Managing Mental Illness in Palliative Care

Advances in Palliative Care Conference

Collabria Care

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Nathan Fairman, MD MPH

Director, Supportive Oncology & Survivorship

UC Davis Comprehensive Cancer Center

UC Davis School of Medicine

Disclosure

- I have no financial conflicts of interest.
- I will disclose any information regarding off-label use of medication.

Objectives

- Explore depression, anxiety, and delirium within the context of serious illness.
- Review pharmacologic and non-pharmacologic management approaches.
- Describe strategies for providing the best care for terminally-ill individuals with mental illness
- Appreciate the need for a coordinated, interprofessional plan of care for patients with mental illness.

Outline

- Overview
- Mr. Rivera, scene 1 — *depression | anxiety*
- Mr. Rivera, scene 2 — *delirium | decisional capacity | surrogacy*
- Mr. Rivera, scene 3 — *end of life care*
- Summary
- Questions + Discussion

OVERVIEW

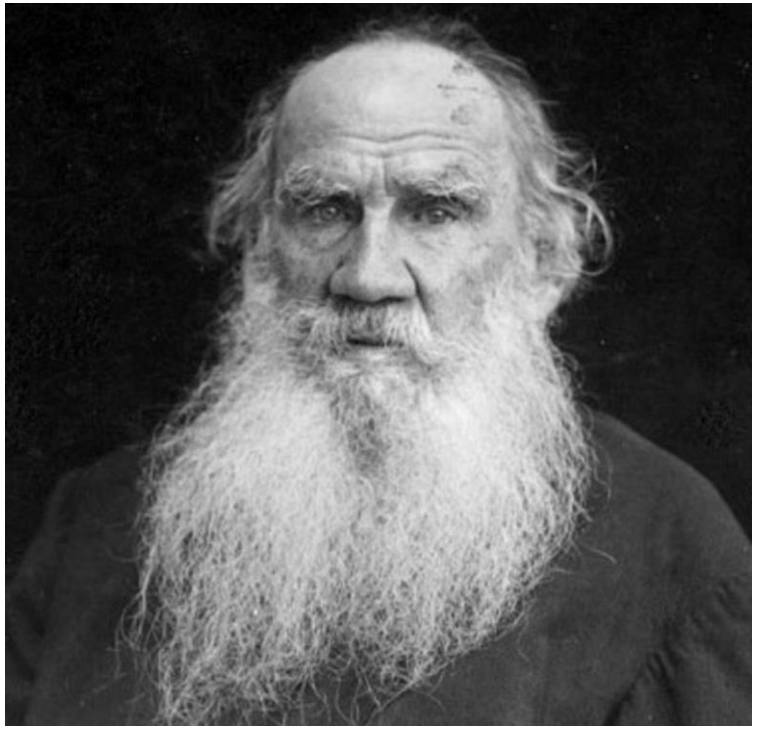
5 reminders

1. This can be hard.
2. We take care of people.
3. Go back to basics – of good HPM.
4. Serious medical illness + serious mental illness
5. Sources of suffering / roles for psychiatry

Reminder #1 *(This can be hard)*

It was true, as the doctor said, that Ivan Ilych's physical sufferings were terrible, but worse than the physical sufferings were his mental sufferings, which were his chief torture."

- Leo Tolstoy (1886), The Death of Ivan Ilych



Reminder #1 *(This can be hard)*

“Mental distress may be perhaps the most intractable pain of all.”

- Cicely Saunders (1963)

Reminder #2 *(We take care of people)*

“managing mental illness”  “taking care of people”

Reminder #3

(Go back to basics – of good HPM)

1. Clarify prognosis and GOC.
2. Address Total Pain *(rely on your IDT).*
3. Optimize non-pharmacologic treatment.
4. Use time-limited therapeutic trials.

Reminder #4

1	**Serious Medical Illness**	*psychiatric distress / disorder* →	Palliative Care + EOLC
2	**Severe Mental Illness**	*serious medical illness* →	Palliative Care + EOLC

Reminder #5

(Sources of suffering / Roles for psychiatry)

abandonment
anger
anxiety
bereavement
boundary-setting
caregiving
coping
delirium
dementia
denial
depression
desire for hastened death
dignity
fear
grief
hope / hopelessness
insomnia
loneliness
loss
pain
personality issues
professional burnout
substance use problems
suicidal ideation

Irwin SA, Ferris F. Can J Psych 2008

Reminder #5

(Sources of suffering / Roles for psychiatry)

- Providing diagnostic expertise
- Providing expertise in treatment planning
- Clarifying ethical concerns (e.g. decisional capacity)
- Assisting with challenging communication tasks
- Providing support to family
- Supporting clinicians in self-care / burnout
- Research & education

Fairman N, Irwin SA. Curr Psychiatr Rep 2013

SCENE 1 *depression | anxiety*

Mr. Rivera *(scene 1)*

- 59 y/o M, COPD + lung cancer (mets to bone)
- Bipolar Disorder, history of psychiatric hospitalization, stable x 1 yr (valproate + aripiprazole)
- History of methamphetamine use, clean x 3 yrs
- Estranged from family
- Discharged to board and care, with hospice enrollment
- Early visits by hospice team: high levels of anxiety + sadness, some misunderstandings about hospice

Scene 1 – Problem List

Patient Challenges

- How to address physical symptoms (pain, dyspnea)
- How to address mental illness
- Limited support
- Decisional capacity / need for surrogate (?)
- “Acceptance” of hospice

Scene 1 – Problem List

Provider Challenges (?)

Depression

Depression: DDC in EOLC

(or, *"who wouldn't be depressed?"*)

Normal sadness ≠ **Clinical depression**

symptoms in emotional / cognitive / somatic domains

true anhedonia

worthlessness, hopelessness

meaninglessness, purposelessness

death is appealing

Block S. Ann Intern Med 2000
Wilson KG. In: Chochinov HM (ed) 2009

Depression: medication TX in EOLC

Back to basics

1. Clarify prognosis and GOC.
2. Address Total Pain *(rely on your IDT)*.
3. Optimize non-pharmacologic treatment.
4. Use time-limited therapeutic trials.

DEPRESSION: DRUG TREATMENTS	
prognosis < 6 mo	**prognosis > 6 mo**
Consider a stimulant: methylphenidate 2.5mg BID	Choose a standard AD: SSRI / SNRI / other

Anxiety

Anxiety

normal experience

- Normal response to stress
- Warning system (coping with danger)

or

pathological response

- Excessive / uncontrollable response to stress
- Response to unknown internal stimulus

Anxiety

symptoms	**vs**	**disorders**
non-psychiatric conditions	**vs**	**psychiatric disorder**
Physical conditions		Adjustment Disorder
Practical concerns		Generalized Anxiety Disorder
Social issues		Panic Disorder
Existential & spiritual concerns		PTSD
		(Delirium)

Anxiety: TX in EOLC

Back to basics

1. Clarify prognosis and GOC.
2. Address Total Pain *(rely on your IDT)*.
3. Optimize non-pharmacologic treatment.
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Anxiety: medication TX in EOLC

ANXIETY: DRUG TREATMENTS	
For rapid relief of symptoms: **choose a BZP vs off-label agent**	**For treating a disorder:** **choose a standard AD**
BZP (lorazepam / clonazepam) gabapentin 100 q1hr PRN Trazodone 25-50 q1hr PRN valproic acid 250 BID propranolol 10 BID / TID ? 2nd gen antipsychotic ?	SSRI / SNRI Remeron (?) TCA

Mr. Rivera – scene 1 summary

“depression”

- prioritize non-pharm intervention
- continue (titrate?) long-standing psychiatric medication

“**anxiety**”

- prioritize non-pharm intervention
- consider short-acting anxiolytic (BZP vs off-label option)

“back to basics”

- clarify GOC, address Total Pain, establish trust, identify the “family”

SCENE 2

delirium | decisional capacity | surrogacy

Mr. Rivera *(scene 2)*

3 weeks later…

- Urgent call from staff at B&C: *“this is exactly what happened before”*
- Suspicious, refusing food, mildly agitated + restless
- Pain seems improved, but dyspnea is worse

Scene 2 – Problem List

- What's going on ?
- What could / should be done ?
- Who should decide ?

Scene 2 – Problem List

- What's going on ?
  a) He's experiencing another manic episode
  b) He's using methamphetamine
  c) He's experiencing delirium
  d) The cancer has spread to his brain
  e) Other …

Delirium

a) Disturbance of attention / awareness

b) Disturbance of cognition

c) Course is acute / subacute; often fluctuates

d) NOT dementia

e) Due to a medical condition

Delirium

Approach to management:

1. Back to basics
2. Make the diagnosis
3. Identify the underlying cause(s)
4. Address the underlying cause(s)
5. Manage symptoms
   - Non-pharmacologic strategies
   - Drug “treatment”

Decisional capacity

Can Mr. Rivera decide for himself ?

If not him, then who ?

Three important reminders:

1. mental illness ≠ incapacity
2. issue-specific and sliding scale threshold
3. use a process-based and team-based approach

Decisional capacity

Who can assess ?

MD, +/- psychologist

Others can help

What are the elements ?

1. Understanding
2. Reasoning
3. Appreciation
4. Communicate a choice

Why does it matter ?

An element of Informed Consent

Ethical obligation to *“respect autonomy”*

Surrogate Decision-making

Who should be the surrogate ?

- Legally
- Ethically

What is the surrogate's role ?

- Substituted judgment
- Best interests

To help us understand the choices Mr. Rivera would make, if he could understand the situation and and speak for himself

Mr. Rivera – scene 2 summary

Delirium

- Identify + address the underlying cause (if consistent with GOC)
- Optimize non-pharmacologic interventions

Decision-making

- Mental illness ≠ incapacity
- Careful assessment of decision-making capacity
- Designation of a surrogate
- Team-based and process-based approach

SCENE 3 *end of life care*

Mr. Rivera *(scene 3)*

10 days later…

- Bedbound; unresponsive; unable to swallow pills
- Dyspnea, pain, mild psychomotor agitation
- Sisters have called
- Two friends taking shifts to care for him
- Decreased urine output; tea-colored

Scene 3 – Problem List

- What's going on ?
- What needs to be done ?

Stopping Psych Meds

Antidepressants

- Continue until unable to swallow
- Consider switch from short $t_{1/2}$ to long $t_{1/2}$ (e.g. paroxetine ➔ sertraline)
- Alternative formulations / routes (e.g. SSRIs avail as liquid; mirtazapine avail as ODT)
- Taper if you can: paroxetine, venlafaxine, bupropion

Stopping Psych Meds (cont'd)

Mood stabilizers

- Continue until unable to swallow
- Lithium: continue unless renal disease (consider VPA vs antipsychotic)
- Depakote: continue unless liver disease (consider antipsychotic)

Antipsychotics

- Continue until unable to swallow
- Consider haloperidol SC / IV or chlorpromazine SC

Attending to Grief

Potential challenges with family estrangement

Looking after the (informal) “family”

Attention to team

SUMMARY

depression
anxiety
delirium
decisional capacity
surrogacy
end of life care

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QUESTIONS + DISCUSSION

Thank you

Nathan Fairman MD MPH
npfairman@ucdavis.edu