Mental Health Assessment at End of Life – Why Bother?

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CONSULTATION WITH CONSULTING PHYSICIAN

PHYSICAL SYMPTOMS

- MANAGEMENT OF INR
- MANAGEMENT OF DIABETES

PSYCHOLOGICAL SYMPTOMS

- MANAGEMENT OF SPMI
- MANAGEMENT OF BEHAVIORS

1 in 5 Americans experience a mental illness

1 in 25 Americans live with a serious mental illness

1.1% live with Schizophrenia
6.9% live with Major Depression
10.2 million adults have a co-occurring mental health and addiction disorder

2.6% live with Bipolar Disorder
18.1% live with Anxiety Disorders

NATIONAL ALLIANCE ON MENTAL ILLNESS, 2017
Patients with mental health conditions want to have their symptoms managed – and have the right to do so.

Mental health symptoms need to be managed like any other health symptom – period.

Ten Basic Principles of Mental Health Law
1. Promotion of Mental Health and Prevention of Mental Disorders
2. Access to Basic Mental Health Care
3. Mental Health Assessments in Accordance with Internationally Accepted Principles
4. Provision of the Least Restrictive Type of Mental Health Care
5. Self Determination
6. Right to be Assisted in the Exercise of Self-Determination
7. Availability of Review Procedure
8. Automatic Periodical Review Mechanism
9. Qualified Decision Maker
10. Respect of the Rule of Law

www.who.int/mentalhealth

NURSING ROLE
Understand of the natural trajectory of illnesses and conditions and critical decision-making points within this process.
Manage serious or life-threatening conditions, including symptom management and end-of-life care, must be evidence-based.
Provide discussion of advance care planning, goals of care, issues of advanced directive, and provision of psychosocial support for clients and their families of varying cultures.
Understand role of hospice and palliative care services, eligibility and how to access these services in their setting and community.
Provide attention to population-specific concerns across the lifespan.
Provide attention to psychosocial, cultural, and spiritual dimensions of care as specified by the patient and family.

SOCIAL WORK ROLE
Maintain social work ethics and values.
Maintain knowledge of the medical and social system that presents frequently present barriers to the patient.
Provide comprehensive assessment and appropriate interventions and treatment plans.
Establish individualized interventions and treatment plans based on patient’s abilities and decisions in palliative and end of life care.
Demonstrate attitude of compassion and sensitivity to patients right to self-determination and dignity.
Provide advocacy and patient’s rights to ensure that patients have equal access to resources to meet their biopsychosocial needs in palliative and end of life care.
Provide documentation for all practice with patients in the medical record.

Hospice & Palliative Care Nurses Association, 2015
National Association of Social Workers, 2014

ADJUSTMENT DISORDER
• Caused by significant changes or stressors
• Risk factor: ongoing stressor such as having a medical illness
• Complicated if pre-existing mental health condition or not resolved
• Symptoms include:
  • Feeling sad or hopeless about things you used to enjoy
  • Frequent crying
  • Worry, anxious, nervous
  • Trouble sleeping
  • Loss of appetite
  • Withdrawal from social supports
  • Avoid important things (work, bills, etc.)
  • Suicidal thoughts/behavior
• Starts within three months of a stressful event and lasts no longer than six months after the event.

National Institute of Mental Health, 2018
GENERALIZED ANXIETY DISORDER
• Excessive anxiety or worry for months and face several anxiety-related symptoms.
• Restlessness or feeling wound-up or on edge.
• Being easily fatigued.
• Difficulty concentrating or having their minds go blank.
• Irritability.
• Muscle tension.
• Difficulty controlling the worry.
• Sleep problems (difficulty falling or staying asleep or restless, unsatisfying sleep).

PANIC DISORDER
• Recurrent unexpected panic attacks, which are sudden periods of intense fear that may include palpitations, pounding heart, or accelerated heart rate; sweating; trembling or shaking; sensations of shortness of breath, smothering, or choking; and feeling of impending doom.
• Sudden and repeated attacks of intense fear.
• Feelings of being out of control during a panic attack.
• Intense worries about when the next attack will happen.
• Fear or avoidance of places where panic attacks have occurred in the past.

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)
• Marked fear of social or performance situations in which they expect to feel embarrassed, judged, rejected, or fearful of offending others.
• Feeling highly anxious about being with other people and having a hard time talking to them.
• Feeling very self-conscious in front of other people and worried about feeling humiliated, embarrassed, or rejected, or fearful of offending others.
• Being very afraid that other people will judge them.
• Worrying for days or weeks before an event where other people will be.
• Staying away from places where there are other people.
• Having a hard time making friends and keeping friends.
• Blushing, sweating, or trembling around other people.
• Feeling nauseous or sick to your stomach when other people are around.

GENERAL TREATMENT OPTIONS
• Psychotherapy.
• Support Groups.
• Stress Management.
• Medication.

SUCIDIAL IDEATION
Risks of suicide are higher in patients with a medical illness and INCREASE as the illness progresses.
• Family history of suicide.
• Rates of suicide are higher in patients with a medical illness and INCREASE as the illness progresses.
• Suicide ideation.
• Patients with uncontrolled pain are at a higher risk of suicide.

Risk Factors
• Rates of suicide are higher in patients with a medical illness and INCREASE as the illness progresses.
• Patients with uncontrolled pain are at a higher risk of suicide.
• History of trauma/abuse.
• Persistent pain.
• Access to firearms.
• Access to firearms.
• Serious/Chronic medical illness.
• Gender (women attempt/men more likely to die).
• History of trauma/abuse.
• Persistent pain.

SUICIDAL IDEATION
Over 90% of people who die by suicide experience mental illness.
**Chemical Abuse**
Excessive use can lead to need for behavioral agreement, lock box intervention, or possible discharge for cause due to safety concerns.

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**Mental Health Symptom**
**Hospice IDT Assessment**
**Referral**
**Mental Health Assessment**
**Implement Mental Health Care Plan**
**Holistic Approach**
**Monitor Symptom**
**Provider Consultation**

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<table>
<thead>
<tr>
<th>REFERRAL:</th>
<th>Social Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL HEALTH SYMPTOM</td>
<td></td>
</tr>
<tr>
<td>Social Work</td>
<td></td>
</tr>
<tr>
<td>Same Day Assessment:</td>
<td>Suicide Risk</td>
</tr>
<tr>
<td>Next Day/Visit Assessment:</td>
<td>Other Mental Health</td>
</tr>
</tbody>
</table>
ASSESSMENT:
MENTAL HEALTH SYMPTOM

Social Work

Generalized Anxiety Disorder-7 (GAD-7)
Palliative Grief Depression Scale (PDSG)
CAGE-AID Substance Abuse Screening Tool

Patient’s Goals

Individualized
Holistic
Current
Revisited

Mental Health Care Plans

Goal: Patient will exhibit increased peace and comfort.

Hospice physician will review and provide psychotropic medications in consultation with patient’s psychiatrist now that patient is homebound.

Hospice IDT will monitor patient’s mental health and PDSG will enable patient’s IDT to recognize symptoms earlier and manage them more effectively.

Hospice SW will provide bi-monthly counseling sessions—clinician will use guided imagery for stress reduction techniques.

Hospice chaplain will provide bi-monthly visits for spiritual support and prayer. Chaplain will utilize aromatherapy to reduce stress and provide a calm presence during the patient’s journey.

Hospice massage therapist will provide monthly visits for symptom management. Massage will help with stress reduction and relaxation as well as reduce anxiety and dyspnea.

Hospice volunteer will provide monthly visits to decrease isolation. Volunteer will provide meaningful legacy work.
How does your agency currently assess mental health?

How can you implement any of these ideas into your organization?

Do you have any ideas of how we can better serve our patients with mental health needs?