Clinical Psychologist’s Roles in Palliative Care and the Treatment of Prolonged Grief – the Sydney Experience

Damaris HUNG

4 May 2016
HA Convention
Overseas Corporate Scholarship
OCS Attachment Program for CPs in Prolonged Grief Disorder

Participants:
Irene HUI (NTE), Damaris HUNG (HKW),
Betty LUK (KWC), Mary WONG (HKE)

Acknowledgements:

Co-ordinating Committee (Clinical Psychology)

Central Committee (Palliative Care)
Therapeutic Input along the Disease Continuum
Common Roles of CPs in Palliative Care

Assessment, Diagnosis & Treatment:
– Psychological distress: anxiety, depression, demoralization
– Psychosocial distress in family caregivers
– Suicidality & desire for Hastened Death
– Anticipatory grief, Bereavement or Prolonged Grief

Some Common Psychotherapeutic Goals
– Enhance coping
– Strengthen relationships
– Reducing symptom burden
– Maintain hope, dignity, meaning
– Come to terms with losses and grief …..

(Cherny et al., 2015)
Case Examples

– F/48 lady w breast cancer worried about being unable to move if disease progressed
– M/70 father worried about being burden to children. Explored that he had taught his children to be filial. Children just doing what patient taught.
– M/45 property agent in pain was upset about relating to his mother.
– Facilitated emotionally distant son to re-connect with father through touch.
Common Roles of CPs in Palliative Care

- Working in inter-professional team
- Promoting inter-professional collaboration

(Godley, 2014)
Places Visited In A Continuum of Psychosocial Care: Palliative Care & Bereavement

Western Sydney Local Health District:
1) Westmead Hospital (24 & 25 Mar 2015)
   - Supportive and Palliative Medicine Service
   - The Crown Princess Mary Cancer Centre
2) Blacktown Mt Druitt Hospital (25 Mar 2015)

South Eastern Local Health District:
Sacred Heart Health Service (30-31 Mar 2015)

South Eastern Local Health District:
Calvary Health Care Sydney, Kogarah (1-2 Apr 2015)

Post-death 13+ month
Traumatic Stress Clinic
(23, 26, 27 Mar & 3 Apr 2015)
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<th>Time\Date</th>
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<td>9:00-9:30</td>
<td>Overview of Training: Richard Bryant</td>
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<td>Cathy Mason</td>
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<td>Treatment structure: Bryant, Cahill</td>
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<td>10:00-10:30</td>
<td>Cancer Centre Tour</td>
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<td>Cancer Psychologist</td>
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<td>Dr. Lee Lecture to chaplains on grief service</td>
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<td>10:30-11:00</td>
<td>Developments in Grief Treatment and Research: Richard Bryant</td>
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<td>Experimental Studies: Bryant, Garber</td>
<td>Neuroscience and Grief: Bryant</td>
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<td>Meet with Dr. Lee</td>
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<td>Palliative care service meeting</td>
<td>Taxi to Mt. Druitt</td>
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<td>1:30-2:00</td>
<td>Assessment Issues: Lucky Kenny/ Richard Bryant</td>
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<td>Treatment challenges</td>
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<td>Mt. Druitt Palliative Care</td>
<td>Meeting with Traumatic Stress Clinic</td>
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<td>Lessons learnt: Richard Bryant</td>
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<td>Palliative care journal club</td>
<td>MDT meeting at Mt. Druitt Palliative Care Unit</td>
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<td>Community Palliative Care: Trish Sutton</td>
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<td>10:00-10:30</td>
<td>Morning Tea</td>
<td>(10:15) Volunteer Services: Christine Harvey</td>
<td>Morning Tea – meet with CEO: Luci Dall’Armi &amp; Peggy Yeomans</td>
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<td>10:30-11:00</td>
<td>Epidemiology of End of Life Experiences: Jane Ingham</td>
<td>(10:45) Inpatient Care: Ken Webb &amp; Anne Williams</td>
<td>Palliative care service – meet with Dr. Frank Brennan</td>
<td>Morning Tea</td>
<td>Talk about inpatient service – meet with Stephen Oakden</td>
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<td>11:30-12:00</td>
<td>Pastoral Care: Mamie Long</td>
<td>Sacred Heart Pharmacy: Devang Rai</td>
<td>Psycho-social studies – meet with Liz Lobb</td>
<td>Speak about CPCT – meet with Caroline Belfanti</td>
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<td>1:00-1:30</td>
<td>Supporting &amp; Managing Bereavement: Megan Thorpe</td>
<td>(1:15) Palliative Care Consults: Dr. Neil Cooney</td>
<td>Presentation on “Remembering Project” &amp; pastoral care discussion: Mary Ashton</td>
<td>Bereavement services – meet with Peter Kadwell</td>
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<td>Afternoon Tea</td>
<td>Allied Health: Alysha Battaerd &amp; Elizabeth Ryan</td>
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<td>Day Centre Activities: Hussen Hijazi</td>
<td>Presentation on palliative care gym program &amp; speak about physiotherapy service: Ros Savage</td>
<td>Discussion on Research/ Clinical trials – meet with Elle Kough/ Liz Lobb</td>
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<td>2:30-3:00</td>
<td>Palliative Care Seminar: Alex Chung &amp; Trish McKinnon</td>
<td>Debrief: Jane Ingham</td>
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<td>Development of Optimal Bereavement Services in Hong Kong (1:00-5:00)</td>
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<td>Presentation on occupational therapy: Karen Thomas</td>
<td>Debrief &amp; Afternoon Tea; Farewell</td>
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<td>Psychological Support in Palliative Care: Adam Finch</td>
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Best Practices in PC
Calvary Health Care Sydney, Kogarah

With Dr. Frank BRENAN (Consultant in Palliative Medicine) and Liz LOBB (Adjunct Professor)

From left to right, with Susah UHLMANN (Director of Mission), Liz LOBB (Adjunct Professor) & Jan GRAHAM (Service Manager, Community Rehabilitation & Service)

With Mary ASHTON (Manager of Pastoral Care Services) at the “Bus Stop” inside Mary Potter House (day respite centre for patients with dementia)
Best Practices: Physical Settings

Sacred Heart Health Service
Best Practices: Physical Settings
Calvary Health Care Sydney, Kogarah
Best Practices: Physical Settings
Blacktown Mt Druitt Hospital
Best Practices: Cater for Religious and Spiritual Diversity

Calvary Hospital embraces and celebrates the religious and spiritual diversity of our community.

Calvary Hospital’s Multi Faith Room has been specifically designed for contemplation and prayer for patients and their families of all faiths. The room contains specific religious icons for Hindu, Buddhist, Muslim, Orthodox and Jewish faiths.
Best Practices: Cater for Religious and Spiritual Diversity
Best Practices: Informed and Engaged Patients & Carers

• Bereavement Services
  – Setting separated from the hospital
  – Letters: 1-mth, 6-mth or 12-mth
  – Individual and group therapy
  – The Walking Group (Calvary)
End-of-life (EOL) care and support

• A survey was conducted with general population in South Australia - 70% people would prefer to die at home (Foreman et al., 2006), but in reality only 14% people died at home, while 54% died in hospitals and 32 % died in residential care (Broad et al., 2013).

• E.g. Palliative Extended Aged Care in the Home (PEACH) package commences in the last seven days of life
  – personal care during the day, daily visits from a community nurse specializing in palliative care, and 24-hour support was also available to patients and/or carers

• Palliative Care Home Support Program provided by Hammond Care
  – 48 hours of specialized supportive palliative home-based care, day or night, provided by specially trained community workers
Best Practices:
Organizational & Clinical Processes

• PC is introduced early
• Advanced Care Plan
• Continuous quality improvement
  • Continuous review on service gaps and develop programs
• Dedication to Research
  • Scientist-practitioner model
Best Practices: Engaged, Involved and Compassionate Communities - Volunteer Work

• **Scope of volunteer work:**
  
  – **IP & Rehab:**
    • office support;
    • assist staff with making beds, transfer Pts to gym & craft activities, assist with meals, help with shopping, run errands
    • Shaves/facials, hair-dressing, manicure
    • aromatherapy, massage, play music, activity groups, provides ‘Happy Hour’
  
  – **Community PC:** home visits, respite for carers
  
  – **Care for Carers Program:**
    • staff support: Organized activities for staff
Best Practices: Engaged, Involved & Compassionate Communities - Publications and Support in the Community
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L1 Recognition of needs

L2 Early Identification of psychosocial distress

L3 Identify & diagnose persisting distress

L4 Diagnosis and Treatment of Psychopathology: e.g. Prolonged Grief Disorder

Specialist Psychological Intervention (Modified from NICE Guidance 2004)
Standing (left to right): Betty LUK, Suzanna AZEVEDO (Research Assistant), Julia TOCKER, Dr. Lucy KENNY, Dr. Katie DAWSON, Catherine CAHILL, Natasha RAWSON, Ben GARBER, Irene HUI

Sitting (left to right): Damaris HUNG, Richard BRYANT, Director of the Traumatic Stress Clinic and Scientia Professor of Psychology at the University of New South Wales, Mary WONG
Traumatic Stress Clinic: Characteristics

1. Offers Level 4 Specialist Care (in Stepped Care Model): **Diagnosis and Tx of Psychopathology: Prolonged Grief Disorder (PGD)**
2. Leader in the field
3. Famous worldwide
4. Strong in research
5. Part of University of New South Wales
6. Funded by grants
7. Free services to clients in Australia
Experimental Studies: Conducted Under “Brain Dynamics Centre”
Traumatic Stress Clinic - Best Practice: Evidence-based Practice, Strong Research

- **Model** based on **evidence from scientific and clinical trials**
- Examines new ways of enhancing tx
- **Process variables: well controlled**
  - Clinical Assessment: validated structured interviews
  - Randomization
  - Double-blind (therapist, patient)
- **Outcome measures: multi-dimensional**
  - Self-report Questionnaires (validated): e.g. anxiety, depression
  - Cognitive function: digit span sequencing
  - Psycho-physiological markers: e.g. cortisol level, reaction time
  - Brain measures: e.g. EEG & brain scan
Traumatic Stress Clinic: Care Pathway

Prolonged Grief?

Yes

Interview by Clinical Psychologist (CP)
(1-2 sessions, around 1.5 hours each)

No

Team Meeting

Self Refer (phone, web)

Tel Screening by Research Assistant (RA) (25 minutes)

PTSD?

No

PTSD Program (CBT based)

Yes

Random assignment to treatment condition

11 sessions (1.5 hours)
one-on-one with CP

Cognitive Behavioral Therapy Treatment (CBT)

Mindfulness Based Cognitive Therapy (MBCT) Program

Post-treatment Re-assessment (immediately after Tx)
Face-to-face (non-treating CP or RA; blind to Tx condition)

6 month follow-up (non-treating CP or RA) – typically face-to-face

2 year follow-up (non-treating CP or RA) – typically on phone

End of Service
Components of CBT for PG

Past Focused
  – Exposure / reliving death
  – Cognitive therapy
    • Meaninglessness of life, anger, guilt
  – Communicating with deceased

Future Focused
  – Goal setting
  – Problem-solving
  – Activity scheduling
  – Facilitating positive memories
  – Relapse prevention
Sharing with other professionals

- PC teams
- Cluster CPs
- Enhanced Training for CPs
- Invite speakers to HA conference to enhance psychosocial care & inter-professional collaboration.
• OCS Training reinforced CP’s work in multi-disciplinary PC team
• CBT treatment for prolonged grief enhanced therapeutic gains for patients
THANK YOU.
References


• Nathan Cherny, Marie Fallon, Stein Kaasa, Russell K. Portenoy, and David C. Currow, et al. eds. 2015. CP in Palliative Care, Oxford Textbook of Palliative Medicine (5 ed.)

