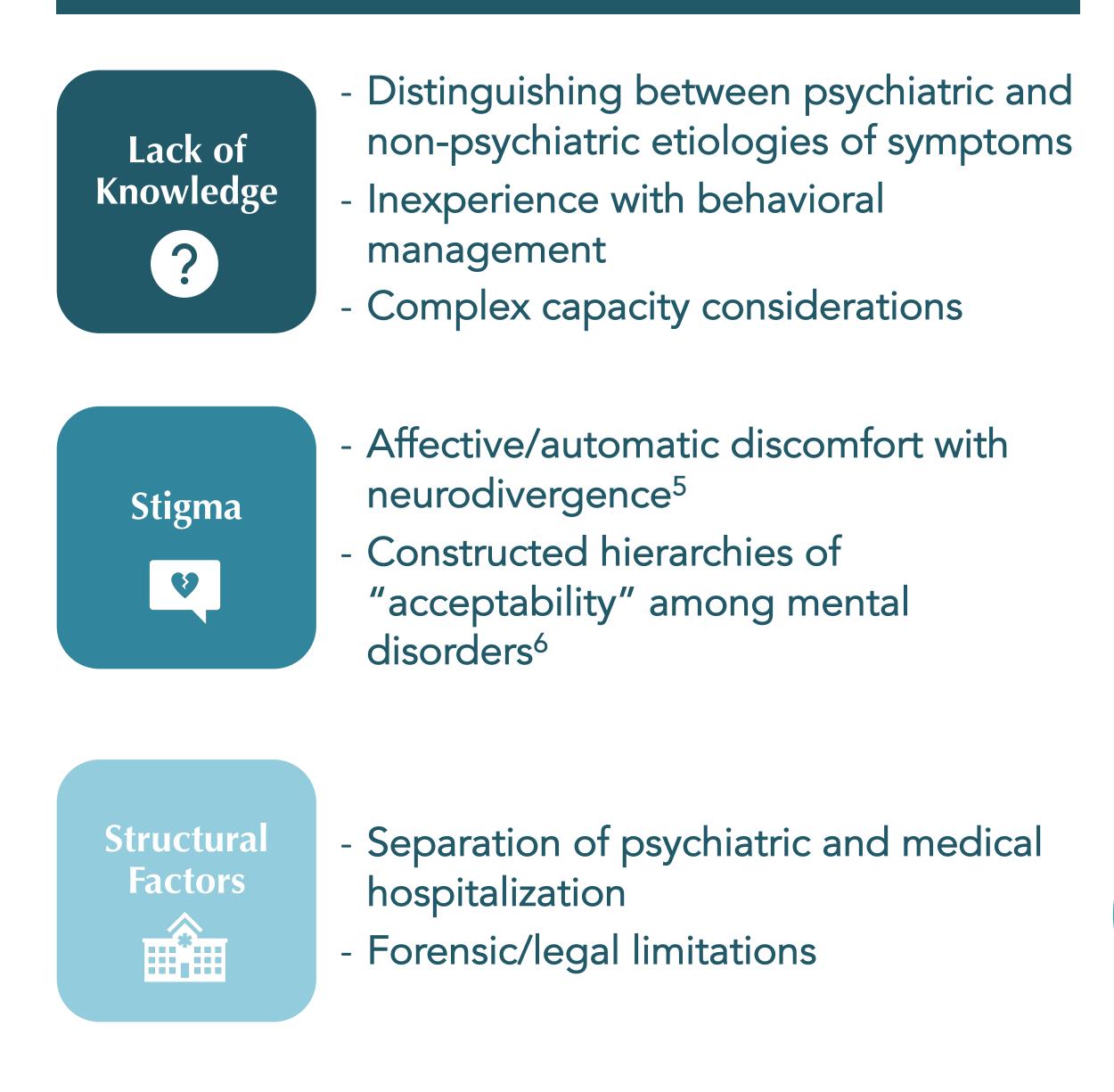
Background

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

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



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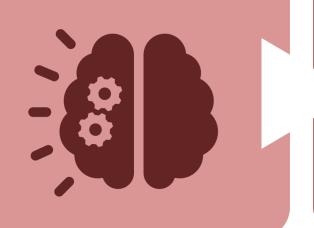
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Case 1: LP, a 51 y/o with schizoaffective disorder

Under public psychiatric conservatorship

Demonstrated progressively worsening acute on chronic" AMS

Admitted for breast cancer with brain metastases





Declined treatment, stating "I don't have Cancer"

Treatment delayed while awaiting court approval (per CA state law)

> As LP decompensated, petitioned court for comfort care + DNR/DNI



Cancer treatment to improve length and quality of life

Advanced directive or surrogate to guide care decisions



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

Kidney transplant recipient (5 years prior)

Stopped

mmunosuppressants due to belief that graft was healthy

Admitted for acute graft rejection



Combative, refused all interventions, called 2 doctors "imposters"

Staff discomfort with behavior delayed treatment, despite surrogate consent to treat

> Family requested palliative care involvement given LB's desire to avoid HD



Surrogate decision-making if decisional capacity is lacking

Palliative care involvement early and at patient/surrogate request



Intubated before court approval to change code status

Mother stated LP would have desired extubation



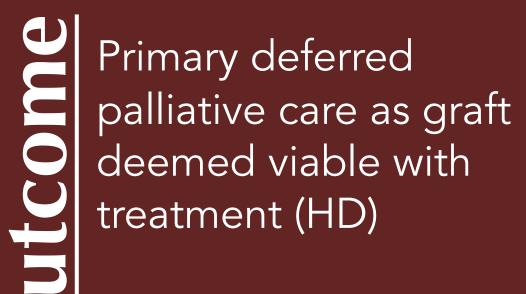
Hospital ethics committee agreed to compassionate extubation



Treatment delayed by slowmoving mental health court

Care ultimately determined by hospital ethics committee

SMI



Instead, requested transfer to acute psychiatric unit

Family independently arranged home hospice



Discomfort providing treatment with behavioral disturbance

Inadequate discussion or consideration of goals of care









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-ofcare discussions may have prevented nonbeneficial 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

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