Bridging Mind and Body at the End of Life: Embedding Psychiatry within an Australian Palliative Care Program

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KEYWORDS

Palliative Care, Psychiatry, Integrated Care

EXECUTIVE SUMMARY

Patients with life-limiting illness experience high rates of under-recognised psychiatric comorbidity, particularly those with severe mental illness (SMI). We evaluated a pilot service embedding psychiatry within a 12-week ambulatory palliative care program for patients with advanced non-malignant chronic disease, estimated to be in the last 2 years of life, in a Regional NSW tertiary hospital. Compared with the six months prior, participants demonstrated reduced emergency presentations and hospital bed days, alongside increased engagement in planned care. Patients and carers reported improved adaptation to illness. Analysis of integrated palliative outcome scale (IPOS) and EuroQol (EQ5d5L) scores across the intervention demonstrated that despite the terminal nature of disease and significant reduction in acute care use, there was no negative impact upon self-reported symptom burden or quality of life. This model demonstrates that integrating psychiatry into palliative care is feasible and associated with improved patient experience and reduced acute health service utilisation.

INTRODUCTION

Patients with life-limiting illnesses frequently experience under-recognised psychiatric comorbidities. Those with pre-existing SMI face barriers to psychiatric and palliative care with poorer outcomes. While psychiatry–palliative care collaboration is established in oncology, practical models for non-malignant illness are scarce. This study evaluates the impact of embedding psychiatry within a palliative care program on the experience of care, symptom burden, quality of life, and health service utilisation

HIGHLIGHTS

- ED presentations reduced by 56% following program completion
- Unplanned bed days reduced by 75% over six months
- Planned care engagement increased across procedures and services
- High patient and carer satisfaction with integrated care model
- Improved adaptation to illness reported by participants
- No negative impact upon symptom burden or quality of life (IPOS, EQ5D5L)

METHODOLOGY/ PROCESS

This service evaluation examined a pilot ambulatory service embedding psychiatric care within a 12-week multidisciplinary palliative care program in an Australian tertiary teaching hospital. Patients with advanced chronic physical conditions (Figure 1) with life expectancy two years or less were referred. While the service was open to both patients and primary carers, this evaluation focuses on the patient cohort (n=21) presenting with pre-existing mental illness or significant psychological distress. Psychiatric intervention was delivered through direct patient consultation, carer-focussed support, specialist case discussion. Health service utilisation for the patient cohort (n=21) was compared for the six months immediately preceding

enrolment and the six months following program completion, alongside patient and carer feedback. Bayesian linear mixed-effects models were used to assess the effect of time on IPOS and EQ-5D outcomes, with random intercepts for participants. Model comparison was performed using Bayes Factors.

RESULTS/ OUTCOMES

Patients (n=21) demonstrated high psychiatric complexity, multimorbidity, and interrelated physical, psychological, and social distress; 80% had known pre-existing psychiatric illness or significant psychological symptoms requiring further evaluation. Comparing the six-month periods pre-enrolment and post-completion for the patient cohort (n=21), Emergency Department presentations fell 56% (n=66 to 29) and unplanned bed days fell 75% (n=342 to 86), contributing to estimated savings of $382,450 (AUD). Engagement in scheduled care improved: 31% increase in planned procedures (n=26 to 34) and 186% increase in planned occasions of service (n=95 to 272). Patients and carers reported high satisfaction with the model, describing improved adaptation to illness. Bayesian analyses provided decisive evidence for no change over time across IPOS and EQ-5D outcomes, indicating that symptom burden and quality of life remained stable despite disease progression (IPOS $BF \approx 2 \times 10^{8}$; EQ-5D BFs up to $1X10^{137}$). Consistent with all these findings, all 95% credible intervals for the effect of time crossed zero, supporting the null hypothesis of clinical stability throughout the intervention period.

CONCLUSION

Embedding psychiatry improves complex symptom management and effectively bridges the equity gap for patients with SMI. This model reflects a clinical shift from reactive, crisis-driven care to a proactive, structured ambulatory model through earlier identification, management of complex symptom burden and strengthened collaboration.

This integrated psychiatry–palliative care model is feasible, scalable, and supports whole-person care while delivering measurable patient and system-level benefits.

APPENDIX

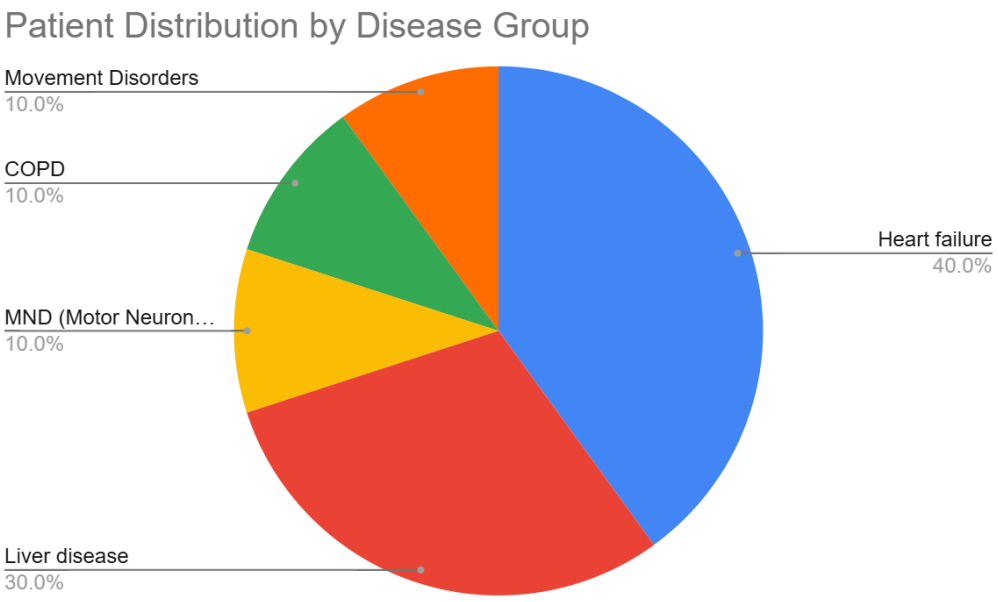

Figure 1. Patient Distribution by Disease Group (n=21)