EVOLVING ROLES FOR PSYCHOLOGISTS

PSYCHOLOGISTS, VETERANS AND END-OF-LIFE CARE

The Department of Veterans Affairs has invested in hospice and palliative care—and in psychologists.

By Hannah Calkins

About 600,000 veterans die in the United States each year, amounting to one in four American deaths, according to Scott T. Shreve, DO, the Department of Veterans Affairs (VA) National Director of Hospice and Palliative Care. One-third of veterans are enrolled in the VA medical system and, Shreve adds, more veterans die in VA hospice beds each year than in all VA intensive and acute care beds combined.

Under Shreve’s direction, the VA has dramatically increased its investment in hospice and palliative care. Palliative care can begin at the time of diagnosis and treatment for the illness. Hospice care begins when treatment has stopped, and the patient is typically told they have about six months left to live.

Importantly, the VA’s investment in end-of-life care includes mental health. There is a mental health provider—often a psychologist—on every hospice and palliative care team in the country.

“Shreve’s example is just one of the many important clinical and interprofessional roles psychologists play on these hospice and palliative care teams. Psychologists also address veterans’ often-complex comorbidities, provide evaluations and consultations on an array of mental health concerns, and facilitate conversations with veterans and family members about goals of care and end-of-life decision-making.

Outside the VA, in the fee-for-service world, it can be difficult for psychologists to participate in this type of integrated, holistic care, says Michele Karel, PhD, a board-certified clinical geropsychologist who serves as Psychogeriatrics Coordinator in the Office of Mental Health and Suicide Prevention in VA Central Office.

That holistic care necessarily extends to the end of a veteran’s life. “We owe our veterans a dignified, comfortable end-of-life experience consistent with their goals and values,” Karel says.

Life and death in the day-to-day

Veronica Shead, PhD, is a clinical psychologist in hospice and palliative care in the VA St. Louis Health Care System. She treats veterans with advanced illnesses in inpatient and outpatient settings on a team that includes two physicians, a nurse practitioner, a social worker and a chaplain.

“Our primary goal is symptom management. That can entail non-pharmacological, behavioral and other psychological interventions to help veterans cope with a range of symptoms, from pain and nausea to anxiety and depression,” Shead says. “We take a bio-psycho-social-spiritual approach to care.”

As a psychologist, a significant amount of Shead’s work also involves assessment, communication and support.

“I work to elicit the veteran’s values—what do they want; what drives them; what should direct their end-of-life care?” she says. That can be a challenging task if the veteran’s cognitive status is compromised by delirium or dementia, but Shead works to assess the veteran’s capacity for decision-making, to understand the veteran’s wishes—often in partnership with their family—and to help convey those wishes to medical staff.

Shead also helps veterans and their families cope with anticipatory and pressing grief.

“Facing illness and death can bring up past losses, and ill veterans are also grieving their own functional losses. Loss of independence and

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control can be extremely difficult for them,” Shead says.

Sometimes, these emotions are compounded by anxiety, depression, post-traumatic stress and other serious mental health issues which may or may not be connected to their service.

“Military and related trauma experiences may impact the end-of-life process, which requires special attention,” Shead says.

The VA also acknowledges that many veterans—particularly those who are elderly, disabled or have life-limiting illnesses—prefer to receive care in their homes. That’s where VA Home-Based Primary Care (HBPC), which often has a palliative component, comes in.

Like Shead, Heaney performs specialized assessments and psychotherapy when cognitive or mental health issues are apparent. He also performs behavioral interventions, provides caregiver support, and helps terminally ill veterans determine meaningful treatment goals.

Chris Heaney, PsyD, is a staff clinical psychologist at the VA Nebraska-Western Iowa Health Care System in Omaha. He works on an interdisciplinary HBPC team and has an additional role with a palliative care team at the VA facility.

“HBPC is often, in essence, palliative care, which can begin the moment the diagnosis of a debilitating illness is made,” he says. “We try to relieve symptoms, address pain and improve quality of life.”

Shreve, Karel, Shead and Heaney all say they find their work to be singularly rewarding.

“Terminally ill veterans have to directly confront the reality of death, which most people avoid thinking about. They remind us that our time is limited,” Heaney says. “And that brings a real urgency and authenticity to the work.”

Shead agrees, saying that for her, there is nothing more powerful than providing peace and comfort to those in grief. However, she finds it disappointing that mental health-integrated hospice and palliative care services aren’t accessible to everyone in the community beyond the VA.

“Many of our loved ones don’t receive the same level of care that veterans do, because comprehensive, interprofessional care that’s inclusive of psychologists just isn’t widely available,” she says.

But Heaney, meanwhile, is optimistic that the VA’s commitment to interdisciplinary care, and its embrace of psychologists, will spread to the private sector.

“The trend will grow,” he says. “The VA demonstrates how beneficial it is, both for the patient and for health systems, when interdisciplinary teams collaborate on holistic, life-affirming treatment.”

Beyond the VA and into the community

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