

Integrating Mental Health Services Into Hospice Settings

The Palliative Care Psychiatric Program, San Diego Hospice and the Institute for Palliative Medicine, San Diego

Persons with incurable disease at the end of life face multiple complex medical and psychosocial issues. Throughout this illness and bereavement experience, palliative care aims to relieve suffering and improve quality of life, so that patients and families can realize their full potential to live, even when someone is dying. Untreated psychiatric symptoms of persons nearing death—either as sequelae of advanced, life-threatening illness or as a preexisting condition—stand in the way of this therapeutic aim.

Psychiatric symptoms can have an effect on physical health, quality of life, and ability to respond to disease-modifying treatments. They can also interfere with a patient's capacity to make decisions, understand his or her situation, interact with caregivers, or reach final goals. However, mental health services in hospice settings are severely lacking. Studies have suggested that in these settings significant psychiatric symptoms are prevalent, often unacknowledged (that is, they tend to be thought of as "normal" responses to anticipated death), not assessed, underdiagnosed, or undertreated. The need for psychiatrists to work with patients and families living with life-limiting illnesses has never been greater. Timely, accurate psychiatric assessment, diagnosis, and treatment are needed if a meaningful end-of-life experience is to be achieved.

Since July 2006 the Palliative Care Psychiatry Program at San Diego Hospice and the Institute for Palliative Medicine has worked to address the psychiatric and psychological issues that cause additional distress for hospice patients and their families. This one-of-a-kind program works

out of a large hospice facility with an average daily census of more than 1,000 patients. Here the Palliative Care Psychiatry Program combines clinical innovation, applied research, and education to improve mental health care for a vulnerable population with serious illness at a highly significant time for both patients and families.

In recognition of its commitment to help relieve suffering by providing psychiatric screening and treatment for patients receiving hospice care, mentoring and educating clinicians about psychiatric palliative care, and disseminating research results, policies, and practices, the Palliative Care Psychiatry Program was selected to receive an APA Gold Achievement Award in the category of academically or institutionally sponsored programs. The winning program in the category of community-based programs is described on page 1392. Each Gold Award winner receives a plaque and a \$10,000 prize made possible by a grant from Pfizer, Inc.

Incorporating mental health services into palliative care

Hospice care is rapidly growing in importance within the nation's health care system. In 2007 more than 1.4 million Americans received hospice care, a 47% increase from 2003. Currently, approximately 39% of all deaths in the United States occur among patients who are receiving hospice services. The number of hospice programs in the United States has exponentially increased to more than 4,700 since the first one opened in 1974.

The Palliative Care Psychiatry Program has been providing mental

health services for hospice patients since Scott Irwin, M.D., Ph.D., a psychiatrist-scientist, was recruited by San Diego Hospice and the Institute for Palliative Medicine in July 2006 to initiate and lead the program on a full-time basis.

Of the 4,700 hospices in the United States and the many more hospices and palliative care programs around the world, the Palliative Care Psychiatry Program is the only program exclusively focused on the mental health needs of hospice and palliative care patients, their loved ones, and their informal caregivers. The program addresses the underrecognition and undertreatment of psychiatric symptoms when the end of life is near. Standard pharmacologic treatments are frequently not appropriate for patients with a very limited life span, but the Palliative Care Psychiatry Program has shown that rapid screening, identification, and treatment of psychiatric symptoms—often within hours of initiating hospice care—can make a drastic difference in the lives of patients and their loved ones.

In addition to its focus on patient care, the Palliative Care Psychiatry Program provides a number of additional services, such as consultations for family members and informal caregivers who are suffering from psychiatric symptoms before the death of a loved one. These consultations often improve relationships between patients and the people who go on living.

Informing others about psychiatric palliative care

The Palliative Care Psychiatry Program also provides direction about psychiatric palliative care to the

worldwide hospice community and the psychiatric community, through mentoring, education, and dissemination of research results, policies, and practices. One way the program does this is by providing consultations for community physicians, pharmacists, and nurse practitioners throughout California through participation in a phone and e-mail help system that is run by San Diego Hospice and the Institute for Palliative Medicine.

In addition, the Palliative Care Psychiatry Program provides national and international dissemination of standards in palliative psychiatric care and status of research findings and has an academic affiliation with the University of California, San Diego (UCSD), School of Medicine and the UCSD Moores Cancer Center that fosters trans- and interdisciplinary education and research on palliative care psychiatry. This collaboration has led to a week-long palliative care psychiatry rotation at the Palliative Care Psychiatry Program that is required for UCSD psychiatry residents (approximately nine per year). The program also offers year-long elective palliative psychiatry rotations for senior psychiatry residents from UCSD (approximately two per year) and ongoing palliative care psychiatry interactive lectures and grand-round education for every third-year UCSD medical student (124 per year) and for family practice and internal medicine residents from eight residency programs operating in San Diego County (80 per year).

The Palliative Care Psychiatry Program mentors trainees on palliative care psychiatry research (11 to date, ranging from undergraduate nursing and B.S. students to psychiatry residents, as well as geropsychiatry and psychopharmacology fellows). It also offers training in basic palliative care psychiatry for palliative medicine fellows from across the United States and from developing countries such as Mongolia, Vietnam, Jordan, the Republic of Georgia, and Pakistan (approximately 15 per year). Presentations and grand rounds are also given by the program on local and national levels, which draw physicians, nurses, and pharmacists from many specialties.

Since the inception of the Palliative Care Psychiatry Program, it has actively identified, developed, and clinically tested rapid interventions to find and then reduce symptoms and sequelae of depression, delirium, and other psychiatric conditions among hospice patients. Before the Palliative Care Psychiatry Program was in place, no patients of San Diego Hospice and the Institute for Palliative Medicine were systematically, formally screened for depression, delirium, or other psychiatric issues. The Palliative Care Psychiatry Program has implemented and tested screening tools at San Diego Hospice and the Institute for Palliative Medicine for quick identification of depression and delirium among hospice patients. Now, all inpatients are formally screened (approximately 1,500 per year), and a screening tool specific to home-based patients (approximately 4,000 per year) is being piloted.

In the first 32 months of the program, referrals for palliative care psychiatry consults increased from almost zero in 2005 to more than 2,850 patient encounters with more than 715 patients (398 in 2008 alone), encompassing more than 3,360 hours of clinical care. In addition, hypnotherapy sessions increased from zero in 2005 to more than 827 over the past 32 months (436 in 2008 alone).

Overcoming obstacles

Because the Palliative Care Psychiatry Program was initiated before the true need for psychiatric expertise was recognized by the organization as a whole, the most significant hurdle was demonstrating a need for such services. By becoming an integrated part of the palliative care team, the Palliative Care Psychiatry Program was able to demonstrate the need for and utility of the clinical and educational services it could provide. The San Diego Hospice and the Institute for Palliative Medicine went from an attitude of "We haven't had psychiatry here for 30 years, why do we need it now?" to "How did we ever live without a psychiatry service?" The vice-president of medical affairs has stated, "The Palliative Care Psychiatry Program has significantly changed

the way we practice medicine here." Psychiatric services are now available to all of the more than 1,000 patients on the daily census and their family members.

Staffing and funding of the program

San Diego Hospice is one of the largest in the United States, with more than 800 staff and 500 volunteers providing care annually for over 4,000 adult and pediatric patients and their families, as well as 10,000 clients who receive services after their loved one's death.

The Palliative Care Psychiatry Program now consists of one full-time and four part-time psychiatrists and two hypnotherapists. These specialists all work as part of multidisciplinary hospice teams, which include palliative medicine physicians, nurses, pharmacists, social workers, spiritual care counselors, and complementary medicine specialists (including specialists in energy therapy, imagery, reiki, acupuncture, and aromatherapy). Need for services currently outpaces the program's ability to provide them.

The funding for the Palliative Care Psychiatry Program primarily comes from Medicare reimbursement and other fee-for-service insurance. In its first 32 months of existence, the program generated gross revenue in the amount of \$576,000, with net revenue breaking even with costs. In addition, general support is provided by benefactors of San Diego Hospice and the Institute for Palliative Medicine through philanthropy. Also, the John A. Hartford Center of Excellence in Geriatric Psychiatry at UCSD has provided grant funding directly to Dr. Irwin in support of his own academic development and to benefit research involving cognitive impairment and decision-making capacity among hospice-palliative care patients. A total of \$45,000 was provided for the grant period March 1, 2007, to June 30, 2009. Funding has also been received from the National Institute of Mental Health, the National Palliative Care Research Center, and the Archstone Foundation.

Research

The program has an applied research focus on the rapid identification and treatment of depression, the management of delirium, and the decision-making capacity and levels of unrecognized cognitive impairment among hospice patients. This includes a total of ten completed or ongoing applied research studies (both retrospective and clinical trials) regarding psychiatric diagnosis and screening, psychotropic medication use, and psychosocial issues such as caregiver stress.

In the hospice setting, Dr. Irwin and colleagues investigate better assessments and treatments for depression, delirium, and other mental health concerns to improve outcomes for those with advanced life-threatening illnesses. Research has included alternative routes for pain medication and administration, the use of short-term stimulants for depression, issues regarding voluntarily stopping oral intake of nutrition, unrecognized cognitive impairments, and psychiatry resident education in end-of-life issues. Dr. Irwin has contributed to more than 45 articles in this field.

The future

Although the traditional hospice model has always emphasized the

unique combination of physical, psychological, and spiritual needs that patients face at the end of life, the actual focus was centered primarily on physical symptoms. At the same time, psychiatry tends to focus on psychiatric illnesses, with only a limited focus on the psychiatric issues that persons with serious physical illness may experience, especially at the end of life. The social workers on hospice teams, those most frequently charged with managing the psychosocial issues of hospice patients and their family members, are often not trained to identify or treat psychiatric illness.

These realities have resulted in unnecessary suffering from psychiatric symptoms for patients at the end of life, a gap that psychiatrists are well poised to fill. However, there are currently relatively few psychiatrists trained to work with persons with serious physical illness. The model used by the Palliative Care Psychiatry Program allows the specialties of hospice care, palliative medicine, and psychiatry to converge and fill this gap within existing clinical models. The direction that the program provides about psychiatric palliative care through mentoring, education, and dissemination of research results, policies, and prac-

tices allows providers to understand and better care for all of the needs of this patient population and their family members. By using the Medicare hospice benefit and standard fee-for-service billing practices, the Palliative Care Psychiatry Program model for providing psychiatric palliative care can be successfully replicated in a number of settings.

There is a great need for psychiatrists to assist in palliative care focused on the relief of suffering, especially with the aging of the population. Psychiatrists with hospice experience can provide consultation to or be members of interdisciplinary palliative care teams. The model used by the Palliative Care Psychiatry Program is now a standard of care for the country. This model will be of tremendous benefit to patients, and as it becomes adopted widely, it will likely contribute to a substantial decrease in needless pain and suffering.

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