

Considerations for Transitioning to Palliative-Oriented Care in Serious Mental Illness: A Case Study

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Introduction

Despite the poor prognosis of severe and persistent mental illness (SPMI), especially with respect to higher mortality rates, end-of-life care discussions for these patients are lacking.¹ The need to recognize futility as it relates to this vulnerable population may be the most appropriate approach for psychiatric conditions in which no existing interventions are likely to result in a reasonably improved quality of life.^{2,3} However, because psychiatric disorders appear on a spectrum, with immense diversity in symptom intensity, duration, and recurrence within the same diagnosis, there are no prognostic criteria, staging guidelines, or universal terminology available for defining a psychiatric disorder as end stage or terminal.^{4,2} Without these criteria, determining the appropriateness of transitioning to end-of-life care in patients with SPMI is very difficult. In addition, hospice teams are often unequipped and uncertain of how to extend their existing treatments to SPMI patients.⁵ Unfortunately, the transition from curative to palliative care or hospice in patients with SPMI is met with even more challenges—clinical, legal, psychological, familial, and ethical factors—all of which require consideration and an interdisciplinary team to navigate.

Patient Case

Overview: Patient is a 52-year-old female with a past psychiatric history of schizophrenia, and no pertinent previous medical history, in which an interdisciplinary approach was used to pursue end-of-life care. The patient had most recently been stabilized with oral fluphenazine but became refractory to this medication, leading to psychiatric decompensation and medication nonadherence.

Hospital Course: Over the following 4 months, she required frequent intramuscular (IM) antipsychotics and benzodiazepines for agitation. The patient was started on fluphenazine long-acting formulation but did not display clinical improvement despite dose titration. Over this period, she had been declining food and water intake from worsening religious delusions, leading to a 36 lb weight loss. She was subsequently transferred to an inpatient medicine service from the extended acute psychiatric unit (EAU) for the stabilization of electrolyte abnormalities and severe malnourishment. In accordance with her religious delusions, the patient continued to restrict food and water intake on the medical unit, medically decompensating further. She also declined workup, such as blood chemistries and EKGs. No symptoms consistent with depression were appreciated, and she remained bright in affect and motivated to sacrifice her life to fulfill her presumed religious duty.

Treatment Considerations: In the past, the patient had trialed aripiprazole, clozapine, haloperidol, olanzapine, quetiapine, risperidone, and valproic acid without significant improvement. ECT was also not pursued since past trials showed minimal benefit and did not align with mother's (legal guardian) and patient's goals of care. The use of restraints to enforce tube feedings was also weighed, but ultimately her mother decided any additional measures would be traumatizing and against the patient's wishes given her declining quality of life and restricted freedom from decades of psychiatric hospitalizations.

Next Steps: Meetings between psychiatry, internal medicine, ethics, legal, social work, and the patient's legal guardian were held. It was determined hospice would best align with goals of care, while also preserving the patient's quality of life despite her refractory, chronic mental illness. The patient's code status was subsequently switched to DNR/DNI, and she continued to receive multidisciplinary care while awaiting hospice—general medical care from internal medicine, comfort care from palliative, and supportive psychotherapy from psychiatry. This extensive interdisciplinary collaboration ultimately allowed for the patient's involuntary psychiatric commitment to be lifted, her medications to be withheld, and for her transfer to a long-term facility on hospice status.

Discussion & Conclusions

Q1: How do end-of-life care discussions differ for patients with SPMI?

- Compared to other medical disciplines, where prognosis is often based on staging guidelines, psychiatric illness severity exists on a spectrum, oftentimes with significant diagnostic heterogeneity. Discussions regarding palliative and hospice care in psychiatry are therefore limited, as there is no universal agreement on when the progression of a psychiatric disorder has truly become refractory to treatment and is considered terminal or end-stage.²

Q2: What clinical pearls did this case highlight?

- Our case draws attention to the small subset of individuals with SPMI who are often in need of additional levels of support, such as the transition to end-of-life care, when the cost-benefit ratio of continuing treatment is too unfavorable.
- We further demonstrate our ability to utilize existing guidelines and related literature to outline the barriers that we encountered (**Figure 2**), which commonly prevent other multidisciplinary teams from transitioning patients with SPMI to end-of-life care as well.
- Discussing cases like these highlights that the SPMI population, a population associated with high mortality risk and poor quality of life, can be equitably transitioned to end-of-life care and treated like any other medical population whose chronic and debilitating illness is resistant to treatment and cure.

Q3: What does the literature show?

- There are several case reports of patients with treatment-refractory psychiatric symptoms who developed severe physical illness that warranted end-of-life care.^{6,3}
- However, our review of the current literature did not yield any studies examining patients transitioning to palliative or hospice care from serious mental illness alone. In fact, of the finite literature that does exist, most is limited to cases of decompensated anorexia nervosa.⁷
- The existing literature on end-of-life care for the SPMI population is also largely limited to surveys on provider perspectives and ethical commentaries.^{8,9}

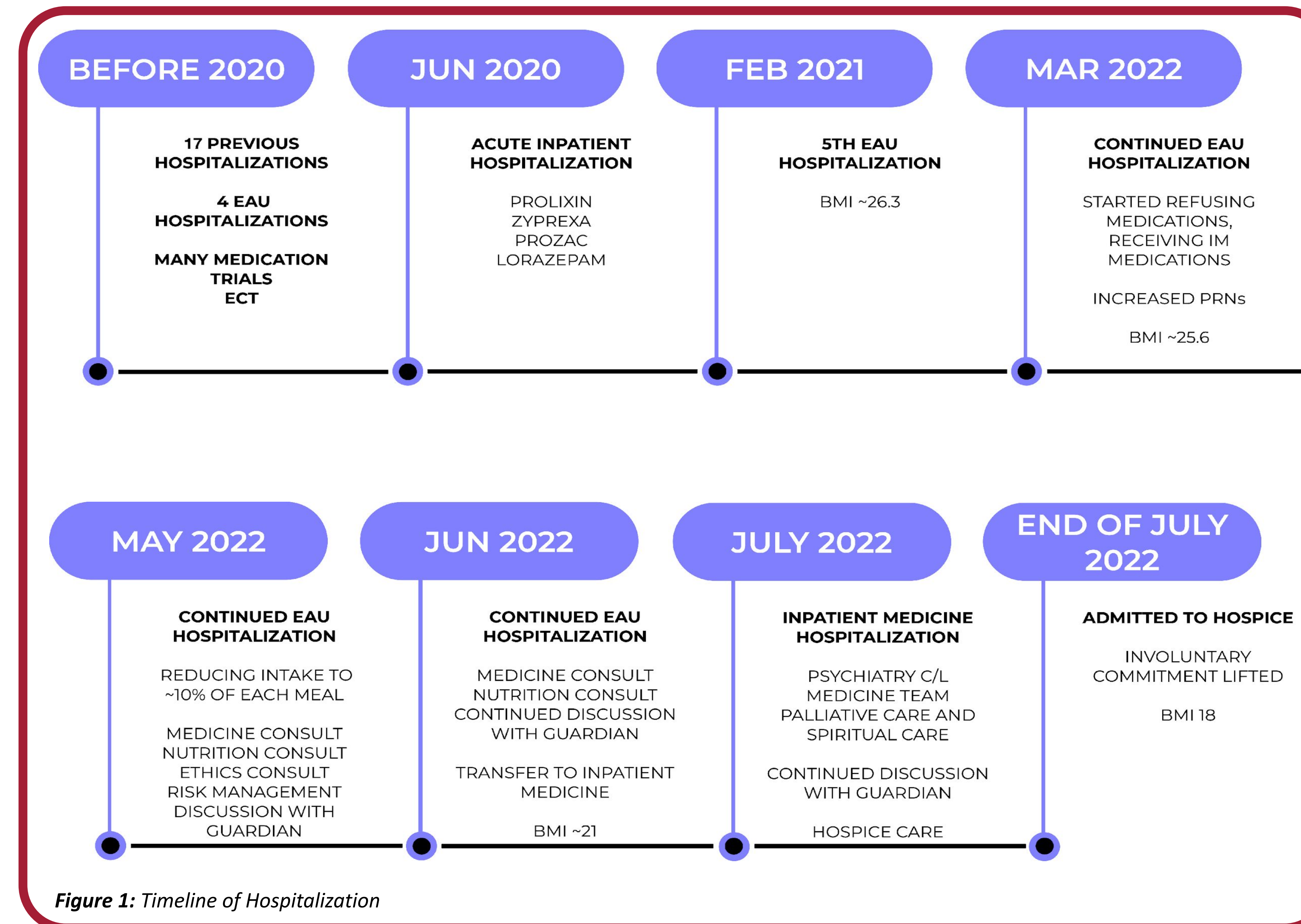


Figure 1: Timeline of Hospitalization

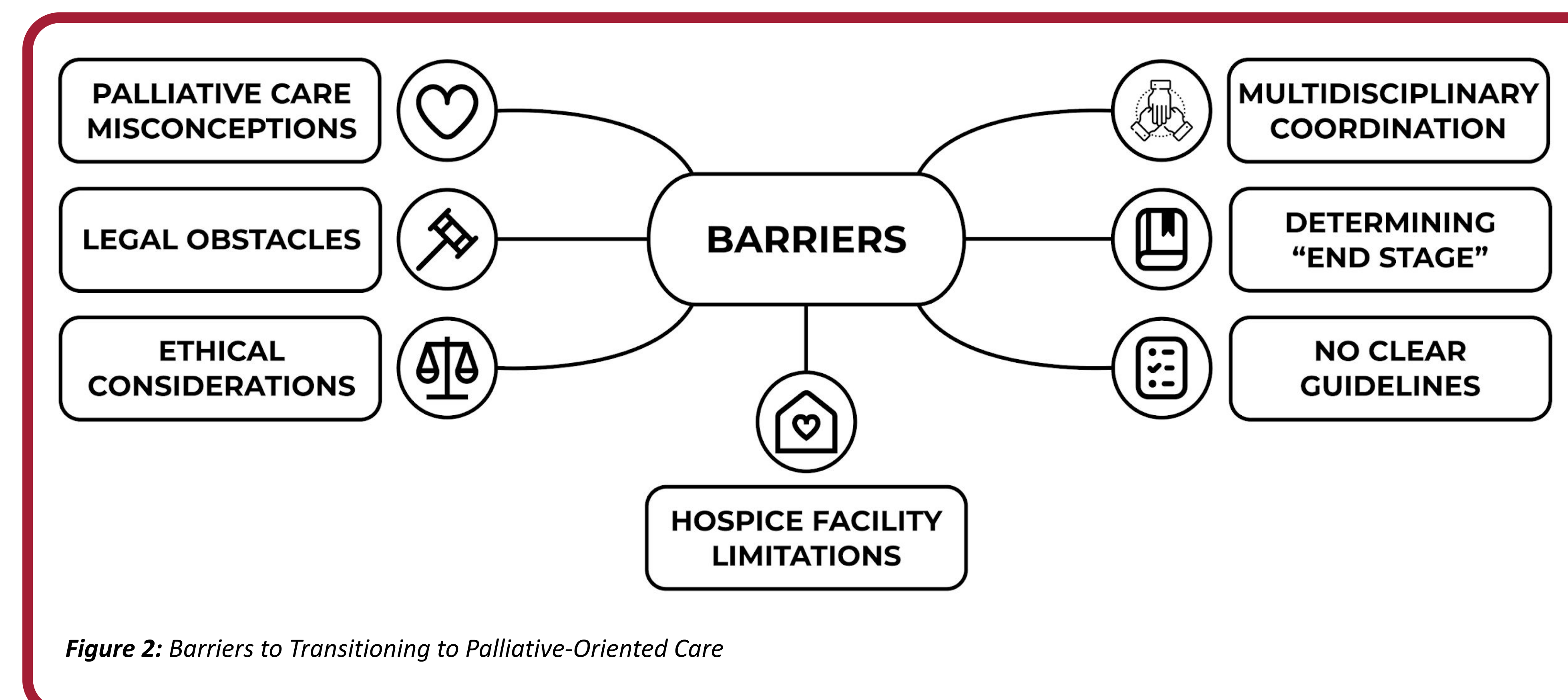


Figure 2: Barriers to Transitioning to Palliative-Oriented Care

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Disclosures

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