Psychiatric illness in Palliative Care

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What We Will Cover

- What is palliative care?
- Prevalence of psychiatric illness in palliative care
- Recognising psychiatric illness
- Management of psychiatric illness
- Supporting patients with psychiatric problems
- The role and limitations of the specialist palliative care team
What is palliative care?

“Palliative care is an approach that improves the quality of life of patients and their families facing the problem(s) associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

World Health Organisation

http://www.who.int/cancer/palliative/definition/en/
When is palliative care appropriate?

“Palliative Care is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.”

World Health Organisation

http://www.who.int/cancer/palliative/definition/en/
Why bother with palliative care?

- “Palliative Care offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness.”

World Health Organisation

http://www.who.int/cancer/palliative/definition/en/
Why palliative care?

There is evidence, (both anecdotal and recently from two U.S. trials,) that patients with cancer who receive early palliative care concurrently with active cancer treatment experience:

- improved health-related quality of life,
- reduced treatment toxicity,
- reduced financial costs of treatment, and
- approaching 30% improvement in survival.
No, Most People Aren’t in Severe Pain When They Die

- Evidence from the Australian Palliative Care Outcomes Collaboration shows that there has been a statistically significant improvement in pain and other symptoms at the end of life in the last decade.
- 26% of all palliative care patients reported having one or more severe symptoms when they started palliative care.
- This decreased to 13.9% as death approached.
- Patient outcomes vary depending on a range of factors, such as resources available and geographical factors.
- Those receiving care in hospital have better pain and symptom control than those receiving palliative care at home.

EAGER, K, Clapham, S, Allingham, S  *The Conversation* Dec 2017
Number of patients (%) reporting side-effects at start of palliative care, and at end of life

Source: University of Wollongong
Prevalence of Psychiatric Problems in Palliative Care

- At least 1/3 patients
  - Pre-existing
  - New

- Adjustment disorder: common
- Depression: 3 - 45%
- Delirium: 28 – 88%
- Cognitive impairment: 11%
- Psychotic disorders: 1%
- Visual hallucinations: 47%
Depression
“Looks like it could be depression.”
Depression

- A clinical mood disorder associated with low mood or loss of interest and other symptoms that prevents a person from leading a normal life.

- Major depression
- Bipolar depression
- Dysthymia
- Seasonal affective disorder
Burden of depression

- Reduced QoL
- Greater difficulty in managing the illness
- Decreased adherence to treatment
- Amplifies pain and other symptoms
  - Effective palliation of symptoms more difficult to achieve
- Earlier admission to inpatient care
- Reduced capacity for pleasure, meaning, connection
- Reduced capacity for preparation for separation
- Anguish and worry in family members and friends
- Increased desire for hastened death
Diagnosing depression

- Patients with advanced disease often experience psychological distress
- Normal and appropriate vs psychiatric disorder
- Misunderstood, underdiagnosed and undertreated
- Clinicians often fail to recognise the extent of a patient’s depression until too late
  - ‘All patients facing end of life are depressed’
  - Lack of knowledge and skill
  - Fear of upsetting/intruding
  - Stigma
  - Apprehension re drug interactions
  - Therapeutic nihilism
- Lack of agreement as to appropriate diagnostic criteria
Assessment
Risk factors

- Younger age
- Female: male 2:1
- Past/family history of depression
- Uncontrolled symptoms
- Type of illness
- Illness and treatment related factors
  - CNS inc XRT to head
  - Hormonal, metabolic, nutritional
  - Autoimmune, viral
  - Drug side effects
- Stress, isolation, demoralisation, adverse life events
- Existential concerns and spirituality
DSM V - Major Depression

Depression and/or loss of interest or pleasure with distress or impairment of function and at least 5 of:
- **Weight loss**
- **Insomnia/hypersomnia**
- **Fatigue/loss of energy**
- **Poor concentration/indecisiveness**
- Depressed mood most of the time for 2/52
- Loss of interest/pleasure
- Feelings of worthlessness/inappropriate guilt
- Psychomotor retardation/agitation
- **Recurrent thoughts of death**, suicidal ideation

and not attributable to physiological effects of a substance or another medical condition
Features of depression

- Cognitive changes
  - Pessimism, feelings of worthlessness, guilt, self-reproach, sense of failure, self-punishment, indecisiveness, reduced concentration, self-esteem and self-confidence, suicidal ideation +/- intent

- Affective changes
  - anhedonia, sadness, crying

- Somatic changes
  - restlessness, sluggishness, loss of energy, anorexia, weight changes, sleep disturbance, loss of libido
Demoralisation syndrome

- ‘Normal response’ unlike adjustment disorder
- Predictably progresses to a desire to die/commit suicide
- Treatment is possible
  - symptom control
  - supportive therapy
  - normalisation
  - resilience building
  - restoration of morale, meaning and purpose

- Hopelessness
- Loss of meaning
- Existential distress
- Helplessness
- No anhedonia
- Mood dysphoric but remains reactive
Assessment

- Appropriate responses to advanced disease
  - Depressed mood, sadness, grief, anticipatory feelings of loss

- Importance of context
  - Symptoms out of proportion to the situation

- Indicators of depression
  - Hopelessness, helplessness
  - **Worthlessness**
  - Inappropriate guilt
  - Lack of pleasure
  - **Suicidal ideation** (active or passive)
Assessment and diagnosis

- Criterion based diagnosis
  - Diagnostic and Statistical Manual of Mental Disorders - 5
  - Adjustment disorder with depressive features
  - Mood disorder secondary to medical condition
  - Rate of diagnosis may vary due to symptom severity threshold

- Diagnostic interview vs tools

- Endicott scale: replaces somatic criteria with cognitive substitutes
  - Depressed appearance
  - Social withdrawal
  - Brooding/self-pity/pessimism
  - Lack of reactivity to pleasurable situations

- Have you been depressed most of the time for the last 2 weeks?
Risk of Suicide

- Male
- Age >40
- FH of suicide
- Unemployed
- Socially isolated*
- Recent bereavement*
- Severe unrelieved symptoms
- Fear of suffering
- Hopelessness
- Continued desire to die

- Persistent thoughts of suicide*
- Expressed intention*
- Suicide note/evidence of active plan or preparation*
- Psychiatric illness*
  - depression
  - schizophrenia
  - personality disorder
- Lack of inhibitory factors
- Misuse of drugs or alcohol
Don’t be afraid to ask about suicidal thoughts and intent!

- Have things ever got so bad you wished it was all over?
- Have you ever thought about harming yourself? How?
- What stopped you?
- Are you still having these thoughts?
- Do you think you might act on them?
Management
Management

- Full medical assessment
  - ?reversible cause
- Management of uncontrolled symptoms
- Psychosocial interventions
- Pharmacological treatment
“Snap out of it.”
Management

- Major depression in the terminally ill is treatable
- Treatment is well tolerated
- Scottish study
  - Cross sectional analysis
  - Patients with cancer with depression (n=1538)
  - >70% NOT receiving potentially effective therapy
  - Low threshold for therapy
Management

- Establish and document outcome goals
- Decide on plan
- Monitor
Non - Pharmacological Interventions

- Address medical predisposing factors where possible
- Patient and family education
- Consistent emotional support
- Reinforce positive coping strategies
- Social, environmental and spiritual approaches
- Psychological therapies (mild/moderate)
- (ECT)
Psychological therapies

- **Supportive therapy**
  - Importance of a supportive therapeutic relationship
  - Patient and family education
  - Discuss concerns, fears, impact of illness, coping with loss

- **Structured cognitive therapies**
  - Reframing maladaptive thoughts
  - New coping skills e.g. relaxation

- **Existential psychotherapy**
  - Dignity therapy
  - Meaning-centred therapy
  - Therapeutic life review
Pharmacological Interventions

- Systematic review: 25 placebo controlled studies of the treatment of depression in palliative care
  - Significant benefit of antidepressant vs placebo within 4-5 weeks
  - Continued improvement over time

- Safe, effective, well tolerated
- No evidence for a preferred category of antidepressant
- Judicious use of antidepressants warranted
- Start low, go slow
- Monitor
Pharmacological Interventions

- Around 80% of patients will respond well to conventional antidepressant therapy
- All antidepressant drugs have similar efficacy
  - Patients with cardiac dysfunction: Citalopram, sertraline or trazodone
  - Patients at risk of seizures: Fluoxetine, sertraline and trazodone
  - Patients at high risk of suicide: SSRIs or lofepramine (safer in overdose)
- Psychostimulants
Pharmacological Interventions

- **SSRI** e.g. paroxetine
- **TCA** e.g. nortriptyline
- **SNRI** e.g. duloxetine
- **Serotonin modulators** e.g. trazodone
- **Atypical antidepressants** e.g. mirtazapine
- **MAOIs** – rarely used in palliative care
- **Psychostimulants** e.g. modafinil
  - Prognosis <4 months, urgent response needed
- **Ketamine**

- Consider side effect profile, interactions, preparation
Pharmacological Interventions

- Explain delayed therapeutic effect
- Warn about common side effects
- Give adequate doses
- Monitor compliance and effects
- Address social and psychological factors alongside
- Continue for at least 3 months after symptoms resolve (1 yr if previous episode)
Common Reasons for the Under-Treatment of Depression/Anxiety

- Belief that they are inevitable/‘natural’
- Nondisclosure by patients
- Misattribution of symptoms to physical illness or treatment
- Failure to try brief, short-term treatment in patients close to death
- Failure to assess outcome of treatment
- Failure to adjust/alter treatment
- Failure to identify/address maintaining factors
- Failure to recognize and treat relapses
Pharmacological Interventions

- Changing antidepressant
  - Choice of drug
  - Cross-tapering according to tolerability

- Discontinuation of antidepressants
  - Withdraw gradually after use for >8 weeks, over 4 weeks if possible
  - Monitor for discontinuation syndrome
  - Reintroduce drug only if severe/prolonged, then reduce more gradually
Referral to a psychiatrist

- Uncertain diagnosis
- History of major psychiatric disorder
- Suicidal or requesting assisted suicide or euthanasia
- Psychosis/delirium
- Unresponsive to therapy with first line antidepressant
- Significant family conflict interferes with wellbeing, treatment or decision-making
Top tips

- Low threshold for treatment
- Establish and document outcome goals
- Don’t forget non-pharmacological management
- Draw on patient’s previous coping strategies
- Start low and go slow with dose of drugs
- Discuss the importance of compliance, delay in effect and potential side effects
- Review at intervals
- Maintenance treatment
More top tips

- Formal psychology assessment and/or access to psychiatric services may be necessary to optimise QoL and support the team

- Remember the family/carers

- Consider the impact on the team
Anxiety
Anxiety

- a state of apprehension and fear resulting from the perception of a current or future threat to oneself

- Adjustment disorder
- Depression
- Generalized anxiety disorder
- Panic disorder
- Post-traumatic stress disorders
- Phobia
“On the outside I’m all ho-ho-ho. But inside I feel weak and shaky, like a bowl full of jelly.”
Causes of Anxiety in Advanced Cancer

- **Situational**
  - related to cancer or not
- **Patient’s ‘inner world’**
  - understanding
  - fears and concerns e.g. the future, family
  - past experience
- **Psychiatric**
  - e.g. depression
- **Organic**
  - e.g. brain mets, metabolic disturbance
- **Drugs**
Causes of Anxiety in Carers

- Emotional strain
- Physical demands
- Uncertainty
- Fear
- Altered roles and lifestyle

- Financial strain
- Lack of confidence in own caring role
- Inadequate services
Burden of anxiety

- May be severely debilitating
- Patients with anxiety are:
  - Less comfortable asking questions about their health
  - Less likely to understand the clinical information
  - More likely to believe their clinicians would offer them futile therapies
  - Less certain that they would have adequate symptom control at end of life
Assessment
Common manifestations

- Physiological
- Emotional
- Cognitive
- Behavioural

- Autonomic symptoms
- Fear, spiritual/existential concern
- Worries about how to achieve a good death
- Avoidance
Assessment

- To what extent is the anxiety interfering with function/sleep/quality of life?
- Has patient tried to deal with episodes themselves?
- What, if anything, helps?
- How has patient dealt with other stressful events in the past?
Management
Non-Pharmacological Interventions

- Correct treatable causes
- Elicit and discuss concerns/fears
- Correct misconceptions
- Assist in the development/use of coping strategies
  - e.g. distraction, relaxation, breathing exercises
- Develop supportive professional relationship
- Consider complementary therapies, psychotherapy, chaplaincy, exercise, lifestyle
- Tailor management to individual circumstances
Pharmacological Interventions

- Relief of pain & other symptoms
- Symptomatic management
  - Useful but limited if used alone
    - Benzdiazepines e.g. Diazepam, Lorazepam
    - Antidepressants e.g. SSRIs, SNRIs
    - [Betablockers e.g. Atenolol]
    - Other agents e.g. Gabapentin, Trazadone
Delirium and Anguish
Common symptoms in the terminal phase

- Fatigue
- Breathlessness
- Pain
- Noisy breathing and/or terminal secretions
- Dry/sore mouth
- Sweating
- Nausea and vomiting
- Agitation
- **Delirium**
- **Anguish**
Delirium (including terminal phase)

- Confusion/disorientation
- Disorganised thinking
- Incoherent speech
- Forgetfulness
- Misinterpretation/hallucinations
- Paranoid ideas
- Noisy/aggressive behaviour
- Restlessness
- Drowsiness
- Disturbed sleep/wake cycle
- Acute onset
- Accompanies organic brain disease
- Fluctuating, often worse in the evening/at night
- May be overactivity of ANS – facial flushing, dilated pupils, tachycardia, sweating
- Heavy sedation required in 3% of cases
Causes of Delirium

- Underlying disease
- Infection
- Anxiety/depression
- Opioid toxicity
- Steroids
- Alcohol/ opioid/ sedative/ nicotine withdrawal
- Hypoxia
- Dehydration
- Hypercalcaemia
- Hyponatraemia
- Hyperglycaemia
- Hypoglycaemia
- Renal failure
- Liver failure
- Hypothyroidism
Assessment and Management

- **Diagnosed clinically**
- Assessment of cognition:
  - Mini mental state exam (30 questions)
  - Abbreviated mental test (10 questions)
- Identification and treatment of precipitants.
- Supportive care
- Restraints and drugs ONLY for those patients posing risk to themselves or others.
Non - Pharmacological Interventions

- Quiet room, appropriate lighting
- Calm, safe, secure, constant environment
  - Avoid bed rails and use of restraints
- Familiar objects
- Visible clock/calendar
- Presence of family or close friend
- Good communication with patient and relatives
  - Involve in decision-making where appropriate
- Multidisciplinary team support
Pharmacological Interventions

- Review drug regime
- Correct reversible causes
- Drugs to consider:
  - **Haloperidol** (antipsychotic and antiemetic properties) 1 - 5mg PO/SC (s/e Parkinsonian symptoms, restlessness, tardive dyskinesia)
  - **Olanzapine** 2.5-5mg PO/SC (fewer extrapyramidal effects)
  - **Levomepromazine** 6.25-25mg PO/SC (s/e drowsiness, hypotension). Also has antiemetic and possibly some analgesic effects.
  - **Diazepam** 2-5mg PO
  - **Midazolam** 2.5 – 5mg SC
Anguish

- Tormented state of mind
- Unresolved emotional problems
  - Difficult life experience
  - Concern for others e.g. young children and/or dependants
  - Existential issues
- Inability to control thoughts
- At the end of life, may be associated with restlessness/thrashing/moaning
Management

- Address emotional difficulties at an early stage (if possible) in an attempt to avoid these problems at the end of life
  - e.g. resolutions, making plans for children & others, making a will.

- Benzodiazepines may be helpful.
Psychosis
Recognising Psychosis

- Loss of contact with reality
- Hallucinations
- Delusions
- Disordered thinking
- Lack of insight
Causes of Psychosis

- Genetic predisposition
- Chemical imbalance in the brain
- Stress
- Psychological defence
- Illegal drugs
- Organic brain disease inc epilepsy
Management of Psychosis

- Antipsychotic medication
- Psychological therapies
- Social skills training
- Occupational therapy
- Supported employment
Loss, grief and bereavement
Definitions

- **Bereavement**
  Reaction to the loss of a loved person by death

- **Grief**
  Emotional and psychological reaction to loss

- **Pathological Grief**
  A departure from the expected grief reaction (intensity and timescale of symptoms)
Differences in Grief

Anticipatory Grief
- Affects dying person and their family
- Duration limited until time of death
- Emotional intensity increases as death approaches

Normal Grief
- Family only
- After death
- Emotional intensity reduces after death
Anticipatory Grief

- Progression through the stages of grief prior to the loss
- All losses from diagnosis to death
  - Control
  - Self image
  - Function
  - Role/independence
  - Relationships (stigma, abandonment, isolation)
  - Life
Bereavement Models: Linear

- Loss
- Shock
- Yearning
- Disorder and despair
- Adaptation
Bereavement Models: Continual

**LOSS ORIENTATED**
- Grief work
- Intrusion of grief
- Breaking bonds/ties
- Denial/avoidance of changes

**RESTORATION ORIENTED**
- Attending to life changes
- Doing new things
- Distraction from grief
- New roles/relationships
High Risk Groups

- Sudden
- Unexpected
- Untimely
- Gruesome
- Shocking
- Traumatic

- Nature of relationship
- Stigma of death
- Previous bereavements
- Previous mental illness
- Social isolation
- Older men
Grief Reactions

- Seen in the context of past experience
- Losses can revive unresolved pain from unfinished business
- Intense grief prior to bereavement is a predictor of poorer outcome afterwards
  - correlates with anxiety and depression within families
- Complicated reactions are usually due to a combination of personality and situational factors
Stress

- Physical
  - Headaches, insomnia, tiredness, poor appetite
- Mental
  - Reduced concentration, worry
- Behavioural
  - Avoidance, alcohol/substance abuse
- Emotional
  - Anxiety, not wanting to get up, swings in mood
Distress

- Loss
- Change
- Uncertainty
- Revulsion
- Lack of understanding
- Lack of confidence
- Lack of support
- Weariness
- Fear/anxiety
- Sadness
- Helplessness
- Sense of unfairness
- Sense of burden
- Anger
- Guilt
Supporting Grieving Patients and Carers

- Time
- Empathy
- Communication skills
- Identify needs/concerns
- Identify potential coping strategies
- Refer to other agencies if necessary
Emotions and Empathy

- How do you feel about this?
- Identify emotion - shock, anger, sadness
- Acknowledge source - recent loss
- Show you understand the connection
- Show you care
- Tissues for tears
- Silence is OK
- Touch may be appropriate
Handling Uncertainty

- Acknowledge the predicament
- Empathise
- Invite the client to tell you how they’re feeling
- Avoid unrealistic reassurance
- Offer continued support
Coming to Terms with Loss

- Assess the nature and extent of the loss
- Acknowledge the distress
- Confirm the reality that nothing can be done to reverse the loss
- Check how the client feels about that
- Move on
  - “Is there anything you would like to do?”
- Offer continued support
Support for Those Suffering Loss and Bereavement

- Informal support
- Multidisciplinary team
- Chaplaincy team/religious leader
- Social services
- Specialist palliative care team
- Community care team
- Self-help groups
- Organisations providing information/advice
- Befriending services
- Counsellors/bereavement support agencies
Remember

- Serious illness and loss causes distress
- Our job is not to make people feel good but to make them feel less bad
- You are not alone, work within the boundaries of your confidence/competence and seek help from others when necessary
- Recognise your own stress/distress
- Share problems and successes with colleagues
Challenges of Mental Health

- Supporting/referring the right people
- Supporting in the right way
- Selling it right
- Timing it right
- Prevention
- Consent/confidentiality
- Availability and awareness of services
What role can/should palliative care services have with these patients?

The limitations
Principles of Effective Management

- Evaluation
- Explanation
- Set realistic goals
- Non-pharmacological management first
- Individualise pharmacological treatment
  - Preference, ability, age, pharmacokinetics, current and previous drug history, duration of treatment
- Simple, acceptable and convenient medication regimes
  - Consider route, frequency, timing, preparation, taste
  - What can you STOP without compromising quality of life?
- Prophylactic / anticipatory prescribing
- Monitoring and review
- Continuity of care
Summary

- Psychiatric problems are common in palliative care and add to distress
- Importance of anticipation / prevention
- Role advance care planning
- Detailed assessment is the key to good management
- Exclusion of reversible cause
- Individualised management plan
- Team approach
- Good communication
Summary

- Offer an explanation to the patient/carer
  - Check understanding and emotional reaction
  - Allow time for questions

- Negotiate a management plan
  - Remember non-pharmacological measures
    - Behaviour, environment, equipment, support
  - Pharmacological management directed by assessment, prognosis and patient preference
  - Reassess frequently

- Referral to psychiatric services may be required to optimise QoL and support the team
“Mental health leaves a huge legacy, not just for those suffering it but for those around them”

Lysette Anthony
Final thought

Some day, we will all die, Snoopy!

True, but on all the other days, we will not.