2015

Intricate Conversations: Caring for Clients with Severe Mental Illness

John D. Chovan
Otterbein University

Intricate Conversations

Caring for Clients with Severe Mental Illness

John D Chovan PhD DNP RN CNP CNS
PMHNP-BC PMHCNS-BC ACHPN AHN-BC
Assistant Professor, Otterbein University
Nurse Practitioner, Mount Carmel Hospice & Palliative Care

Acknowledgements

Doug Cluxton, MA, LPC
Manager, Bereavement Services
OhioHealth Hospice

Mount Carmel Hospice & Palliative Care Team

Department of Nursing, Otterbein University

Disclosures

- Dr. Chovan has no conflicts of interest to disclose.
- Although not planned, at some point, the discussion may include mention of off-label medication use.

Syllabus

- Introduction & Background
- Severe and Persistent Mental Illness 101
- Challenges to Care
- Intricate Conversations Framework
- Operationalizing the Framework
- Charge to the Profession
- Wrap-Up

Objectives

1. *Describe* the **characteristics** of persons living with severe mental illness who intersect with hospice and palliative care, and their **communication challenges**.
2. *Describe* the **Intricate Conversations framework** for understanding the special needs of patients and family members with mental illness.
3. *Identify* **proposed approaches** to optimizing quality of life of persons with severe mental illness through **Intricate Conversations**.

Introduction & Background

Intricate Conversations

Introduction & Background

GOALS OF CARE / PALLIATIVE CARE PERSPECTIVE

Difficult Conversations

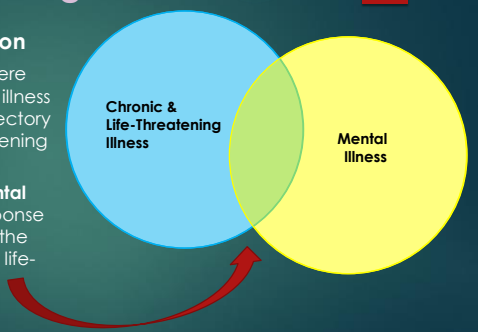
- We try to avoid them
- They are necessary
- Promote appropriate, client-centered care
- Meet the client where they are

Intricate Conversations

- Layers on the special needs of persons with severe mental illness
- Stigma of conversation compounded by stigma of mental illness
- Strengths model
- Meet the client where they are

Introduction & Background

- **Scope of the Discussion**
  - Persons **living with** severe and persistent mental illness journey along the trajectory of a serious, life-threatening illness.
  - Persons for whom **mental illness emerges** in response to their journey along the trajectory of a serious, life-threatening illness.

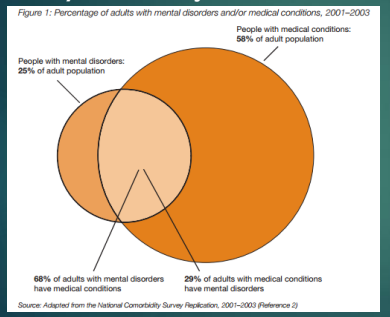


Introduction & Background

- The time is now
- Convergence of national energies
  - Quality and cost-effectiveness
  - Persons with terminal and life-threatening illnesses
  - Mentally ill persons
  - Patient-Centered Care
  - Evidence-Based Practice

Introduction & Background

The Synthesis Project – RWJ Foundation, 2011

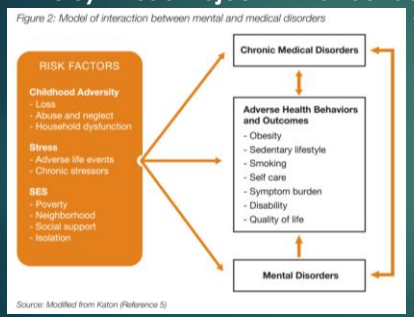


Comorbidity is the rule rather than the exception.

- elevated symptom burden, functional impairment, decreased length and quality of life, and increased costs.

Introduction & Background

The Synthesis Project – RWJ Foundation, 2011



The pathways causing comorbidity of mental and medical disorders are complex and bidirectional.

- medical disorders may lead to mental ones
- mental conditions may place a person at risk for medical disorders, and
- mental and medical disorders may share common risk factors.

Introduction & Background

The Synthesis Project – RWJ Foundation, 2011

Models that integrate care to treat people with mental health and medical comorbidities have proven effective.

- **"The most effective treatment for persons with comorbid mental and medical conditions involves a 'collaborative care' approach . . ."**

Introduction & Background

National Energies – Quality & Cost Effective Healthcare

- **US Department of Health and Human Services – *Strategic Plan 2014-2018***
  Strategic Goal 1: Strengthen Health Care

A. Make coverage more **secure** for those who have insurance, and extend **affordable** coverage to the uninsured
B. Improve health care **quality** and patient safety
C. Emphasize primary and **preventive care**, linked with community prevention services
D. Reduce the growth of health care costs while promoting **high-value, effective care**
E. Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations
F. Improve health care and population health through meaningful use of health information technology

Introduction & Background

National Energies – Terminal & Life-Threatening Illnesses

- **Institute of Medicine (2014) – *Dying in America***

1. Ensure **access** to care when approaching end of life.
2. Develop and adopt **quality standards; tie to reimbursement**.
3. Support **specialized training** of healthcare professionals.
4. Support quality care **consistent with client values, goals, and informed preferences**.
5. Advocate for and use **fact-based information** about care of people with advanced serious illness to encourage advance care planning and informed choice based on the needs and values of individuals.

Introduction & Background

National Energies – Terminal & Life-Threatening Illnesses

- **Institute of Medicine (2014) – *Dying in America***

1. Ensure **access** to care when approaching end of life.
2. Develop and adopt **quality standards; tie to reimbursement**.
3. Support **specialized training** of healthcare professionals.
4. Support quality care **consistent with client values, goals, and informed preferences**.
5. Advocate for and use **fact-based information** about care of people with advanced serious illness to encourage advance care planning and informed choice based on the needs and values of individuals.

Introduction & Background

National Energies – Caring for persons with mental illness

- **National Institute of Mental Health**
  Strategic Research Priorities

Strategic Objective 2: Chart Mental Illness Trajectories to Determine **When, Where, and How to Intervene**

Strategic Objective 3: **Develop New and Better Interventions that Incorporate the Diverse Needs and Circumstances of People with Mental Illnesses**

Strategy 3.3: **Strengthen the application of mental health interventions in diverse care settings by examining community and intervention delivery approaches and how they may affect intervention outcomes.**

Who are our Clients with Severe Mental Illness?

Intricate Conversations

Severe Mental Illnesses

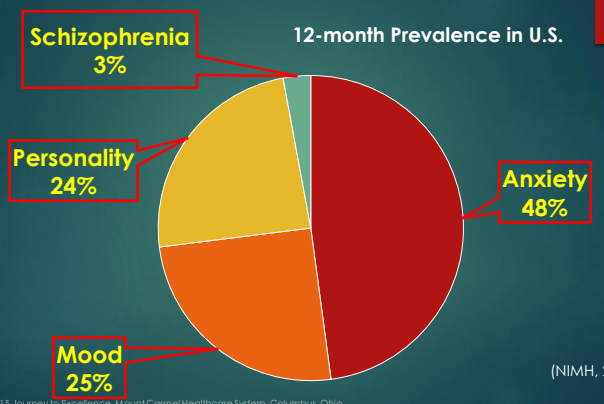
Thought Disorders
- Schizophrenia

Mood & Anxiety Disorders
- Persistent Depressive Disorders
- Bipolar Disorders
- Generalized or Specific Anxiety Disorders
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder

Personality Disorders
- Borderline Personality Disorder
- Dependent Personality Disorder
- Antisocial Personality Disorder

American Psychiatric Association (APA). (2013). *Diagnostic & statistical manual of mental disorders* (5th edition). Washington, DC: Author.

DSM 5



Severe Mental Illness - Exemplars

Thought Disorders
- **Schizophrenia** ✓

Mood & Anxiety Disorders
- Persistent Depressive Disorders
- Bipolar Disorders
- Generalized or Specific Anxiety Disorders
- **Obsessive-Compulsive Disorder** ✓
- Post-Traumatic Stress Disorder

Personality Disorders
- **Borderline Personality Disorder** ✓
- Dependent Personality Disorder
- Antisocial Personality Disorder

Severe Mental Illness - Exemplars

Thought Disorders

- Schizophrenia
  - Difficulty identifying reality, thinking clearly, interacting socially; often characterized by paranoia, hallucinations
  - Epidemiology
    - Onset: mid- to late-20s; males > females – 4:3
  - Traits
    - Positive symptoms (e.g., hallucinations, delusions); SAPS, PSRS, PANSS
    - Negative symptoms (e.g., avolition, anhedonia); NSA-4, BNSS, PANSS
    - Communication difficulties → interpersonal relating
  - Impact
    - Morbidity – side effects of antipsychotic drugs, self-medication, disregard for self-care
    - Mortality – life expectancy decreased by 10-25 years

Case Example: Virginia H.

- 52-year-old bereaved mother
- Primary caregiver of son Denny until he died at age 31 from colon cancer
- Dx: schizophrenia, bipolar disorder ?
- Tx: Psychiatric treatment → psychotropic medication
- Bereavement client for ~ nine months

Challenges to Care

Thought Disorders

- Schizophrenia
  - Poor insight → impact on autonomy
  - Communication with team and others
  - Veiled descriptors of symptoms
  - Treatment: antipsychotics

Severe Mental Illness - Exemplars

Mood & Anxiety Disorders

- Obsessive-Compulsive Disorder
  - Intrusive thoughts that cause uneasiness, apprehension, fear or worry and repetitive behaviors to reduce the anxiety
  - Traits
    - Rituals take up lots of time; good insight into disease; often creates interpersonal difficulties – OCI, Y-BOCS
  - Impact
    - Time consuming rituals, thoughts → negative impact on ability to function in school, work, and family settings.

Case Example: Steve M.

- 45 year-old hospice patient living at home; cared for by his wife of 13 years
- Had 2 daughters, ages 8 and 10
- Described as "workaholic" by wife
- Had been an avid distance runner
- Dx : Lung cancer – Had stopped smoking x 10 yr ago
- Obsessive-Complusive Disorder – No hx of mental health treatment
- Angry and avoidant/distancing
- Rituals had included repetitive vacuuming of his home office carpet

Challenges to Care

Mood & Anxiety Disorders

- Obsessive-Compulsive Disorder
  - Impact of rituals on time management
  - As functional levels decline, can no longer perform rituals
  - Treatment: SSRIs, anxiolytics; talk therapy

Severe Mental Illness - Exemplars

Personality Disorders

- Borderline Personality Disorder
  - Marked impulsivity; unstable affect, relationships, and self image
  - Traits
    - Black & white thinking; deficits in conflict resolution; MBPDS, ECS
    - Inconsistent interpersonal relationships, manipulative, risk for self harm
  - Impact
    - Evoke strong reactions in caregivers; splitting behaviors, need good boundaries & team approach, multiple hospitalizations, self harm behaviors to "feel something".

Case Example: Nancy C.

- 65 yr-old single hospice patient, diagnosed with Stage IV breast cancer, lived alone
- Dx: Borderline Personality Disorder
- Inconsistent past mental health tx and none for past 10 years
- Hx of frequent calls to Triage and On Call service complaining of vague symptoms, refused offers of home visit
- Was difficult for on call to end phone calls – "Don't hang up on me!"
- Complained that only her primary nurse, Tina, was competent. Consistently demanded that only Tina visit her.

Challenges to Care

Personality Disorders

- Borderline Personality Disorder
  - Splitting behaviors
  - Unstable personal relating
  - Safety
  - Treatment: Dialectical Behavior Therapy

Additional Challenges to Care

Patient Autonomy

- Patient Self-Determination Act
  - Informed consent
  - Right to refuse any medical treatment
- Advance directives
- Is the patient able to make their own healthcare decisions?
  - Capacity versus Competence
  - Competence is determined by a judge
  - Surrogate decision maker
  - Capacity can be time variant
  - Mental illness can have an impact on insight, judgment, and critical thinking

Additional Challenges to Care

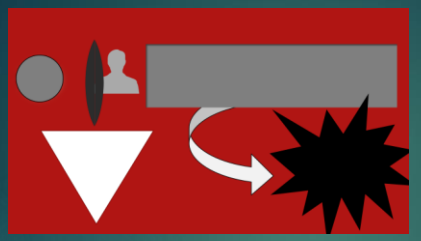
Patient Autonomy

- Is it OK for a person to make health care decisions based on their own perception of reality rather on the common perception of reality?

- **Epistemic Authority**
  - "Knowledge claims are worthy of regard by listeners and worthy of response by those with a duty to care." (Rentmeester, 2014)
  - May be different from what is commonly held.
  - Is in no way an invalid interpretation of reality.

Additional Challenges to Care

Affect	mood, impact of mood, mood changes; BDI
Behaviors	safety, rituals, adherence, self-care, self-image, self-respect
Decision-Making	autonomy, epistemic authority, lack of a support structure, hope, goals of care, capacity vs competency, guardian, surrogate, advance directives, code status
Interpersonal Relationships	families are often gone, support structure, trust, respect, guardian, case workers

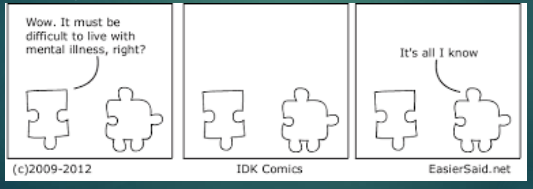


The Intricate Conversations Framework

Intricate Conversations

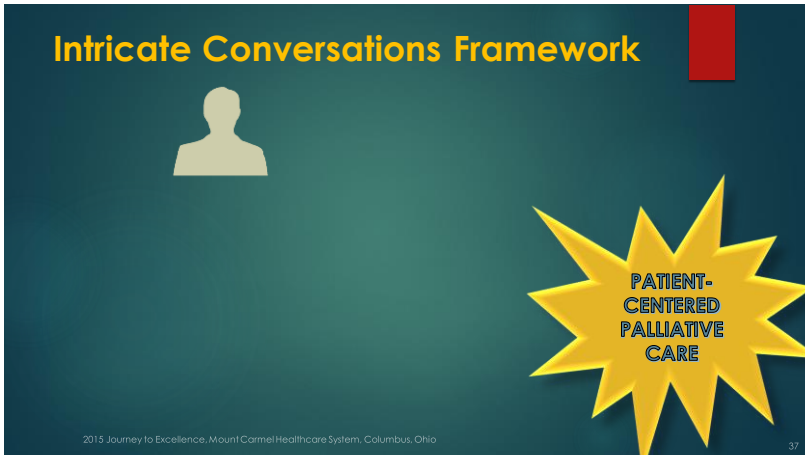
Intricate Conversations Framework

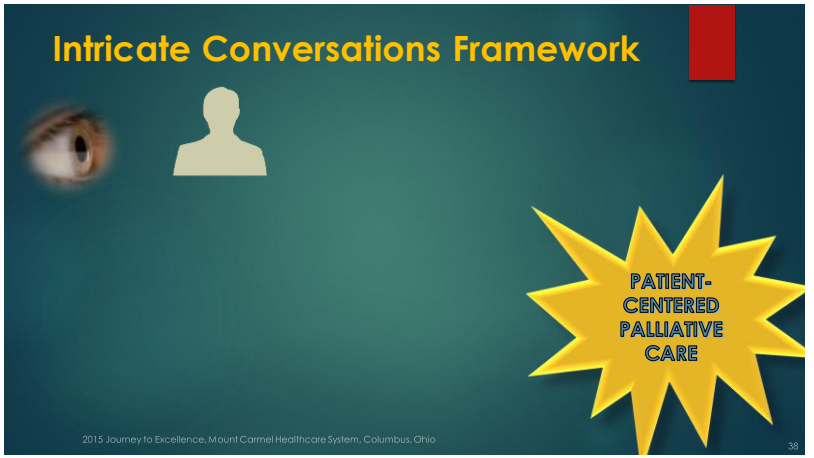
- Understand your own beliefs & misconceptions
- Build trust and rapport
- Learn about their environment
- Understand features of their mental illness
- Be respectful
- Therapeutic use of self



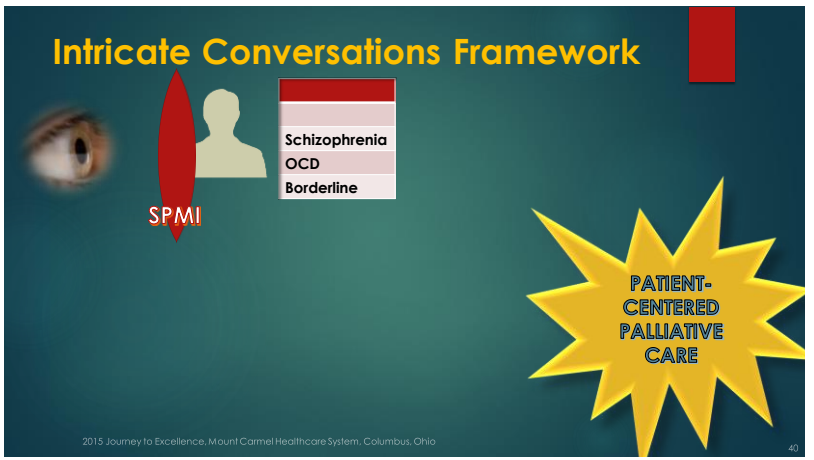
Intricate Conversations Framework

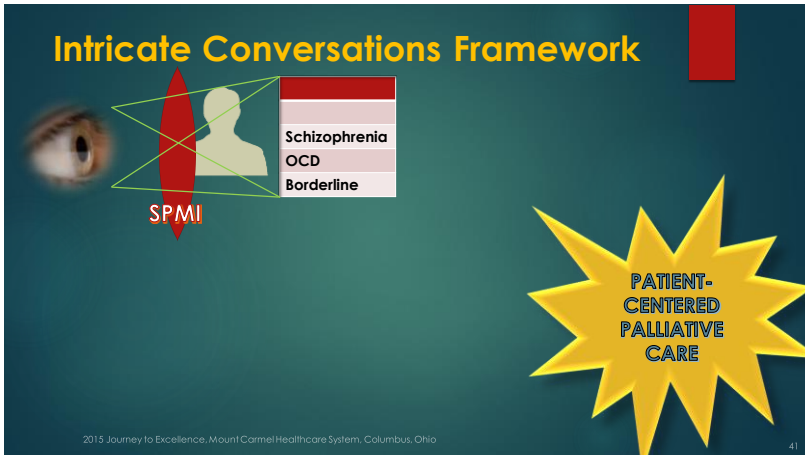
Intricate Conversations Framework

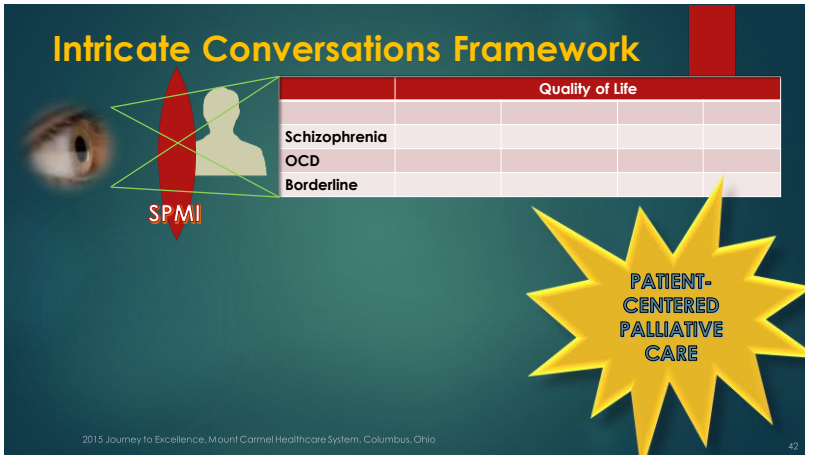

Intricate Conversations Framework
PATIENT-CENTERED PALLIATIVE CARE
2015 Journey to Excellence, Mount Carmel Healthcare System, Columbus, Ohio
37

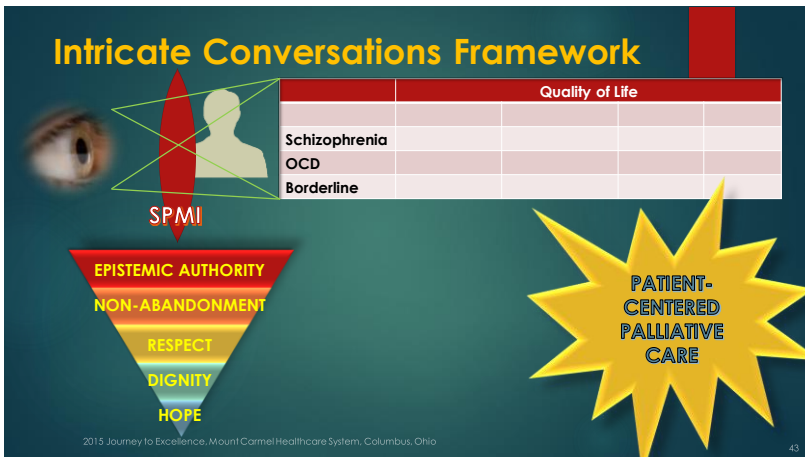

Intricate Conversations Framework
PATIENT-CENTERED PALLIATIVE CARE
2015 Journey to Excellence, Mount Carmel Healthcare System, Columbus, Ohio
38

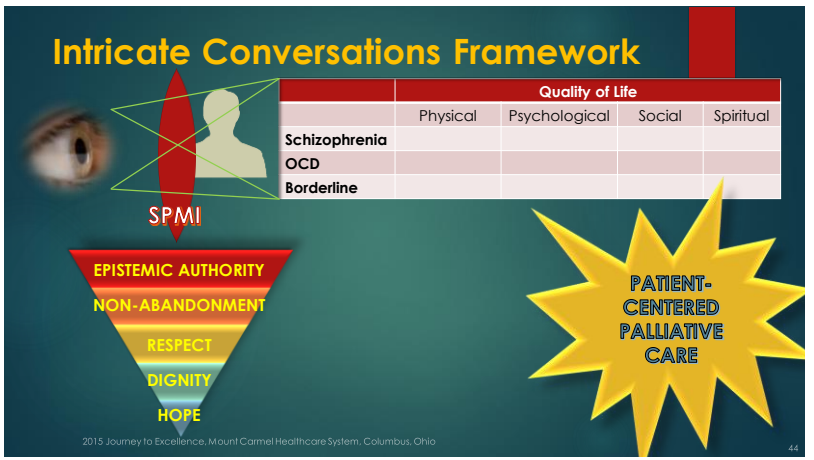

Intricate Conversations Framework
Schizophrenia
OCD
Borderline
PATIENT-CENTERED PALLIATIVE CARE
2015 Journey to Excellence, Mount Carmel Healthcare System, Columbus, Ohio
39

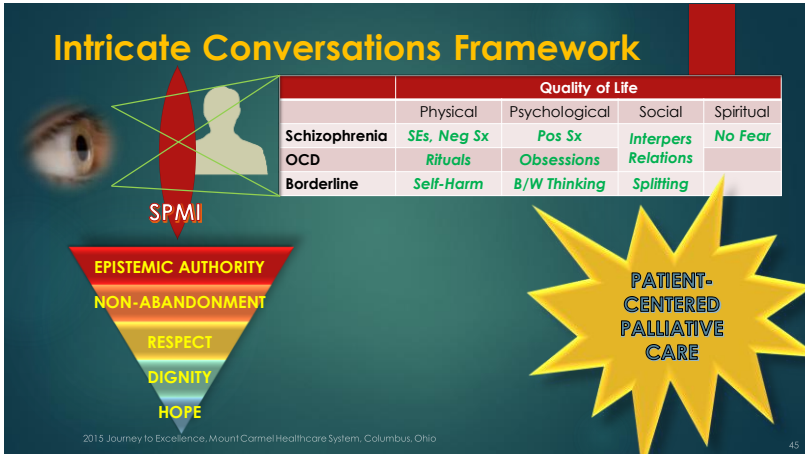

Intricate Conversations Framework
SPMI
Schizophrenia
OCD
Borderline
PATIENT-CENTERED PALLIATIVE CARE
2015 Journey to Excellence, Mount Carmel Healthcare System, Columbus, Ohio
40

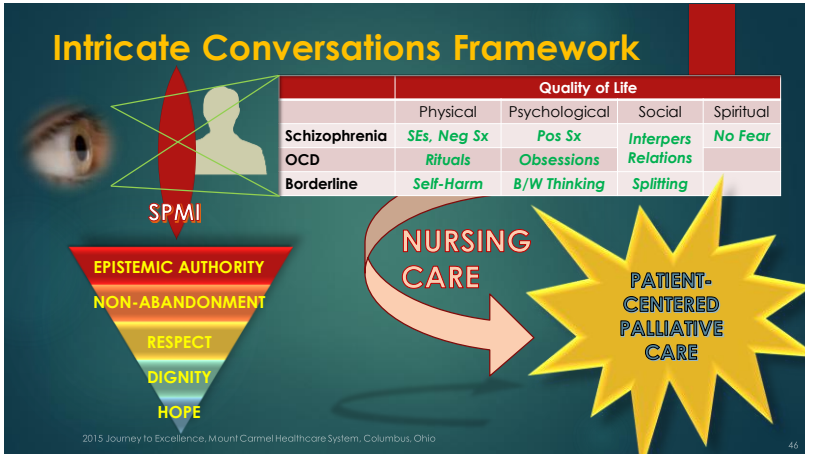

Intricate Conversations Framework
Schizophrenia
OCD
Borderline
SPMI
PATIENT-CENTERED PALLIATIVE CARE
2015 Journey to Excellence, Mount Carmel Healthcare System, Columbus, Ohio
41


Intricate Conversations Framework
Quality of Life
Schizophrenia
OCD
Borderline
SPMI
PATIENT-CENTERED PALLIATIVE CARE
2015 Journey to Excellence, Mount Carmel Healthcare System, Columbus, Ohio
42


Intricate Conversations Framework
Quality of Life
Schizophrenia
OCD
Borderline
SPMI
EPISTEMIC AUTHORITY
NON-ABANDONMENT
RESPECT
DIGNITY
HOPE
PATIENT-CENTERED PALLIATIVE CARE
2015 Journey to Excellence, Mount Carmel Healthcare System, Columbus, Ohio
43


Intricate Conversations Framework
Quality of Life
Physical
Psychological
Social
Spiritual
Schizophrenia
OCD
Borderline
SPMI
EPISTEMIC AUTHORITY
NON-ABANDONMENT
RESPECT
DIGNITY
HOPE
PATIENT-CENTERED PALLIATIVE CARE
2015 Journey to Excellence, Mount Carmel Healthcare System, Columbus, Ohio
44





Specific Strategies: Clients with Schizophrenia

- Unhealthy lifestyle choices: less exercise, more smoking, alcohol abuse, and poor diet.
- Antipsychotic medications can adversely affect physical health.
- Some do not willingly verbalize their pain or related symptomology. PAIN-AD observational tool.
- Listening carefully and interpreting communication is key to symptom management.
- Calm, one issue at a time, intentional use of non-verbals, active listening, clear & direct.

2015 Journey to Excellence, Mount Carmel Healthcare System, Columbus, Ohio
49

Specific Strategies: Clients with Obsessive Compulsive Disorder

- OCD is chronic and laden with self-doubt and guilt.
- Therapy and pharmacologic treatment works.
- Clients can learn to face their fears and resist compulsions.
- Active listening, body language are reassuring.
- Track progress and anxiety levels: evaluative tools.

Specific Strategies: Clients with Borderline Personality Disorder

- Remember that the client is suffering.
- The client not defined by the borderline personality disorder.
- Tactfully respond to the client's distress, but along with strict limit-setting
- Recognize splitting behaviors and interrupt them.
- Consider written treatment contracts.
- Engage in your own self-care.
- Use experienced consultants.

Intricate Conversations

1. Persons with SMI have **palliative care needs** similar to general population
2. **Integrate** principles of palliative care into all care for people with SMI.
3. Ensure **access** to care.
4. Tap into the **benefits of others** to help each other with new situations and with personal and professional clients.
5. Readjust the expectations of the **professional** caregiver.
6. Mental illness should not reflect on the **individual's value** as a person.

(continued)

Intricate Conversations

7. Maintain therapeutic relationship based on **hope, dignity, respect, and valuing the epistemic authority** of the client.
8. Underscore **non-abandonment** with clients.
9. Use evaluative tools to **understand** the clients' current world view as well as changes over time.
10. Work with clients to define **what quality of life means to them**.
11. Develop **policies and guidelines** to address needs of this population.

Summary

Intricate Conversations

Intricate Conversations

- A framework for caring for persons with severe and persistent mental illness
- Considerations:
  - personal traits
  - traits d/t illness, including safety
  - impact of therapies on individual
  - impact on caregiver
  - respecting individual choice
  - pain & symptom management – whole person
- We still have a long way to go

Charge to the Profession

" What then should we expect regarding the future of end-of-life care for persons with serious mental illness? The answer should be:

'The same we do for everyone else.' "

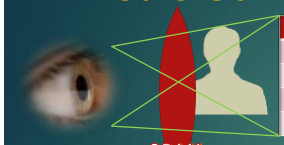
Applebaum (2005)

A Final Thought……

" As we improve end of life care for people with serious mental illness, we will learn how to provide better care for all. "

Woods, et al. (2008)

Intricate Conversations Framework



	Quality of Life			
	Physical	Psychological	Social	Spiritual
Schizophrenia	*SEs, Neg Sx*	*Pos Sx*	*Interpers Relations*	*No Fear*
OCD	*Rituals*	*Obsessions*		
Borderline	*Self-Harm*	*B/W Thinking*	*Splitting*	

SPMI

EPISTEMIC AUTHORITY
NON-ABANDONMENT
RESPECT
DIGNITY
HOPE

NURSING CARE

PATIENT-CENTERED PALLIATIVE CARE

References (1 of 3)

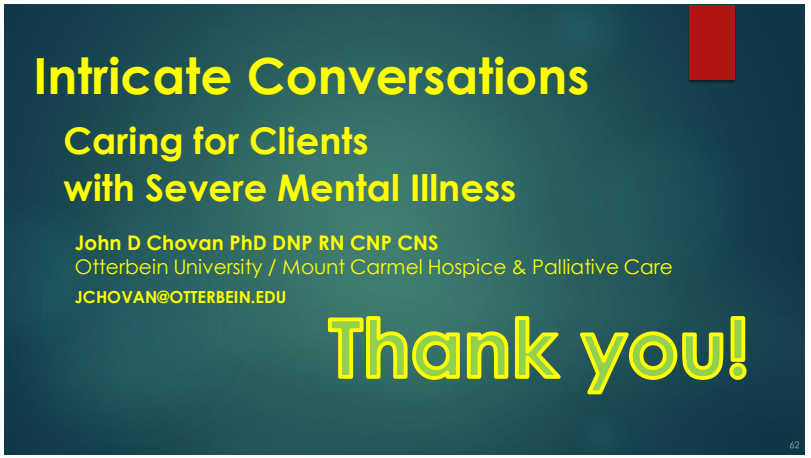
1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association; 2013.
2. American Psychiatric Association. *Practice Guideline for the Psychiatric Evaluation of Adults.* 2nd ed. Arlington, VA: American Psychiatric Association; 2013.
3. American Psychological Association. *Coping with a Diagnosis of Chronic Illness.* Psychology Help Center. http://www.apa.org/helpcenter/chronic-illness.aspx Updated: August, 2013.
4. Baez MA, Avery JD. Terminally ill schizophrenic patients: An ignored population. *J Palliat Med*. 2010;13(3):237.
5. Beck AT, Steer RA, Brown GK. *Manual for the Beck Depression Inventory-II.* San Antonio, TX: Psychological Corporation; 1996.
6. Berk M, Berk L, Udina M, et al. Palliative models of care for later stages of mental disorder: maximizing recovery, maintaining hope, and building morale. *Aust N Z J Psychiatry*. 2012;46(2):92-9.
7. Chovan JD, Cluxton D, Rancour, P. Assessing patients and families. In, Ferrell B, Coyle N. eds. *Textbook of Palliative Nursing.* 4th ed. New York, NY: Oxford University Press; 2015.
8. Feely MA, Havyer RDA, Lapid, MI, et al. Management of end-of-life care and of difficult behaviors associated with borderline personality disorder. *J Pain Symptom Manage.* 2013;45(5):934-8.
9. Goodell, S, Druss, BG, & Walker , ER (2011). Mental Disorders and Medical Comorbidity. *The Synthesis Project.* Princeton, NJ: RWJ Foundation.
10. Hawkins J, Foti ME. Draft Guidelines: End-of-Life Care of Patients with Serious Mental Illness. http://www.promotingexcellence.org/downloads/mass/Draft_Guidelines.pdf; Accessed: August 24, 2014.
11. Institute of Medicine Committee on Approaching Death. *Dying in America: Improving Quality and Honoring Individual Preferences near the End of Life.* The National Academies Press: http://books.nap.edu/openbook.php?record_id=18748; 2014.
12. Isaac M, Janca A, Sartorius N, eds. *ICD-10 Symptom Glossary for Mental Disorders*. Geneva, Switzerland: World Health Organization; 1994.

References (2 of 3)

13. Ita D, Keorney M, O'Slorain L. Psychiatric disorder in a palliative care unit. *J Palliat Med*. 2003;17(2):212-8.
14. Kay SR, Fiszbein A, Opler LA. The positive and negative syndrome scale (PANSS) for Schizophrenia. *Schizophr Bull*. 1987;13(2):261-76. doi: 10.1093/schbul/13.2.26
15. Kelly B, McClement S, Chochinov HM. Measurement of psychological distress in palliative care. *J Palliat Med*. 2006;20(8):779-89. doi:10.1177/0269216306072347.
16. Krause S, Rydall A, Hales S, Rodin G, Lo C. Initial validation of the death and dying distress scale for the assessment of death anxiety in patients with advanced cancer. *J Pain Symptom Manage*. 2014. doi:10.1016/j.jpainsymman.2014.04.012.
17. Lai C, Luciani M, Galli F, et al. Attachment style dimensions can affect prolonged grief risk in caregivers of terminally ill patients with cancer. *Am J Hosp Palliat Care*. 2014.
18. Leeds-Lloyd-Williams, M, Ward J. Which depression screening tools should be used in palliative care? *J Palliat Med*. 2003;17:40-3. doi:10.1191/0269216303pm664oa
19. Lloyd-Williams M, Payne S, Reeve J, Dona RK. Thoughts of self-harm and depression as prognostic factors in palliative care patients. *J Affect Disord*. 2014;166:324-9. doi:10.1016/j.jad.2014.05.029.
20. McLafferty L, Childers JW. Borderline personality disorder in palliative care #252. *J Palliat Med*. 2012;15(4):485-6.
21. Meier DE, Beresford L. Growing the interface between palliative medicine and psychiatry. *J Palliat Med*. 2010;13(7):803-6.
22. National Institute of Mental Health. *Borderline Personality Disorder*. National Institutes of Health. http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml; 2014.
23. National Institute of Mental Health. *Obsessive-Compulsive Disorder; OCD*. National Institutes of Health. http://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml; 2014.
24. National Institute of Mental Health. *Schizophrenia*. National Institutes of Health. http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml; 2014.
25. National Institute of Mental Health. *Strategic Research Priorities*. National Institutes of Health. http://www.nimh.nih.gov/research-priorities/strategic-objectives/index.shtml; 2014.
26. Paice JA. Managing psychological conditions in palliative care. *Am J Nurs*. 2002;102(11):36-42.

References (3 of 3)

27. Patterson KR, Croom AR, Teverovsky EG, Arnold R. Current state of psychiatric involvement on palliative care consult services: results of a national survey. *J Pain Symptom Manage*. 2014;47(6):1019-27. doi:10.1016/j.jpainsymman.2013.06.015.
28. Quill T, Miller FG. eds. *Palliative Care and Ethics*. New York, NY: Oxford University Press; 2014.
29. Randall F, Downie RS. *Palliative Care Ethics: A Companion for All Specialties*. New York: NY: Oxford University Press; 1999.
30. Rentmeester, CA. Regarding refusals of physically III people with mental illnesses at the end-of-life. *J Ment Health*. 2014;43(1):73-80.
31. Stahl SM. *Essential Psychopharmacology: The Prescriber's Guide*. 4th ed. New York, NY: Cambridge University Press; 2013.
32. Sweers K, deCasterle BD, Detraux J, De Hert, M. End-of-life (care) perspectives and expectations of patients with schizophrenia. *Arch Psychiatr Nurs*. 2013;27(5):246-52.
33. Taylor J, Swetenham K, Myhill K, Picot S, Glaetzer K, Loon Av. IMhPaCT: an education strategy for cross-training palliative care and mental health clinicians. *Int J Palliat Nurs*. 2012;18(6):290-4.
34. Terpstra TL, Terpstra TL. Hospice and palliative care for terminally ill individuals with serious and persistent mental illness: widening the horizons. *J Psychosoc Nurs Ment Health Serv*. 2012 Sep;50(9):28-34. doi: 10.3928/02793695-20120807-02.
35. Terpstra TL, Williamson S, Terpstra T. Palliative care for terminally ill individuals with schizophrenia. *J Psychosoc Nurs Ment Health Serv*. 2014 Aug;52(8):32-8. doi: 10.3928/02793695-20140522-01.
36. Tremblay A, Breitbart W. Psychiatric dimensions of palliative care. *Neurol Clin*. 2001;19(4):949-67.
37. U.S. Department of Health and Human Services. *HHS Strategic Plan and Secretary's Strategic Initiatives.* HHS.gov: http://www.hhs.gov/strategic-plan/priorities.html; Updated: March 2014.
38. Woods A, Willison K, Kington C, Gavin A. Palliative care for people with severe persistent mental illness: a review of the literature. *Can J Psychiatry*. 2008;53(11):725-36.
39. Zigmond AS, Snaith RP. The hospital anxiety and depression scale. *Acta Psychiatr Scand*. 1983;67(6):361-70.


Intricate Conversations
Caring for Clients
with Severe Mental Illness
John D Chovan PhD DNP RN CNP CNS
Otterbein University / Mount Carmel Hospice & Palliative Care
JCHOVAN@OTTERBEIN.EDU
Thank you!
62