Psychiatry and Palliative Care – Not So Strange Bedfellows

Thoughts from My Hospice Experience

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1

Objectives

- Understand aspects of psychiatry in palliative medicine such as assessing decisional capacity in patients with chronic mental illness
- Understand aspects of palliative medicine in psychiatry including common issues that arise in patients with advanced illness and a psychiatric diagnosis
- Explore controversial issues that arise at end of life including suicide prevention and palliative sedation

2

Common Ground

- Psychiatry and Palliative Medicine are both specialties with holistic focus
  - The Whole Body
  - Mind
  - Spirit
  - Social Experience

3

Does it go both ways?

- Plenty of psychiatric aspects of palliative care but….Palliative Psychiatry?
- Plenty of controversy
  - End of life decisions
  - Competency
  - Suicide
  - Palliative sedation

4

Franciscan Hospice

- Regular psychiatry rounds for 5 years
- Psychiatric support to Hospice patients and staff
- Wide variety of psychiatric challenges discussed

5

Common Problems

- Dementias
- Delirium
- Mood disorders –depression/bipolar
- Anxiety
- Personality Disorders
- Substance Abuse
- Schizophrenia

6

And…..not so common Problems

- A woman with 7 personalities and an over involved therapist
- Differential diagnosis of a new onset of Rhyming in an 87 year old woman
- A man with unexplained 6 month course of neuropsychiatric deterioration from normal to death

7

Why so many psychiatric issues in hospice?

- Stresses of severe medical problems
- Neuropsychiatric disease is one of the fastest growing challenges in Hospice care
- Mentally ill people more likely to develop chronic medical illness
- The capture syndrome: patients with psycho-social pathologies stuck with hospice staff due to their illness – nowhere to run and hide

8

Making the right diagnosis: easy-----or tricky

- Visual hallucinations in a neurotic man with an anxiety disorder who has Parkinson disease and drinks too much
- Delusions there's poison in the food in a older woman with memory loss and a history of schizophrenia
- Elation in a woman with Systemic Lupus Erythematosus (SLE)on high dose steroids who's hospice social worker reminds her of her sister she can't stand ---and she just went on vacation

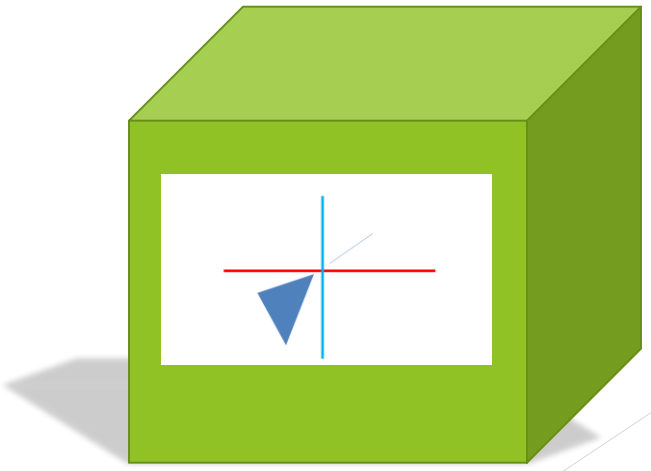
9

Quick helpful tools

- The cube
- Anxiety assessment
- Personality disorder identification
- Competency

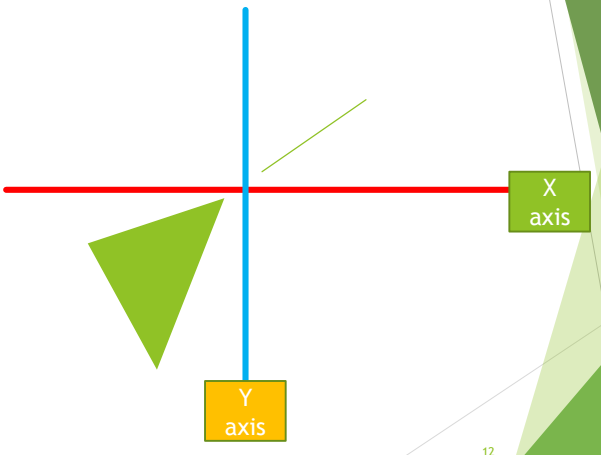
10

The Cube



11

Inside the Cube



12

X axis – Baseline Mental Stability

- Neurotic
  - Relatively stable relationship, work, friend, peer history
- Personality Disorder
  - Chaotic, intense, or odd relationship, work, friend, peer history
- Schizophrenia
  - No relationship, work, friend peer history
    - Typical of developmental delay as well

13

Y axis – Affective (mood)

- Normal
- Depression
- Mania
- Fluctuating

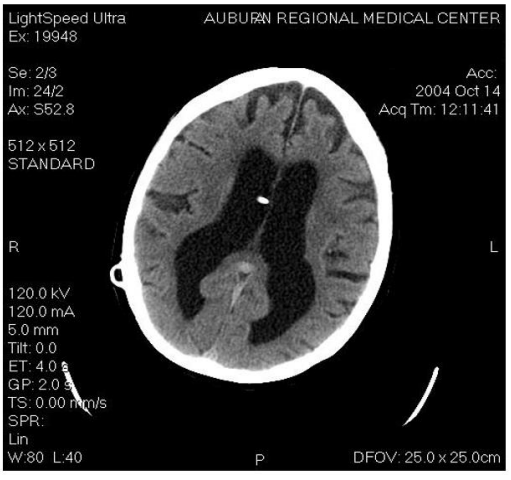
14

Z axis- Neurological

- **Hallmark ---impaired cognitive ability**
  - Delirium
    - Clouded consciousness
    - Acute onset
  - Dementia
    - Chronic confusion
    - Alert with memory loss
  - Developmental delay
    - Paucity of relationships and Special education
  - Traumatic Brain Injury
    - History of head trauma

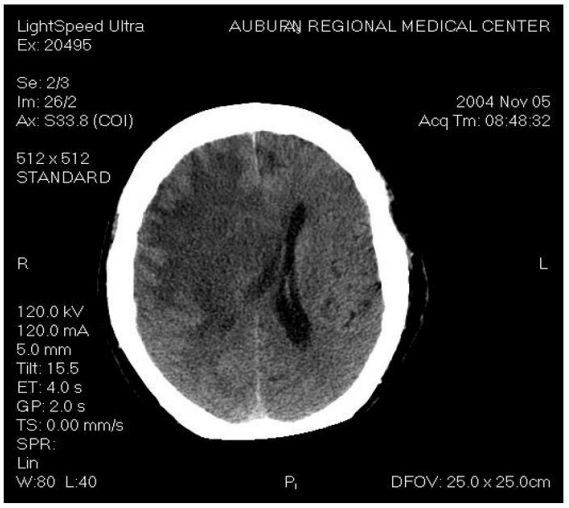
15

Normal Pressure Hydrocephalus (NPH) with shunt



16

Brain Tumor



17

Examples of Three Dimensional Problems in the Cube

- Neurotic Lupus patient with Depression caused by a steroid induced delirium
- Patient with Dementia presents in a manic state with sexually inappropriate behavior induced by Prozac
- Anxious and depressed Schizophrenic with visual hallucinations (not typical of Schizophrenia --usually auditory) found to be in alcohol withdrawal
- Borderline Personality disorder with memory loss due to hypothyroidism after being placed on Lithium for mis-diagnosis of Bipolar illness

18

Anxiety Assessment

- Consideration of anxiety that may be severe due to Hospice or palliative situation
- Look for exacerbation of following:
  - Anxiety
  - Panic attack
  - Obsessive-Compulsive Disorder (OCD)
  - Post-Traumatic Stress Disorder (PTSD)
  - Dissociative states---catatonia, amnesia, conversion, multiple personalities

19

Personality Disorder Assessment

- Splitting ---characteristic of Personality Disorders
  - Projected internalized bipolar view of self due to failure of repression often as the result of abuse
- May be very subtle and not obviously generated directly in patient
- Warning signs –
  - Staff arguing over the patient
  - Multiple supportive or concerned parties become a part of the confusion and complexity of what is otherwise be a relatively simple case

20

Capacity to make decisions

- Competency a legal term---we assess capacity and that opinion should be a team decision
- Differentiate complex decisions—medical, social or financial decisions---from basic ones like what food to eat or desire for sexual pleasure
- About one third of cases in grey zone
  - standardized and individual assessments vary
  - Ask question---what is in best interest of patient

21

Non-pharmacologic Psychiatric Management

- Identification and resolution of delirium if present
- Psychological support
  - Counseling
  - Spiritual guidance
  - Family and cultural acknowledgement
- Specific behavioral interventions
  - Limit setting with group approach
  - Identification and acceptance of specific needs
  - Family interventions

22

Pharmacologic Management

- Identification and resolution of delirium if involving medication
- The least amount of the most effective medication
  - Antidepressants
  - Antipsychotics
  - Antianxiety
  - Non antipsychotic Mood Stabilizers

Antidepressants

- SSRI - Selective serotonin reuptake inhibitors
  - Prozac, Zoloft, Paxil, Celexa
- SNRI- Serotonin and norepinephrine reuptake inhibitors
  - Cymbalta, Effexor
- Non Serotonin
  - Wellbutrin, Ritalin, Remeron

Antipsychotics

- High potency
  - Risperdal, Haldol 1mg
- Medium potency 10mg
  - Zyprexa, Geodon
- Low Potency 100mg
  - Seroquel

25

Antianxiety

- Benzodiazepines
  - Ativan, Xanax, Klonopin
- Non Benzodiazepines
  - Buspar, antidepressants

26

Non-antipsychotic mood stabilizers

- Depakote
- Tegretol
- Lamictal
- Lithium

27

Medication controversies in palliative medicine

- Force medication
  - Court system sanctioned
  - Emergency settings
- Surreptitious medicating
  - Technically not allowed
  - Practically done all the time

28

Suicide

- Suicidal is dramatically on rise across the US
- 50% of emergency room psychiatry deals with suicidal thinking
- Core standard of suicide assessment remains the voicing of having suicidal thoughts
- Only 10% imminently suicidal patients voice suicidal ideation within a week of suicide
- Traditional medical model is to detain and or hospitalize
- One of highest risks is to be within 3 months post psychiatric hospitalization

29

Geographic Suicide in US

- Rural States have highest rates
  - Alaska, Montana, Wyoming
  - Washington number 26
- Rural Counties have highest rates
  - Whatcom, Asotin, Pacific – rates above 17/100K/Y
  - King 13 /100K/Y

30

A Palliative approach to "I'm feeling suicidal"?

- Admit or hold---confused, psychotic, severe anxiety, rage, or severe vegetative signs with depression—20%
- Palliative --We're sorry to have to tell you this but your being suicidal puts you at the same risk of dying of some cancers. There is nothing we can do to change that. An admission will not help. We can help with your situation and depression and anxiety in the clinic but in the end only you can decide to kill yourself or not – 80%

31

Suicide Ideation Follow-up Study

- 6043 CPEP visits (Comprehensive-Psychiatric-Emergency-Program)
  - 3068 with suicidal thoughts/behavior associated
  - 601 admitted
  - 2467 Treated and released from the CPEP
- 2467 patients cross matched with all completed suicides for one year in NYC (all 5 boroughs----643)
  - No patients matched
  - 31 deceased patients seen at our hospital 3 months before suicide (average 42 days)
  - None seen by psychiatry
  - None mentioned suicide
  - None were asked about suicide

32

Completed Suicidal Statistical Risks

- White
- Male
- Older and now middle aged
- Alcoholic/substance abuse
- Medical Problems/chronic pain
- Single
- Financial Problems
- Schizophrenia
- Major or Bipolar Depression
- Hx of Suicide attempt or voicing suicidal thoughts
- War veteran with PTSD

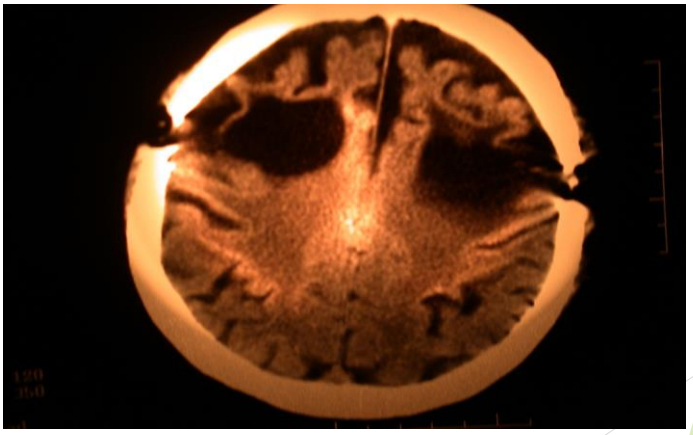
- Literature shows 100% completers voice suicide in year prior but only 10% in week prior

Suicide Management Considerations

- A patient actively offering suicidal thoughts is likely not imminently suicidal with some common sense exceptions------
  - Psychosis
  - Rage
  - Intoxication
  - Evidence of severe depression
  - Confusion
  - Severe anxiety

- All patients should be screened for suicide by all services in the hospital

Palliative sedation and dementia



35

Palliative sedation in dementia refractory to treatment

- Auburn Protocol
  - 4 weeks of hospitalization
  - Multiple failed pharmacologic attempts including pain management
  - Multiple staff and family in agreement
- Palliative sedation is a side effect to a definitive treatment of behaviors that are:
  - Distressing
  - Creating severe caregiving issues
  - Creating severe safety issues

36

Consequences of the palliative sedation dilemma

- Patient suffering
  - "How do you know they're suffering" (hospital administration)
- Family suffering
  - "please, sedate my mother" (Anesthesiologist, Tacoma)
- Poor medical economics
  - Multiple patients with 100 plus day LOS

37

The opiate crisis: a clue of where we need to go

- Started as an over use of narcotics for pain with a simplistic approach having little emphasis on the factors that psychiatry and palliative medicine bring to fore:
  - The whole body
  - Mind
  - Spirit
  - Culture and social experience
- Maybe we should come first?

38

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suicide

Q & A

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