Management of Comorbid Behavioral and Physical Illness Near the End of Life

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Learning objectives

1. Identify comorbidities associated with mental illness and potential end-of-life concerns associated with this population.
2. Describe the importance of integrating psychiatry and medicine when managing end-of-life care for individuals who are affected by comorbid mental and physical disorders.
3. List strategies and practice models for optimal management and end-of-life support for older adults with mental illness and associated comorbidities.

Impact of Illness

Normal path of life - anticipated future

Illness path - unpredictable future

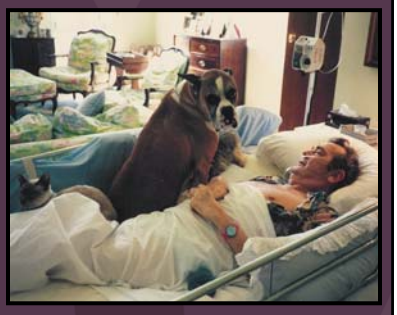
What People Want

- Want to live life to fullest
  - "Fix" disease
  - Relieve suffering
- 90% believe family responsibility to provide care to loved ones
- 90% want to die at home

Egan, K., & Labyak, M. (2001). In Textbook of Palliative Nursing (pp. 7-26).

What People Get

- 23% die at home
- 77% die in institutions
  - 53% in hospitals
  - 24% in nursing homes



Gruneir et al. (2007) Med Care Res Rev 63: 351

What do You want your Illness Experience to be?

Opportunity for Modern Health Care

Normal path of life - anticipated future

Illness - unpredictable future

Desired change

"Cure sometimes, treat often, comfort always"

~ Hippocrates

Palliative Care / Palliative Care Psychiatry

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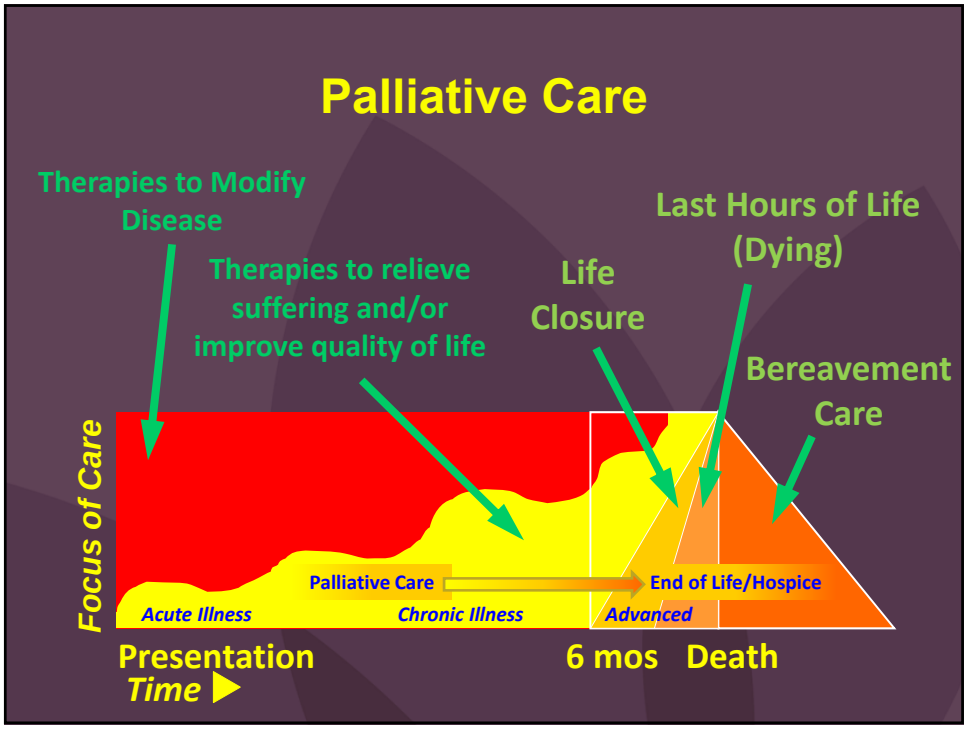
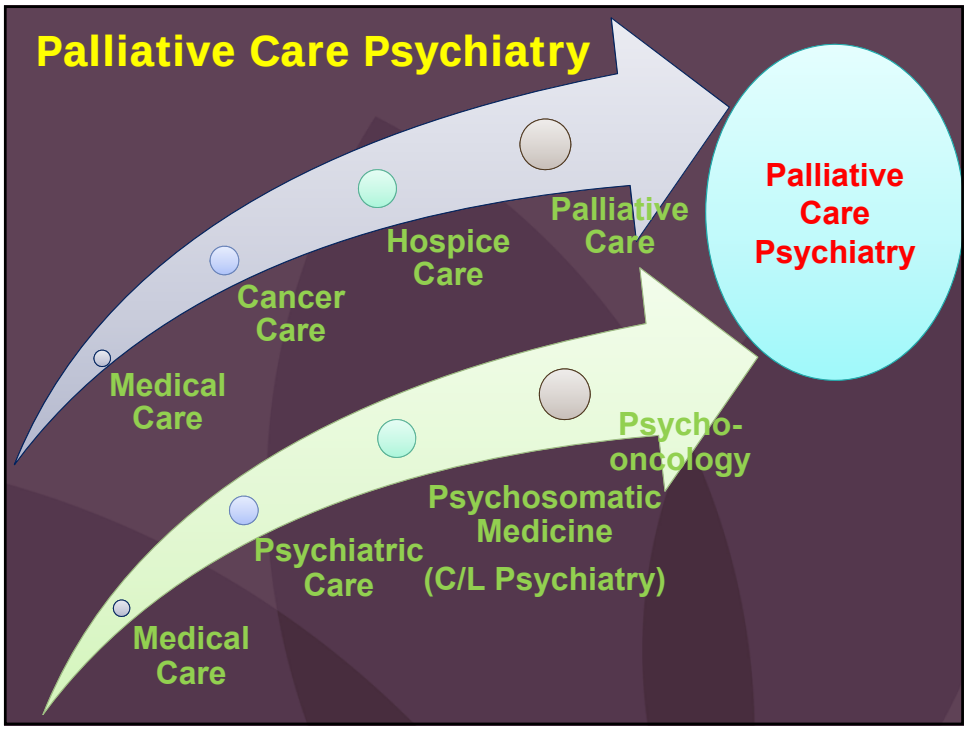
Palliative Care

- Palliative care is specialized medical care for people with serious illnesses
- Focus is on providing relief from symptoms, pain, and stress - whatever the diagnosis
- Goal is to improve quality of life for both patient and family
- It is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support
- It is appropriate at any age and any stage of a serious illness, and it can be provided together with curative treatment

CAPC 2011 Public Opinion Research on PC


Palliative Care
Therapies to Modify Disease
Therapies to relieve suffering and/or improve quality of life
Life Closure
Last Hours of Life (Dying)
Bereavement Care
Focus of Care
Palliative Care
End of Life/Hospice
Acute Illness
Chronic Illness
Advanced
Presentation
6 mos
Death
Time


Palliative Care Psychiatry
Palliative Care Psychiatry
Palliative Care
Hospice Care
Cancer Care
Medical Care
Psycho-oncology
Psychosomatic Medicine
(C/L Psychiatry)
Psychiatric Care
Medical Care

Outcomes of Palliative Care

- More effective than usual care alone in:
  - Reducing patient and family suffering
  - Improving quality of care
  - Enhancing symptom control
  - Lessening feelings of disrespect
- Costs less than standard care alone
- Prolongs life (as opposed to hastens death)

Morrison, et al., Health affairs, 30: 2011
Temel, et al., The New England journal of medicine, 8: 2010
Morrison, et al., Archives of internal medicine, 168: 2008
Taylor, et al., Social science & medicine, 65: 2007
Byock, et al., Journal of palliative medicine, 9: 2006
Teno, et al., JAMA,291: 2004
Pitorak, et al., Journal of palliative medicine, 6: 2003

General Approach to the Palliative Care Patient from a Psychiatric Perspective

Know the Person

" What should I know about you as a person to help me take the best care of you that I can? "

" What are the things at this time in your life that are most important to you or that concern you most? "

" Who else (and / or what else) will be affected by what's happening with your health? "

" Who else should we get involved at this point, to help support you through this difficult time? "

Chochinov Personal Communication

Appreciate Patient Concerns

Loss of autonomy	91%
Less participation in enjoyable activities	88%
Loss of DIGNITY	84%
Losing control of bodily functions	56%
Being a burden on others	35%
Concern of inadequate pain control	21%

Oregon Death with Dignity Act 2010 Annual Report

Dignity

Latin:

- Dignitatem: "worthiness"
- Dignus: "worth, worthy, proper, fitting"

http://dictionary.reference.com/browse/dignity

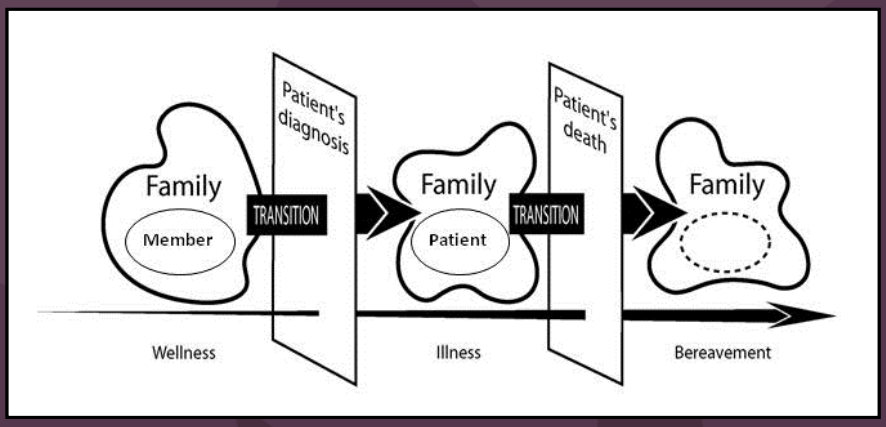
Address Factors that Affect a Sense of Dignity

Percent of patients with cancer who agreed or strongly agreed:

• Not being treated with respect or concern	87%
• Feeling like a burden	87%
• Feeling a lack of control	84%
• Feeling life was meaninglessness, left no lasting impression	83%
• Bodily functions	83%
• Not feeling worthwhile or valued	81%

Chochinov et al. JPM 2006;9:666

Tend to Those Affected



Ferris FD, et al. (2002) JPSM 24: 106.

Provide Whole-Person Care

Disease management	Physical	Psychological
Loss, grief		Social
End of life / death management	Practical	Spiritual

Ferris FD, et al. (2002) JPSM 24: 106.

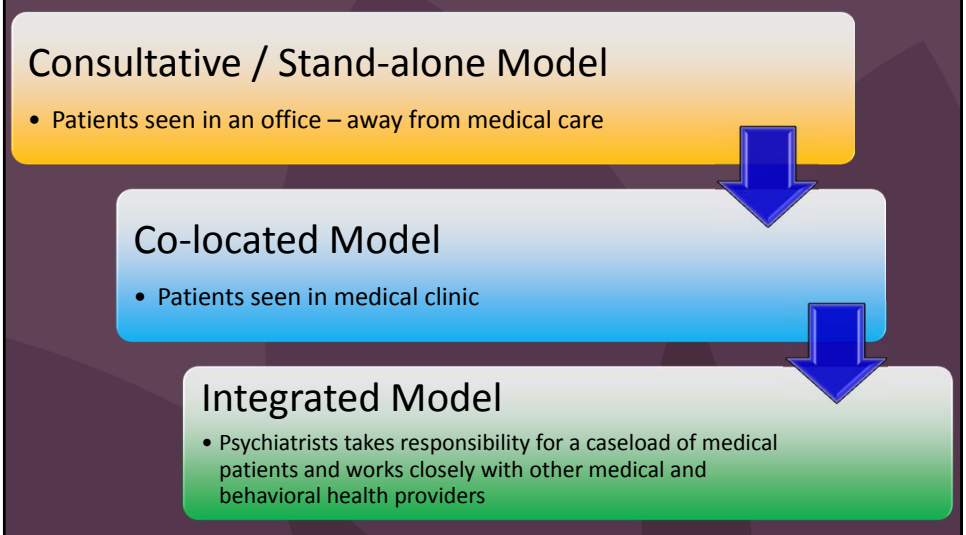
Appreciate New Health Care Goals

VALUE BASED CARE

- **The Triple Aim:**
  - **Increased access / Better quality care**
  - **Better outcomes / Satisfaction**
  - **Lower costs**

Value = Quality / Cost

Shift the Care Provision Model



http://uwaims.org

Provide Effective Integrated Care

Patient Centered Team Care / Collaborative / Integrated

- Effective collaboration requires more than physical co-location

Population-Based

- Patients tracked in a registry: minimize falls through the cracks

Measurement-Based Treatment to Target

- Treatments are actively changed until the clinical goals are achieved

Evidence-Based

- Treatments used are evidence-based

Accountable

- Providers are accountable and can be reimbursed for quality of care and clinical outcomes, not just the volume of care provided

http://uwaims.org

Impact More Patients

Consultative / Stand-alone Model

- 2745 slots a year; high no-show rate

Co-located Model

- 2745 slots a year; lower no-show rate

Integrated Model

- Manage a caseload of 4050-8100 patients per year

Outcomes of Integration

Integrating psychiatric and medical care increases inpatient and outpatient *value*:

- **Increases quality**
  - **Less physical pain**
  - **Better functioning**
  - **Higher quality of life**
  - **Greater patient and provider satisfaction**

- **Reduces cost (ROI: $6.5 saved / $1 invested)**
  - **Long-term care admissions**
  - **Re-admissions**
  - **Health costs / utilization**

http://www.ahrq.gov/about/nac2012/nac0712/cohenmeyers/cohenmeyerssl10.htm
Hussain M, Seitz D: Psychosomatics 2014:55:315-325

Specific Psychiatric Issues

Specific Causes of Suffering that Might Benefit from Psychiatry

- Agitation
- Anxiety
- Bereavement
- Caregiver Stress
- Desire for Hastened Death
- Delirium
- Dementia
- Depression
- Insomnia
- Any DSM V Dx

- Most patients in palliative care settings have no previous psychiatric history

Irwin SA & Ferris FD (2008) Can J Psych 53: 713.

Prevalence

Delirium	up to 88%
Depression	up to 42%
Dementia	> 30%
Anxiety	> 70%

Irwin SA & Ferris FD (2008) Can J Psych 53: 713.

Mental Health Experts for End-of-Life Care

- Diagnoses are hard to make
- Differential diagnoses are complicated
- Clinicians forget about non–pharmacological interventions
- Clinicians are uncomfortable with psycho–pharmacological interventions, especially off–label

Irwin SA & Ferris FD (2008) Can J Psych 53: 713.

What is Depression?

- Symptom, Episode, Disorder
- Depressed mood
- Decreased interest or pleasure
- Helpless, hopeless, worthless, guilt
- Indecision, poor concentration
- Suicidal ideation
- Weight change
- Sleep change
- Decreased energy
- Psychomotor change

American Psychiatric Association. (2000) DSM. 943.

Depression in Palliative Care

- Somatic symptoms often NOT helpful
- Focus on cognitive and emotional symptoms:
  - Dysphoria, despair, sadness
  - Anhedonia
  - Worthlessness, helplessness, hopelessness
  - Guilt
  - Loss of self-esteem
  - Desire for hastened death

Block SD. (2000) Ann Intern Med 132: 209
Chochinov HM, Breitbart W (eds): Handbook of psychiatry in palliative medicine

Depression: Screening

1 or 2 questions to ask:

1) Over the past 2 weeks have you ever felt down, depressed, or hopeless?

2) Over the past 2 weeks, have you felt little pleasure or interest in doing things?

Sensitivity 96-100% *Specificity 57-100%*

Pignone MP, et al. (2002) Ann Intern Med 136: 765.
Chochinov HM, et al. (1997) Am J Psychiatry 154: 674.
Robinson JA, Crawford GB. (2005) Palliat Med 19: 278.

How to Treat Depression. . .

Review Desired Outcomes

Relieve

- Non-pharmacological
- Pharmacological

Consult psychiatrist / mental health professional for assistance

Psychotherapy . . .

- We all do supportive psychotherapy
- Group therapy reduces stress and mood symptoms
- Existential group therapy focused on value and meaning

Classen C, et al. (2001) Arch Gen Psychiatry 58: 494
Spiegel D, et al. (1981) Arch Gen Psychiatry 38: 527
Goodwin PJ, et al. (2001) N Engl J Med 345: 1719
Breitbart W. (2002) Support Care Cancer 10: 272
Breitbart W, et al. (2004) Can J Psychiatry 49: 366
Greenstein M, Breitbart W. (2000) Am J Psychother 54: 486

. . .Psychotherapy

- Weave into routine care
  - Include family when possible
- Improve understanding of situation
- Educate about modifiable factors
- Create a different perspective
- Identify strengths, coping strategies

Current Depression Treatment Guidelines

- Moderate to severe depression:
  - Psychotherapy + Antidepressants
    - Titration of dose over weeks
    - If no moderate improvement by 6-8 weeks
      - Adjust treatment, monitor ANOTHER 6-8 weeks
    - Continuation after remission = 16 to 20 weeks
      - Then maintenance
    - Partial response is associated with poor outcomes

American Psychiatric Association. (2000) Am J Psychiatry 157: 1
Rodin G, et al. (2007) Curr Oncol 14: 180

Why the Guidelines Fall Short

- STAR*D
  - 14 weeks monotherapy with SSRI
    - ≈ 50% response and ≈ 30% remission
- Hospice
  - average time on hospice in US ≈ 10 weeks (median ≈ 3 weeks)
  - 1/3 of SDH patients die within 1 week

Sussman N. (2007) Prim Care Companion J Clin Psychiatry 9: 331
NHPCO Fact and Figures Hospice Care in US (2010)

Psychostimulants

- Rapid effect in hours to days
- Minimal adverse effects
- Can continue indefinitely
- Titrate to effect or side effect
- Tolerance may not be a factor
- Diminish opioid induced sedation
- May provide adjuvant analgesia

Bruera E, et al. (2003) J Clin Oncol 21: 4439
Wallace AE, et al. (1995) Am J Psychiatry 152: 929
Homsi J, et al. (2001) Am J Hosp Palliat Care 18: 403
Bruera E, Watanabe S. (1994) J Pain Symptom Manage 9: 412

What is Anxiety?

- Expected, NORMAL, transient response to stress
- May help with warning of danger or coping with the stress

What is Pathologic Anxiety?

- Excessive response to external stress
- Response to an unknown internal stimulus

Characteristics of Pathologic Anxiety

- Autonomy: No recognizable trigger
- Intensity: Exceeds ability to cope with stress
- Duration: Persistent (instead of transient)
- Behavior: Impaired coping, disabling behaviors
  - Avoidance
  - Withdrawal

Symptoms of Pathologic Anxiety

- Physical: Autonomic arousal
  Tachycardia, tachypnea, diaphoresis, diarrhea, dizziness
- Affective: Edginess, terror, impending doom
- Behavioral: Avoidance, compulsions, psychomotor agitation
- Cognitive: Worry, apprehension, obsessions, fears, dread

Anxiety Disorders

- Adjustment Disorder
- Panic Disorder
- Post-traumatic Stress Disorder*
- Generalized Anxiety Disorder
- Obsessive-Compulsive Disorder*
- Social Phobia
- Specific Phobia

Management

- Supportive counseling
- Relaxation techniques
- Pharmacotherapy
- Combinations are best

Complimentary Therapies

- Guided imagery
- Muscle relaxation
- Hypnosis
- Meditation
- Massage
- Aromatherapy
- Healing Touch
- Energy therapy
- Biofeedback
- Exercise (if possible)
- Bright light exposure
- Avoid caffeine, alcohol
- Treat insomnia

Payne DK, Massie MJ. Anxiety in palliative care. In: Breitbart W, ed. Handbook of Psychiatry in Palliative Medicine. New York, NY: Oxford University Press; 2000:435
Carter C, Holloway R, Schwenk TL. Patient Care. November 15,1994:36–52.

Acute Anxiety in the Medically Well

- Benzodiazepines – ideal for short term management, may play a role long term
  - Anxiolytics, muscle relaxants, amnestics
  - Contraindicated in elderly/medically ill
    - (amnesia, delirium, falls)
  - Choose based on half-life (t½)
  - Almost never more than one at a time
  - Taper slowly to avoid withdrawal

Triozzi PL, Goldstein D, Laszlo J. Contributions of benzodiazepines to cancer therapy. Cancer Invest. 1988;6(1):103-111

Chronic Anxiety in the Medically Well

- SSRIs (e.g. paroxetine, sertraline, escitalopram)
  - Latency 2–4 weeks
  - Well tolerated
  - Once-daily dosing
  - Start with lower doses in anxiety or advanced illness (can cause anxiety)
  - Titrate to therapeutic dose
    - Often higher than needed for depression
  - Check for medication interactions

Alternatives/1st Line in the Medically ill

- Gabapentin (100 mg q1hr)
- Trazodone (25-50 mg q1hr)
- Buspirone
- Valproate/other anticonvulsants
- Opioids?
- Atypical antipsychotics?

Schatzberg AF, Cole JO, DeBattista C. Manual of Clinical Psychopharmacology. 4th ed. Washington, D.C: American Psychiatric Pub.; 2003.

Learning objectives

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2. Describe the importance of integrating psychiatry and medicine when managing end-of-life care for individuals who are affected by comorbid mental and physical disorders.
3. List strategies and practice models for optimal management and end-of-life support for older adults with mental illness and associated comorbidities.

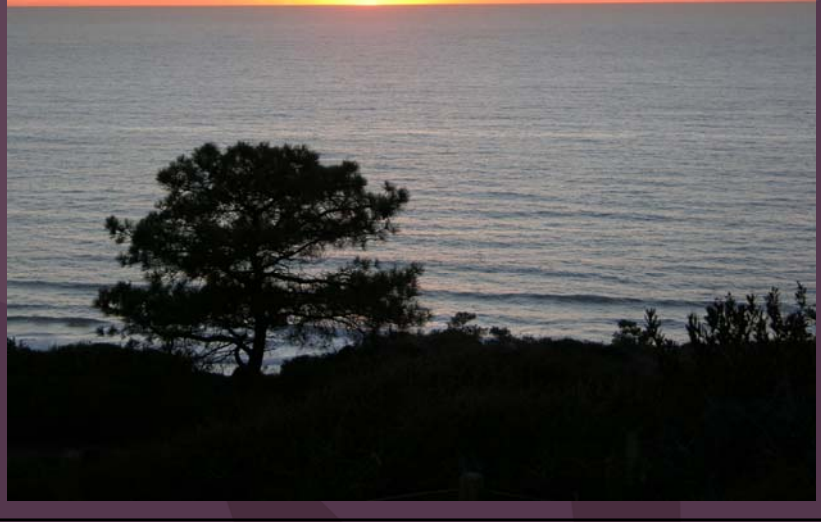
"Although the world is full of suffering, it is full also of the overcoming of it"

~ Helen Keller

Strengthening Meaning, Value, and Dignity

Transdisciplinary Care

What experience do we want for our patients & families, our loved ones, and ultimately ourselves?



QUESTIONS?

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