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

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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 and 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.* (Am J Geriatr Psychiatry 2014; 22:540–544)

Key Words: 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 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 to this population.

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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. Although 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 cachexia)[9] 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 (2009 StataCorp, College Station, TX). 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.

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