

Leading the Integration of Physical and Mental Health Care

# Palliative care in patients with severe mental illness

Presented by:

Harleen Toor MD CCFP(PC)

Ciara Whelan MD CCFP(PC)



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## Learning Objectives

- Explain the barriers faced by patients with severe and persistent mental illness in accessing comprehensive palliative care
- Discuss how to optimize care of patients in various care settings
- Describe how to ensure services are provided in a way that recognizes potential challenges in assessing patient capacity and goals of care
- Outline approaches that may facilitate the delivery of equitable and comprehensive palliative care for both symptom management and advance care planning

## Outline

- Outline the challenge of providing palliative care in the context of severe mental illness
- Present three cases illustrating palliative care management of patients at CAMH
- Briefly review the approach to difficult conversations around goals of care and advance care planning in this population
- Outline the benefit of collaborative psychiatry – palliative care collaborations

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- The World Health Organization (WHO) defines palliative care as “an approach that improves the quality of life of patients and their families facing the problem 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”

## The problem

- Provision of palliative care to patients with mental illness may be directly or indirectly limited by a number of factors
  - Challenges in initiating advance care planning due to impaired decision-making capacity
  - Patients admitted to facilities without expert palliative care eg. Long term care
  - Siloing of psychiatric and palliative care
  - Internalized stigma from non-psychiatric healthcare providers
    - Discomfort with working with patients with hallucinations/delusions, agitation
  - Social determinants of health
    - Due to social isolation, stigma, discrimination, patients may not have resources or sufficient social capital to self-advocate or seek out palliative care



## Importance of providing palliative care to patients with severe mental illness

- Health equity for vulnerable populations
- Dignity at the end of life
- Battling ‘presumed incompetence’
  - Patients may be assumed to be incapable of informed decision-making solely based on psychiatric diagnosis
  - Advance directive completion is very low for people with SPMI

# Challenges in palliative symptom management

- Opioids
  - Opioids remain first-line for management of many types of cancer-related and terminal pain
  - Also first line for management of dyspnea at the end of life
  - Careful initiation, titration, and monitoring needed for patients with comorbid substance use and advanced/terminal illness
- Benzodiazepenes
  - Used for palliative sedation
  - Anxiety, dyspnea at the end of life
  - Similar concerns as opioids
- Methadone
  - Exemption no longer needed to prescribe for analgesia
- Antipsychotics
  - Used often at the end of life eg. Nozinan
  - Haldol, prochlorperazine, olanzapine also used often for management of chemotherapy- or cancer-related nausea/vomiting



# Case 1

- 49 yo Inuit woman
- Referred by MSH oncologist
- Metastatic breast cancer to lymph nodes, lung, and bone
- Underwent mastectomy, axillary lymph node dissection, radiation to pelvic, SI mets, and progressed on paclitaxel
- Offered treatment with capecitabine, but declined treatment for unknown reasons

- Admitted to CAMH for 9 years
- Previously lived in Nunavut and had no family or community social supports in Toronto
- Psychiatric history
  - Antisocial personality disorder
  - Borderline personality disorder
  - Schizoaffective disorder
  - Delusional disorder
  - Previous history of alcohol use disorder



## Clinical question

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- Does this patient have capacity to make decisions regarding cancer treatment given the patient's paranoid and delusional thought processes?

## Approach

- Seen in the outpatient palliative care clinic at MSH
- Patient was accompanied by a social worker and nurse from CAMH
- Patient was seen in clinic by a palliative care physician, palliative care/oncology social worker, and an Aboriginal Patient Navigator

# Goals of care discussion

- Illness understanding
  - Limited but she did express understanding that regardless of if she pursued further systemic therapy, her disease was incurable and she would likely die of her illness.
- Values
  - Patient wished to return home to Nunavut to die
  - She expressed the desire to have whale meat one more time before dying
  - She wished to see her family, particularly her sister, before she died.
- Treatment preferences
  - She did not want further treatment of her cancer
  - This was based on the concern that she would not be able to make it back home while well enough for the journey
  - She preferred to go back home now rather than receive treatment in Toronto

## Impression

- The patient had carefully considered the potential risks and side effects of chemotherapy and weigh this with her wish to die in her own community, with the comfort of her loved ones around her.

## Plan

- Recommendations around management of end of life symptoms were made
  - Opioids for management of pain and dyspnea
    - Hydromorphone 1mg q4h and 1mg q1h PRN for pain and dyspnea
    - Eventually switching to long-acting hydromorph contin with ongoing q1h PRN breakthroughs
  - Alternative antipsychotics with known palliative benefits eg. Nozinan, olanzapine
  - End of life symptom management: glycopyrrolate for terminal secretions, transition to subcutaneous medications, titration of CADD pump for pain management
  - Advice around deprescribing
    - Discontinue statin, vitamins to reduce pill burden

## Plan

- Arrangements made for the patient to be transferred to a Nunavut hospital on compassionate grounds
- Consultative support provided to physicians in Iqaluit
- She died 5 weeks later, in the company of her family.

- Thoughts?



# Case #2

- 50 yo woman
- Referred by CAMH hospitalist
- Admitted for five years
- Schizoaffective disorder – bipolar type
- Metastatic breast cancer to bone
- Treated with mastectomy
- Declined chemotherapy but accepted hormone therapy
  - Treated with tamoxifen and radiation to the lumbar spine and pelvic mets

## Presentation

- Recent development of left humerus metastasis
- Multiple missed radiation oncology appointments
- Sporadically declining blood work, imaging
- Occasional aggressive and confrontational behavior towards providers
- At times, agitated during appointments and would leave partway through encounters
- Declined any medication administered intravenously or subcutaneously (eg. Bisphosphonates)

## Approach

- Appointment scheduled as the last of the day to allow ample time
- Patient was accompanied by CAMH SW and nurse
- Patient left after a minutes into the encounter following difficulty coping with difficult conversations around her illness
- Upon discussion with CAMH staff, decided to allow patient time to process the visit, with the opportunity to return
- She returned 20 minutes later, and the visit resumed

## Goals of care

- Illness Understanding
  - Adequate illness understanding although pervaded with confusion around how the disease was manifesting
  - Needed some education around how cancer spreads. Specifically, explained that her breast cancer had spread to her bones, not that she had both breast and bone cancer.
- Values
  - Sole goal to have pain better controlled
- Treatment preferences
  - Agreed to re-referral to radiation oncology and recommendations around analgesics

## Plan

- Patient was using high doses of hydromorphone without relief
  - Rotate to fentanyl based on equi-analgesic doses and dose reduction for incomplete cross tolerance
  - Fentanyl patch changed every 72 hours, so easier for staff to administer without frequent conversations every time next dose was due
- Discussed PO bisphosphonates with oncology pharmacist eg. Clodronate
- No benefit from maxeran, olanzapine, and gravol
  - Switch to Haldol and ondansetron
  - Ondansetron particularly useful in the context of upcoming radiation
  - Beware constipation from ondansetron (coupled with potential opioid-induced constipation from fentanyl) and bowel regimen optimized with stimulant agents (senna) and osmotic agent (PEG PRN)

## Plan

- Hand over to radiation oncology
  - Suggested rad onc allow sufficient time for encounter
  - Recommended that patient be accompanied for consultation and radiation treatment by her social worker and/or psychiatric nurse
- Patient received treatment to her left humerus, which markedly improved her pain

## Key Points

- Capacity assessments must be completed in the context of a patient's goals of care
  - **Early and frequent palliative care involvement is necessary to ensure timely conversations around this topic**
- Interprofessional approach necessary
  - SW, nursing, Aboriginal Patient Navigator, psychiatry, oncology, palliative care
- Systematic review on palliative care for people with severe mental illness
  - Dearth of empirical studies to guide management

## Additional resources

- Facilitating a safe clinical environment for patient: extra time, reducing noise, crowding, and accommodating lateness
- Providing resources such as transportation to radiation treatments, volunteers to accompany patients during long chemotherapy sessions



# Case #3

- 58 yo woman
- Referred by PMH Oncologist
- Metastatic breast cancer to liver, pleura, diffuse bone ++
- Endometrial cancer
- No longer on active treatment

- Admitted to CAMH on forensic unit for last 5 years
- Daughter in Toronto
- Psychiatric history
  - Major depressive disorder
  - Anxiety



## Clinical question

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- Will this patient accept palliative care?
- How to provide palliative care in the CAMH setting?

## Approach

- Preliminary meeting with CAMH Hospitalist, social worker, nurse and then invited patient's daughter
- First visit with patient: translator, CAMH Hospitalist, and TL palliative care physician all present
- Subsequent visits generally along with CAMH Hospitalist and nursing staff
- Goals of care planning meeting involving LHIN community care coordinator and many other CAMH staff members

## Goals of care discussion

- Illness understanding
  - Understood extent of her illness and was consistent in her wish for comfort care
- Values
  - Patient wished to remain at CAMH for end of life rather than transferring to PCU
- Treatment preferences
  - She did not want further cancer treatment or investigations/treatment of potential complications ie DVT
  - She was extremely stoic and cautious with medication changes

## Impression

- The patient clearly communicated that her primary wish was for comfort care until end of life in the place where she felt safest and where she considered home – CAMH.

## Plan

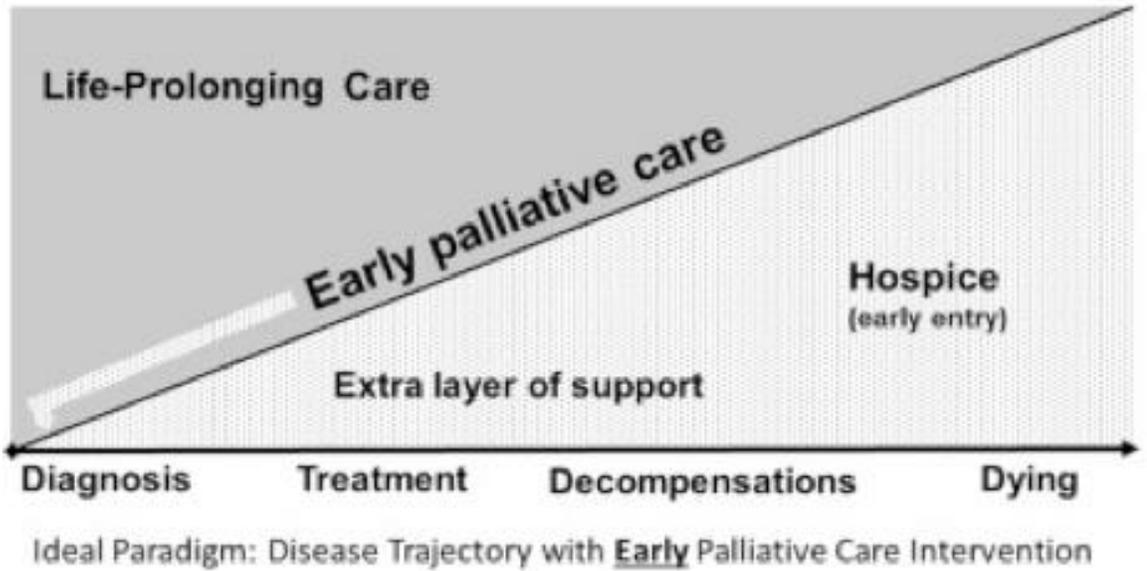
- Recommendations around end of life planning were made:
  - Preparing for functional decline (OT/PSW/equipment/supplies)
  - Subcutaneous symptom relief set – discussed with Hospitalist who also reviewed with pt and her daughter.
    - Hydromorphone, Midazolam, Methotrimeprazine, Glycopyrrolate
    - CADD pump (with LHIN support) vs intermittent injections
  - Supplemental oxygen availability
  - Backup options if no longer feasible to manage in this unit
    - transfer to another unit?
    - move to PCU (ORB?)

## Plan

- Offered PCU tour to patient – she declined
- Over the next 2 months the CAMH team made adjustments according to her care needs, TL palliative MD consulted on pain and symptom management
- She died peacefully on CAMH forensic unit



# Palliative care models



“Reconceptualizing palliative care as a continuum of support” Wang, David H., MD. Published March 31, 2017. Volume 69, Issue 4. Pages 437-443.

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- Inpatient
  - Home and community
  - Hospice and palliative care units
  - Outpatient/clinic

## Inpatient palliative care

- For CAMH patients admitted to Mount Sinai, palliative care can be consulted
- Provide symptom management, advance care and end of life planning
- Spiritual care
  - Eg. Smudging ceremonies possible

## Home palliative care

- Seamlessly integrated with LHIN home and community care
- Can provide SC medications, nursing, PSW care
- Not 24/7 care

## Hospice and Palliative Care Units

- PCUs located within a hospital eg. SHSC, SMH, PMH, Bridgepoint
- Hospice housed separately eg. Kensington Hospice, Casey House
- 24/7 nursing and physician support
- <3 months prognosis

## Outpatient Palliative Care

- Early involvement
- Longitudinal relationships
- Compatible for patients with active goals of care, full code
- Consultative or MRP role

## Key Messages

- Early identification of patients requiring palliative care
- Accommodation and cultural competency essential
- Advance care planning early and often
- Consultation for help with symptom management and end of life care



Thank you!

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- Questions
- Comments
- Contact
  - [Harleen.toor2@sinaihealth.ca](mailto:Harleen.toor2@sinaihealth.ca)
  - [Ciara.whelan@sinaihealth.ca](mailto:Ciara.whelan@sinaihealth.ca)