Mental Health Care at the End of Life
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OBJECTIVES
- Recognize major psychiatric syndromes at the end of life
- Review treatment approaches, new and old
- Include both the patient and the family
- Focus on goals of care

The Takeaway!
- EOL care - whether medical or psychiatric - is
  - Person oriented, because the person is dying
  - Family oriented, because the family is losing a loved one
- The clinician-caregiver must make a shift from the customary (and comfortable) RECOVERY MODEL
- To the PALLIATIVE MODEL, made necessary by the fact of approaching death (uncomfortable).
  - And assist the patient and family to do the same

Death and Dying
Certainty and Uncertainties
- Death awareness: Abstract vs. actualized
- Death anxiety: Avoided or embraced
- Death acceptance: A bottomless practice of not-knowing, bearing witness and compassion
- Compassion: the transformation of fear of death to selfless concern for the other
- Bearing witness: attentive and present
- Not-knowing: not “in your head” - not in your “comfort zone”

Paradigm Shift: from this

Paradigm Shift: to this
Paradigm Shift: and this

THE STAR METHOD

PERSON

Values/AD

Cognition

Coping

Family/friends

Spirituality

Medical/Psych issues

Goals

Needs

PERSON

Medications

Personality

PALLIATIVE/HOSPICE CARE

- For the relief of suffering
  - Physical, emotional, moral, existential
- The support of well being
  - Resilience
  - Positive outlook
  - Attention
  - Generosity

EOL GOALS: The “good enough death”

- Finishing well
- Connected to loved ones
- Secure
- Comfortable
- At peace
- Legacy
Mental Health Assessment

- Symptoms
- Syndrome
- Diagnosis
- Situation
- Goals and elements of well being
  - What must be present for life to have meaning?
  - What is the dealbreaker?

Syndromes

- Anxiety: worry, restlessness, tension, anger
- Depression: low interest and pleasure, low mood, withdrawal
- Dementia: agitation, apathy, functional decline
- Delirium: fluctuating attention, consciousness, arousal
- Psychosis: hallucinations, delusions, paranoia
- Insomnia: varieties of sleep disturbances
- Demoralization
- Personality Disorders

Anxiety

- Most common symptoms/syndrome/diagnosis in the elderly
- An abiding state, or one tied to specific recurring precipitant
- Generalized, phobic, obsessive/compulsive, post traumatic, somatic
- Arises out of vulnerability, impaired security or trust

Treatment of Anxiety

- Provide and clarify accurate information
- Identify need, loss, stressor, threat, vulnerability
- Provide support, access to soothing
- Education, rehearsal
- CBT, hypnosis, relaxation
- Antidepressant medication when symptoms are moderate to severe or not improving
- SSRIs, augmentation agents, ketamine

Depression

- Overlap with other illnesses: fatigue, low appetite and energy, reduced activity, sleep issues, physical symptoms
- Overlap with grief, anticipating loss
- Comorbid with pain, dependency
- Induced by a variety of illnesses and medications
- Mood may not be sad, but rather anxious or blunted
- Thoughts dwell on helplessness, worthlessness, hopelessness, guilt: "a toothache in the soul"
Psychosis

- Psychotic symptoms are usually part of another problem:
  - Delirium, dementia, substance induced, depression, medications, or other physical illnesses (neurologic, hypoxemic, metabolic)
  - May be due to a preexisting psychotic illness
  - May emerge in late life, usually as paranoia
- Accurate information, skilled response by caregivers
  - Counter-projective interviewing, empathy, reframing
  - Antipsychotics if symptoms cause distress or may cause harm
  - Start low dose, titration according to ½ life

Delirium

- Secondary to medical or neurologic illness
  - Agitated or quiet
  - Terminal delirium
- Calm, low stimulus environment
- Treat underlying illness, pain, etc
  - Haldol with or w/o lorazepam, or may use another antipsychotic
  - Palliative sedation in terminal delirium

Insomnia

- Identify cause:
  - “the ravaged sleep of care”
  - Pain, other symptoms of discomfort or disturbance
  - Induced by illness or environment: damaged biological clock
  - Caregiving at odd hours
  - Medications
  - Comorbid psychiatric disorder
- Treatment of Insomnia
  - Improve management of medical symptoms
  - Modify environment, schedules of caregiving, activity
  - Treat comorbid psychiatric issues
  - Behavioral interventions, relaxation, hypnosis
  - Trazodone, low-dose mirtazapine, melatonin, benzodiazepine
  - Avoid Benadryl or other anticholinergic; stimulants, etc.

Demoralization

- Loss of purpose and meaning and connection
  - Existential distress, burden on others
  - Dependency, incompetence, impotence, uselessness
  - Perception or fear of loss of dignity
  - Desire to hasten death or suicidal ideation
- Meaning oriented therapy, dignity therapy, legacy therapy

PERSONALITY DISORDERS

- EXTERNALIZATION
- ATTENTION SEEKING
- VICTIMIZATION
- IDEALIZATION/CONTEMPT
- JOINING WITH LIMIT SETTING
- CONSISTENCY AND CONSEQUENCES
- CLARITY OF TREATMENT PLAN
Dementia

- Vulnerability
- No treatment
- BPSD: depression, anxiety, insomnia, restlessness, confusion, agitation, psychosis, combativeness, delirium
- Multiple medical complications: falls, infections, skin breakdown, dehydration, poor nutrition, constipation, incontinence
- Family conflicts about support/prevention vs letting go
- Caregiver stress and decision making

BPSD: Provocation

Stress, Stimulation, Discomfort, Needs

- Stress: all things that are overly demanding, or overly stimulating
- Stimulation: Too much or too little
  - space, objects, color, movement, sounds, touch, exercise, soothing, relationships, memories, feelings, thoughts
- Discomfort: Hunger, lack of sleep, cold, hot, humid, wet, tight or loose clothes, incontinence, posture/position
- Physical illness/symptom burden: Pain, infections, dyspnea, GI distress, skin breakdown, fatigue, etc.
- Needs: As above, plus possible internal or personal needs

BPSD: Treatment

- Enhance prognostic awareness
- Clarify goals and process of decision making
- Support caregivers
- Palliative approach respects patient’s increasing vulnerability
- BPSD are complex, but often can be ameliorated

BPSD: Treatment

- Accommodate the patient
- Reduce all stressors
- Support caregivers
- Interventions and environment must be flexible and adaptive to patient needs and capacities
- Medications may be effective, when targeted strategically
- One-to-one supervision is the only reliable intervention

BPSD Pharmacology

- The good: target symptom or syndrome is defined and side effect profile is OK. Ongoing monitoring
- The bad: poor and inadequate assessment leads to a shotgun approach, minimal monitoring, side effects
- The ugly: dangerous, incapacitating or uncomfortable side effects, especially if not noticed

BPSD

- Treatable only with behavioral interventions
  - When confined to a specific situation or demand
  - When arising out of confusion per se: wandering, etc
- Treatable with medications
  - Overlapping with symptoms of a psychiatric syndrome
  - Patterned and more pervasive
  - Associated with aggression or other excess reactivity
  - Perceived to be associated with unrelieved suffering
BPSD Pharmacology
The Good, the Bad, and the Ugly

- Good medications:
  - SSRIs, mirtazapine, trazodone, buspirone, prazosin, doxazosin, melatonin, and some antipsychotics (quetiapine, risperidone, olanzapine)

- Bad medications: Benzodiazepines, nearly all medications in high doses

- Ugly medications: Anticonvulsants (maybe gabapentin is OK). High dose high potency antipsychotics

New Stuff

- Neudextra: for ALS. Not indicated for BPSD. May be effective if symptoms of Pseudobulbar affect are present. Costly. Safe.
- Alpha blockers: the old is new again: Prazosin Doxazosin
  - Prazosin: 5-10mg, titrate by 1mg every 3 days
  - Doxazosin: 2-8mg, titrate every 5 days
  - Observe for orthostasis, monitor BP, adjust other BP meds

BPSD: Other stuff

- Estrogen: doesn’t work
- Exercise: may help sleep and agitation, but may also provoke BPSD. And it increases cognitive decline
- Cannabis/cannabinoids
  - Little evidence in literature, but it is positive
  - No dosing guidelines
  - Mostly safe
  - May be costly or illegal

KETAMINE

- For depression and anxiety, especially if treatment resistant or at end of life
- 0.5mg per kilogram, oral or by IV infusion
  - Oral: daily for 2-4 weeks, may repeat course as needed
  - IV: M-W-F up to two weeks, may repeat course as needed
  - Lorazepam for psychotomimetic or dissociative reactions
  - Mild fatigue is the most common side effect
  - Esketamine nasal inhaler is coming soon