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Unmet Need for Mental Health Care among Veterans Receiving Palliative Care: Assessment is Not Enough

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Abstract

Objective—To determine whether inpatient palliative care teams' assessments of psychological distress affect receipt of in-hospital mental health care (psychotherapy, psychological support, and health and behavior interventions) for seriously ill veterans.

Methods—Retrospective review of medical records from 287 seriously ill veterans who received inpatient palliative care consults between 2008–2010 in the NY/NJ Veterans Healthcare Network.

Results—Of the veterans who were cognitively or physically able to answer questions on the Condensed Memorial Symptom Assessment Scale, 44% reported psychological distress. Of those with distress, 38% accessed mental health care. In logistic regression models adjusted for sociodemographic and health characteristics, there was no evidence that psychological distress reported during the palliative care consult was associated with subsequent mental health care receipt from any type of provider.

Conclusions—Efforts to increase mental health care to psychologically distressed palliative care patients need to convert assessments into receipt of needed care.

Keywords

Veterans; psychotherapy; access to care; anxiety; depression; palliative care

Veterans with comorbid psychological distress in addition to serious physical illnesses suffer from worsened pain control, reduced quality of life, and increased mortality.^{1–3} The Veterans Health Administration (VHA) provides palliative care, a team-based approach to

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symptom management and care transitions,⁴ to veterans suffering from life-limiting physical illnesses. Although the VHA directs palliative care teams to include at least a part-time psychologist and recommends that psychological needs of seriously ill veterans be addressed, the extent to which psychological needs among seriously ill veterans are assessed and managed by palliative care teams is unknown.

Recently, the VHA embarked upon initiatives aimed at improving access to mental health care for veterans.^{5–6} Psychological distress, including depression and anxiety symptoms, often co-occurs with advanced physical illness. If seriously ill veterans have unmet need for mental health care, interventions to improve mental health care access should be targeted at this population.

Guidelines for palliative care stress the importance of managing “psychological reactions” in addition to diagnosable mental illnesses among individuals with serious physical illnesses.⁷ Understanding the need for non-psychotropic medication mental health care is key to reducing psychological distress and its adverse consequences in this highly vulnerable group of patients. Whereas some psychotropic medications are effective for depression and anxiety at the end of life, many are not effective for subclinical levels of distress and have long lag times before positive effects are felt. Moreover, the American Geriatrics Society “Choosing Wisely” list cautions against use of antipsychotics, benzodiazepines, and sedative-hypnotics as first-line treatments for older adults with psychiatric symptoms (<http://www.choosingwisely.org/doctor-patient-lists/american-geriatrics-society/>). Alternative options, such as psychotherapy, psychological support, and palliative care, mitigate distress in individuals with serious physical illnesses without the risk of adverse drug events or side effects due to polypharmacy.^{4,8}

In this study, we review medical records of veterans who were hospitalized with serious physical illnesses to determine the extent of unmet mental health care need and whether psychological distress identified during the palliative care consult predicts provision of mental health care. Our goal is to identify targets for interventions to improve veterans’ access to mental health care.

Methods

Data and Sample

We reviewed medical records of 287 veterans hospitalized in Veterans Integrated Service Network (VISN) 3 acute care facilities with serious physical illnesses (advanced cancer, severe congestive heart failure or chronic obstructive pulmonary disease, or AIDS/HIV with comorbid cancer, cirrhosis, or cachexia⁹) who had a palliative care inpatient consult between fiscal years 2009 and 2010. We excluded consults that occurred in hospitalizations with acute psychiatric admissions, for chemotherapy, and with lengths of stay shorter than 48 hours. We abstracted information on the index hospitalization in the study period that included a completed consult and mental illness history at the same facility in the year before hospitalization. This project was approved by the Institutional Review Board of the James J Peters VA Medical Center.

Variables

Psychological distress—The VISN 3 electronic palliative care consult template includes the Condensed Memorial Symptom Assessment Scale (CMSAS),¹⁰ where individuals are asked to rate the frequency of psychological symptoms experienced over the past week (worry, nervousness, and sadness; 0=none to 4=almost constantly). Complete frequency data were not recorded for 22% (50/220) of those capable of responding to the CMSAS; we used a binary variable to indicate whether patients indicated they were sad, nervous, and/or worried during the consult. For those with severity data, we created a categorical variable distinguishing between no symptoms, at least one symptom rarely or sometimes, and at least one symptom frequently or almost constantly.

In-hospital mental health care receipt after the palliative care consult—Mental health care from palliative care providers included emotional/psychological support or psychotherapy from physicians, nurses, social workers, psychologists, or chaplains on the palliative care team. Mental health care from non-palliative care providers included emotional/psychological support, health and behavior interventions, counseling, support groups, and psychotherapy from psychologists, psychiatrists, social workers, nurses, and chaplains. Evaluative visits were not counted as mental health care.

Control variables for multivariate regression—Sociodemographic, physical and mental illness, and palliative care consult characteristics were included as control variables and are listed in Table 1.

Analyses

All analyses were performed with Stata SE/11.2 (StataCorp. 2009). Multivariate logistic regressions examined whether psychological distress assessed during the palliative care consult predicted mental health care receipt after the consult and controlled for sociodemographic, illness, and consult characteristics.

Results

Of those physically and cognitively capable of answering the CMSAS (n=220), nearly half (44.1%, n=97) reported psychological distress in the past week (see Table 1 for other descriptive statistics). Because ability to answer CMSAS questions was strongly positively associated with mental health care receipt (Pearson's $\chi^2=16.48$, degrees of freedom [df]=1, $p<.001$), we restricted the remainder of our analyses to the 220 veterans who were able to respond to the CMSAS.

Unmet need for mental health care

Sixty-two percent of patients who reported any psychological distress (60 of 97) and 65% who reported frequent distress (20 of 31) during the palliative care consult did not receive any in-hospital mental health care after the consult. Half of the patients who reported psychological distress (49 of 97) did not receive in-hospital mental health care before *or* after the consult.

Mental health care receipt – logistic regression

Psychological distress reported during the palliative care consult was not significantly associated with post-consult receipt of mental health care from a palliative care provider in unadjusted or adjusted logistic regression analyses (Unadjusted Odds Ratio [OR]= 0.97, 95% Confidence Interval [CI]= 0.32–2.97, Wald $\chi^2 = 0.003$, df=1, $p=.96$; Adjusted Odds Ratio [OR]= 0.95, 95% CI= 0.26–3.42, Wald $\chi^2 = 0.01$, df=1, $p=0.93$). When the outcome included mental health care from all providers after the consult, distress still was not significantly associated with mental health care receipt (OR= 1.34, 95% CI= 0.47–3.82, Wald $\chi^2 = 0.29$, df=1, $p=.59$; AOR= 1.28, 95% CI= 0.40–4.10, Wald $\chi^2 = 0.17$, df=1, $p=.68$). The results did not change when we performed sensitivity analyses among patients with symptom severity data (n=170) and with at least three days between consult and discharge (n=159; data not shown).

Conclusions

In this study, we quantified unmet need for mental health care among seriously ill veterans and determined the extent to which psychological distress was assessed and addressed by members of inpatient palliative care teams. Although psychological needs were assessed during palliative care consults for the majority of patients who were physically and cognitively able to respond to the CMSAS, there was no evidence that information gathered from assessments influenced provision of mental health care.

Although some veterans received in-hospital mental health care before the palliative care consult, half of those with psychological distress had no mental health care at any time during the hospitalization. Psychological distress is associated with increased inpatient health care use, worse evaluations of pain and quality of life, and greater risk of suicidal ideation and mortality.^{1–3,11–12} For these reasons, even transient psychological distress in the hospital may indicate a need for mental health care.

For individuals who are near death, the time between consult and discharge may be the only opportunity to address psychological distress. Only one-third of distressed veterans in our sample who died in the hospital received post-consult mental health care. The mean time between consult and death was 10.6 days (standard deviation=13.2), suggesting that there was an opportunity for mental health care provision. Mental health care for patients is beneficial during the dying process as well as earlier in the course of an advanced illness.¹³ These data identify a need to improve upon mental health care delivery in dying veterans.

Psychotherapy and psychological support alleviate depression and anxiety symptoms, improve ratings of pain, and carry no risk of interacting with other treatments.⁸ Moreover, the majority of seriously ill patients want to discuss illness concerns with their physician and desire to be free of anxiety.¹⁴ While the use of screening tools is an important first step to targeting care to those who need it the most, assessing needs is of little benefit if the information gathered is not used in a meaningful way.¹⁵

Our study is limited in that our results rely on information available in the medical chart, but this information is all that is accessible to future providers making decisions about a given

patient. Our sample is relatively small; with a larger sample size, we would have greater power to detect smaller significant relationships between distress and post-consult mental health care. This study, however, evaluates components of mental health and palliative care that are difficult to capture in larger administrative datasets for a group of vulnerable patients.

Future studies should examine reasons for the gap between assessment and action for individuals with recognized psychological distress and identify the types of care most beneficial for different levels and types of distress. Potential barriers to mental health care include treatment refusal, superseding clinical goals (e.g., attending to life-threatening critical care needs), and a lower priority placed by providers on mental health care receipt for individuals with serious physical illnesses. Interviews with providers are needed to understand the extent to which these barriers exist.

Although assessment of psychological distress and documentation of results of assessment by palliative care team members were present for the majority of our sample, we did not find evidence that documented distress influenced post-palliative care consult mental health care receipt. VHA mental health service improvement initiatives should focus on translating information gathered from assessments into useful action that mitigates psychological distress among veterans with serious physical illnesses.

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Table 1

Characteristics of Sample (N = 287)

Variable	N / Mean	% / SD
Sociodemographics and Physical Illnesses		
Age at index hospitalization	74.4	11.2
Race		
White only	151	52.6
Black only	110	38.3
Other / Not recorded in chart	26	9.1
Hispanic ethnicity	28	9.8
Advanced diseases meeting inclusion criteria ^a		
Cancer	163	56.8
CHF	56	19.5
COPD	96	33.4
Died during the index hospitalization	72	25.2
History of Mental Illnesses Noted in Year Prior to Hospitalization^b		
Major depression, depressive disorder, dysthymia	44	15.3
GAD, post-traumatic stress disorder, panic, agoraphobia	39	13.6
Adjustment disorder / reaction	31	10.8
Schizoaffective disorder or schizophrenia	18	6.3
Alcohol dependence / abuse	37	12.9
Drug dependence / abuse	27	9.4
Symptoms or History of Depression/Anxiety Noted During Hospitalization Before Palliative Care Consult		
	97	33.8
Characteristics of Palliative Care Consult		
Counseling listed as reason for palliative care consult request ^a	150	52.3
Palliative Care consult note completed by ^a		
Nurse	111	38.7
Physician	175	61.0
CMSAS assessment of sadness/worry/nervousness		
Assessed during consult	201	70.0
Not assessed due to patient physical or cognitive issues	67	23.3
Not assessed due to other or unknown reasons	19	6.6
Of those able to be assessed ^{a,c}		
Sad, Nervous, and/or Worried - Any	97	44.1
Sad, Nervous, and /or Worried		
No symptoms	84	38.2
At least one symptom rarely or sometimes	60	27.3
At least one symptom frequently or almost constantly	31	14.1
Severity missing ^d	45	20.4
Days between PC consult and discharge	10.3	14.4

Variable	N / Mean	% / SD
Receipt of Mental Health Care in Year Before Admission		
Non-medication mental health care ^e	70	24.4
Psychotropic medication ^f	107	37.3
Receipt of Mental Health Care During Hospitalization Before Palliative Care Consult		
Non-medication mental health care ^{e,g}	30	10.5
Psychotropic medications ^f	76	26.5
Receipt of Mental Health Care After Palliative Care Consult		
Non-medication mental health care from palliative care provider ^g	54	18.8
Non-medication mental health care from other care provider ^e	35	12.2
Psychotropic medication ^f	51	17.8

CHF = congestive heart failure, COPD = chronic obstructive pulmonary disease, CMSAS = Condensed Memorial Symptom Assessment Scale, GAD = generalized anxiety disorder SD = standard deviation

^{a)} Patients could have more than one

^{b)} Includes both current and historical diagnoses noted by a provider in the patient's problem list or medical history list during the year prior to hospitalization

^{c)} Percentage of the portion of the sample who was cognitively or physically able to answer CMSAS questions (n = 220)

^{d)} Symptom present but severity not recorded or symptom not assessed

^{e)} Emotional/psychological support from psychologists, psychiatrists or chaplains, and health and behavior interventions, counseling, support groups, and psychotherapy from psychologists, psychiatrists, social workers, nurses, and chaplains outside of the palliative care team

^{f)} Antidepressants, antipsychotics, and sedative/hypnotic/anxiolytics, excluding those prescribed for pain and intravenous sedatives such as midazolam

^{g)} Emotional/psychological support or psychotherapy from physicians, nurses, social workers, psychologists, or chaplains on the palliative care team