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Toward holistic care: Including substance use in mental health-palliative care integration

Christopher Magoon, M.D.[1,2] and Daniel Shalev, M.D.[3,4]

[1]New York State Psychiatric Institute, New York, NY; [2]Department of Psychiatry, Columbia University Irving Medical Center, New York, NY; [3]Division of Geriatrics and Palliative Medicine, Weill Cornell Medicine, New York, NY and [4]Department of Psychiatry, Weill Cornell Medicine, New York, NY

Guest Editorial

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Author for correspondence:
Christopher Magoon,
New York State Psychiatric Institute,
1051 Riverside Dr, New York City,
NY 10032, USA.
E-mail: christopher.magoon@nyspi.columbia.edu

Palliative care takes a whole-person approach to address suffering among patients living with serious illness. Traditionally, a great deal of attention has been paid to physical symptoms, but there have been fewer clinical services directed toward psychiatric and psychological aspects of serious illness. In recent years, increasing awareness of the prevalence and severity of mental health comorbidities in patients with serious illness has driven a movement to improve integration of mental health services into serious illness care, and specifically into palliative care (Cheung et al., 2019). This is reflected in the academic literature and in the inclusion of psychological and psychiatric aspects of palliative care in standardized guidelines around the domains of palliative care (Ferrell et al., 2018). Much of the existing efforts toward improving mental health integration into palliative care have been aimed at addressing the needs of patients with comorbid serious medical illness and depression, anxiety, or serious mental illnesses such as schizophrenia (Fulton et al., 2018). However, as yet, such interventions and models of care have largely excluded patients living with substance use disorders.

The division between patients with primary psychiatric disorders and substance use disorders is reflective of broader realities beyond palliative care. Many models of mental health-medical care integration exclude patients with substance use disorders (Savic et al., 2017). Patients with substance use disorder are susceptible to stigmatization, siloed care, and suboptimal outcomes across medical settings (Brezing and Marcovitz, 2016). To meet the needs of our most vulnerable patients with serious illness, mental health services aimed at patients with serious illness must include care for substance use disorders.

There are a dearth of data on the prevalence of substance use among patients with serious illness. What data do exist indicate that substance use disorders may be common among patients receiving palliative care; approximately one in four patients receiving palliative care may meet some or all criteria for a substance use disorder (Jenkins et al., 2000). This is in keeping with estimates of prevalence by clinical palliative care program directors (Patterson et al., 2014).

Many patients accessing palliative care receive opioid pain medications. Therefore, opioid use disorder is of particular concern in this clinical population. While the prevalence and incidence of opioid use disorder have decreased in recent years, non-medical opioid use is still widespread. In 2020, 9.5 million Americans used opioids for non-medical indications and, even more concerningly, over 1.2 million began non-medical opioid use ("TIP 54: Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders | SAMHSA Publications and Digital Products", 2012). According to the Centers for Disease Control and Prevention, as many as one in four patients in the general population who receive long-term opioids will struggle with addiction ("Prescription Opioids | CDC's Response to the Opioid Overdose Epidemic | CDC", 2021). Additionally, those with substance use disorders are more likely to develop life-limiting conditions than the general population, furthering their need for palliative care services (Ebenau et al., 2020).

Palliative care providers are treating more patients with substance use disorders, and they often feel unequipped to do so (Patterson et al., 2014). One 2012 study surveyed 57 palliative care fellows and reported that they largely felt unprepared to care for these patients. Over three quarters of fellows had seen a patient with a substance use disorder within the past two weeks and nearly half had seen a patient whom they were concerned about opioid misuse. Despite this high clinical volume, only 41% felt prepared to manage opioid misuse, and only 37% responded that they knew how to differentiate pain from addiction. Fewer than one in four respondents felt satisfied with how they treated this subpopulation. Nonetheless, the survey data did show that specific training can be effective, as those who had more specific training in caring for these patients reported greater perceived competency (Childers and Arnold, 2012). Such training is contingent on clear guidelines and disseminated education paradigms. Unfortunately, there are presently no widely accepted guidelines for the treatment of substance use disorders in those with life-limiting illnesses. Furthermore, there are not widely disseminated, operationalized curricula on substance use disorders in palliative care training programs of any discipline.

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Efforts to increase integration of mental health into palliative care are inchoate. While a number of psychosocial and pharmacologic interventions exist to improve mental health among patients with serious illness receiving palliative care, few models have been proposed to upscale such interventions and deliver them on a population level (Cheung et al., 2019). Existing interventions are largely oriented around depression, anxiety, existential distress, and serious mental illness. However, many patients with serious illness contending with these comorbidities may also have comorbid substance use. Efforts to improve quality of life, ameliorate psychological and psychiatric symptoms, and provide whole-person-centered care are unlikely to succeed without addressing substance use alongside medical needs and primary psychiatric comorbidities.

While integrating substance use services into palliative care may seem daunting, there are successful examples both from outside and within palliative care. One group at MD Anderson, for example, reported study findings from their interdisciplinary "Clinical Hight Alert Team" who met with patients that demonstrated aberrant behaviors related to their opioid medications such as requesting early refills, reporting lost/stolen doses, and receiving opioids from multiple providers (Arthur et al., 2018). The interdisciplinary team, which consisted of a palliative care physician, palliative care nurse, social worker, pharmacist, and patient advocate met with patients "in a supportive and nonjudgmental manner with emphasis on the need for patient and family safety…to address any concerning issues related to the patient's opioid use, openly discussing the goals of opioid therapy, expectations, potential risks, and alternatives related to their pain management." This intervention was shown to decrease both aberrant behaviors and opioid doses, without increasing patients' pain levels. Although this program was specific to substance use and did not address other mental health comorbidities, it demonstrates the potential of interprofessional, cross-disciplinary integrated care models that can address multiple dimensions of care.

The gold standard for the care of patients with medical, mental health, and substance use care needs are integrated models of care. While such models remain the exception rather than the standard, there is growing interest in the implementation of such tripartite integration. Data from HIV and hepatitis care have demonstrated robust benefits of integrating medical care with behavioral health approaches that include mental health and substance use treatment (Chuah et al., 2017). Palliative care is well positioned as a discipline to lead the charge in innovative models of care that address mental health, medical, and substance use needs. Palliative care services already consider patients' psychosocial health part of their mandate. In addition, palliative care clinicians are already comfortable functioning in interprofessional, cross-disciplinary frames to provide care to patients with complex, multidimensional needs. Finally, the field of palliative medicine is devoted to the amelioration of suffering, and patients with serious or life-limiting medical illness who also have comorbid mental health and substance use needs are particularly vulnerable to both physical and psychosocial suffering.

Addressing the needs of individuals with substance use disorders in the palliative care setting is a feasible goal. As palliative care programs continue to recognize the burden of mental health comorbidities among patients with serious illness and develop clinical and research programs to address these comorbidities, the inclusion of substance use disorders will allow our field to better serve our most vulnerable patients and serve as leaders in integrating full-spectrum behavioral health services into complex medical care.

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