

and 12/145 requiring recurrent intermittent urinary catheterisation. 60/145 patients had seizure plans, 13/145 had dystonia and agitation plans and 6/145 patients had hypothalamic instability plans. 55/145 admissions had an underlying mental health diagnosis.

**Discussion** Many patients admitted to the AYAH had a neurodegenerative or neurostatic condition with significant admissions for elective respite. 7 patients have died, all from cancer. This review highlighted the importance and availability of clinical psychology and psychiatry support given that 38% of our admissions had a mental health diagnosis. Nursing requirements between patients varied widely and could be very intensive. This information may be useful to those looking at setting up similar services in the future.

### OP-30 A REASON TO LIVE: HOW ADOLESCENT AND YOUNG ADULT PALLIATIVE CARE MADE A YOUNG MAN A FIGHTER

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**Background/Rationale** The Manly Adolescent and Young Adult Hospice (AYAH) was developed by NSW Health to provide specialized support to adolescents and young adults (AYAs) aged 16–30 with life-limiting illnesses. This case review focuses on Bodhi, an 18-year-old transgender male with hereditary spastic paraplegia, who presented to AYAH for multiple admissions (Spray, 2024). The review explores the importance of multidisciplinary psychosocial involvement throughout palliative care and the progression towards end-of-life care. Bodhi and his family have provided permission to discuss his case to highlight the importance of AYA palliative care awareness.

**Methodology** Bodhi first presented to AYAH as a 17-year-old young man with significant low mood, emotional lability, a history of suicide attempts, and suicidal ideation. These concerns were exacerbated by physical symptoms of nerve pain and functional dystonia. He regularly ruminated on seeking Voluntary Assisted Dying (VAD) upon turning 18. To support Bodhi and his family, integration between community and inpatient care was essential for a seamless transition. Regular handovers and involvement in Bodhi's clinical formulation were reflected, discussed, and disseminated through weekly multidisciplinary meetings, which were then communicated to external facilities.

**Impact on Practice** The psychological case review was conceptualized using a Contextual Schema Therapy framework, an integrative model combining aspects of cognitive, behavioural, and psychodynamic therapies to identify gaps in Bodhi's care. The identified gaps were:

1. Poor pain management
2. Significant existential distress
3. Distress around themes of feeling 'defective.'

These concerns were gradually addressed during Bodhi's respite and symptom management admissions through a combination of medical and psychosocial interventions.

Psychological input focused on addressing individual existential distress using tools such as Voicing My Choices (Samson-Daly et al., 2023). The Clinical Psychologist utilized

Acceptance and Commitment Therapy (ACT) to help Bodhi identify goals and accomplish bucket list tasks. Coordination between AYAH Clinical Psychology, social work, psychiatry, and grief counselling ensured a seamless transition of care and provided Bodhi and his family with a sense of purpose as his disease progressed.

**Discussion (Lessons Learned, Future Direction)** This case illustrates the importance of addressing both physical symptoms and psychological distress within AYA palliative care. By developing a relationship with Bodhi through multiple admissions, he was able to reframe his psychological distress and gain a sense of agency over his medical condition. As a result, Bodhi declined pursuing VAD and chose to die peacefully at home with the support of community palliative care. His legacy continues through his surviving family.

### REFERENCES

1. Spray T. (2024, March 19). Hospice helping the young. *North Side Living*. <https://northsidelivingnews.com.au/milestone-for-hospice/>
2. Samson-Daly UM, Zhang M, Evans HE, McLoone J, Wiener L, Cohn RJ, Wakefield CE. Adapting the voicing my choices advance care planning communication guide for Australian adolescents and young adults with cancer: appropriateness, acceptability, and considerations for clinical practice. *Cancers* 2023;15(7):2129.

### OP-31 PALLIATIVE MEDICINE IN AUSTRALIA AND NEW ZEALAND: THE BIRTH OF A NEW DISCIPLINE

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**Background** Contemporary Palliative Care arose in the mid-20th century, initially in the UK, in response to health care that was increasingly aimed at treatment and cure, but with a correspondingly decreasing focus on addressing patient and family suffering, particularly at the end of life. In Australia and New Zealand, Palliative Care Services developed later; Palliative Medicine was only formally recognized as a specialist discipline in the early 2000's.

My PhD research explores the social history of these developments through the experiences and insights of the first cohort of doctors designated as Palliative Medicine Specialists by the Royal Australasian College of Physicians (RACP).

#### Study objectives

1. Document the experiences of the first cohort of doctors, the RACPs 'Foundation Fellows', who became Palliative Medicine Specialists in Australia and New Zealand.
2. Analyze and interpret the social history and development of Palliative Medicine in Australia and New Zealand.
3. Seek an informed insight into what might be of most benefit for the future of palliative practice in a rapidly changing health care and social environment.

**Methods** Narrative Inquiry, consisting of an Electronic Survey posted to all RACP Foundation Fellows, and a series of 25 Narrative Interviews conducted in person or via Zoom, and analyzed inductively according to Narrative Methodology.

**Results** Survey response rate 39%, of whom 58% agreed to be interviewed.

Analysis of demographic data.

Exploration of interviewees' motivations, their values, and their struggles and achievements.

Developing a narrative of discipline development for Palliative Medicine.