

P-2 VOLUNTARY ASSISTED DYING IN SOUTH AUSTRALIA: AN ANALYSIS OF THE FIRST 12 MONTHS

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Voluntary Assisted Dying (VAD) Act 2021 was passed by the South Australian (SA) Parliament with a range of safeguards embedded and commenced January 31st, 2023. VAD polarizes opinions, is permit based and rigidly legislated. We report quantitative and qualitative data for the initial 12 months of operation, highlight aspects critical to the success of the program, areas for improvement and strategies to achieve this.

The VAD program encompasses several teams, each critical to providing VAD care: Initial contact and Navigation, Medical professionals for assessment and care of patients, operational teams in the Department of Health, a central Pharmacy team, with supervision and review by the Ministerial appointed VAD Review Board.

In the first 12 months, 195 people received a VAD permit, of which 110 died from administration of the VAD substance. This equates to < 1% of all deaths in SA. Most (57%) occurred in the person's home, 30% in hospital/hospice. The majority (71%) had a malignancy, 75% aged > 65 years, 53% male gender. Palliative care was being received by 77% of the people issued VAD permits. The majority (68%) resided in the metropolitan area.

Seventy-one doctors provide VAD care as coordinating or consulting practitioners. Most (60%) are General Practitioners, the remainder from a range of medical specialties (Palliative Care 4%). Twenty-seven percent of doctors live in rural areas.

The VAD service has received positive feedback from patients, family, and health care professionals. Our doctors describe VAD as 'some of the most important work they perform'. Clinicians report being well-supported by the entire team and feel safe in the work they are undertaking. Trained volunteer witnesses ensure patients without family/friends can complete requisite written documentation.

Ongoing challenges include growing a sustainable workforce, clinician remuneration, raising community awareness, bereavement processes post VAD and providing equitable access and care for all patients.

P-3 SYSTEMIC PROCESSING OF GRIEF: ENGAGING A MULTIDISCIPLINARY TEAM IN A SCHEMA THERAPY MODEL

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Existing investigations on palliative care of AYAs have indicated poor end of life support for the young patients and their families. These reports are linked to young adults having a higher survival rate in thus have limited dedicated resources for end-of-life care (Grinyer & Barbarachild, 2011). Management of this group requires interdisciplinary clinical involvement to work with the heterogeneity of the patient groups due to the need of addressing the complex medical concerns that coincide with psychosocial developmental phases and existential distress (Wein, Pery, & Zer 2010). The Manly

Adolescent and Young Adult Hospice (AYAH) was developed by NSW Health to provide specialised support to AYAs between the ages 16–30 with life limiting illnesses. This case review is on Layla** and her family, a 30-year-old female with head and neck cancer and complex psychosocial background who underwent palliative care during her stay at the AYAH. This review explores the importance of multidisciplinary involvement and support at end-of-life care.

Methodology This case review was conceptualised using a Schema Therapy framework to uncover family patterns of coping were playing out within a hospice setting. By analysing the schema chemistry (Safran & Segal, 1990), the Clinical Psychologist was able to identify processes by which an individual's behaviour can 'pull' others into a familiar pattern of interaction. In turn, creating formulations for key family members and how they interact with each other during period stress allowed for identification of gaps in providing psychosocial care at the AYAH for both family members and staff.

Impact on practice As Layla's physical condition deteriorated, family distress was palpable, especially from Layla's mother, Madeline**, which impacted the family and AYAH Team dynamic. Madeline's interaction with the treating team paralleled themes of early experiences of unmet emotional needs within her personal life. Madeline's observation of her daughter's deterioration triggers her schema of emotional deprivation, the expectation that one's desire for emotional support will not be adequately met by others. To be able to support the family and the AYAH staff, the following was identified by the clinical psychologist: 1) the need for psychoeducation and 'pre-brief' to allow for a united front across staff, 2) regular family sessions and independent psychological support for individual family members, and 3) opportunities for staff supervision throughout Layla's end-of-life care.

Discussion This case illustrates how psychological models are present within AYA palliative care. Lack of family support can detrimentally impact team functioning if family psychological needs are not met. Through supporting Madeline and her family, the treating team was able to review what were considered difficult behaviours as representations of grief. It challenged the team to reframe how family interaction can impact responses to challenging engagement styles as a cry for help.

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P-4 BRIDGING THE GAP: UNDERSTANDING THE DIVIDE BETWEEN THOSE WHO CONSIDER AND THOSE WHO RECEIVE MEDICAL ASSISTANCE IN DYING

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Introduction Medical Assistance in Dying (MAiD) allows eligible individuals to access medical interventions to end their lives when facing an advanced, irreversible condition accompanied by unbearable suffering.^{1 2} Many individuals who seek a MAiD may not receive MAiD, due to the lengthy and complex nature of the MAiD process.³ We aimed to understand

the differences between participants who considered MAiD but did not undergo the procedure and those who underwent a MAiD.

Methods We conducted a secondary analysis of decedent interview data from the Canadian Longitudinal Study on Aging (CLSA) in Canada. Next of kin and proxies of deceased CLSA participants were interviewed about end-of-life characteristics and MAiD considerations for participants who died between June 6, 2016, and March 15, 2022. We examined clinical and demographic characteristics and their association with considering MAiD compared to receiving MAiD. We conducted a descriptive analysis comparing non-MAiD deaths to MAiD-related deaths. Regression methods identified the association between demographic and EoL characteristics factors with consideration and reception of MAiD.

Results There was a total of 981 deceased participants with a completed decedent interview. Approximately 25.4% considered MAiD and 6.7% experienced MAiD. In both groups, most participants were male, married, and died of cancer. Considering MAiD was more likely if individuals died in hospice or palliative care (OR 1.73; CI 1.12–2.67), had health care or end-of-life arrangements (OR 1.75; CI 1.15–2.76), and experienced peace with dying (OR 1.87; CI 1.23–2.92). For those who had a MAiD, they were less likely receive palliative care, but had a better overall quality of death and dying experience. Individuals considering MAiD reported dying in place (64.7 vs 56.3; SD: 0.75) and peace with dying (78.3 vs 63.7; SD 0.77) more frequently than those who did not consider MAiD.

Discussion Given that more than a quarter of older adults are considering MAiD, honest and informed conversations between health care providers and patients regarding MAiD need to become a part of the EoL care planning process.⁴ Palliative care settings may offer effective symptom management and psychosocial support that may alleviate the need for MAiD. Considering MAiD as an end-of-life care pathway, even if not received, enhances the overall quality of the dying experience, by providing autonomy during the end-of-life decision-making process contributing to a positive death experience.^{5 6}

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P-5

PALLIATIVE SEDATION IN ADULTS ADMITTED IN A HOSPICE SETTING

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Introduction Palliative sedation(PS) is the monitored use of medications intended to induce a state of decreased or absent

awareness (unconsciousness) at the end of life(EOL) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and health-care providers.^{1 2}

A hospice is a place designed to provide palliative care and emotional support to the terminally ill in homelike setting so that quality of life is maintained and family members and active participants in care. The hospice of this study is in Hyderabad and of 22 beds under Pain Relief and Palliative Care Society (PRPCS).

Aim To evaluate demographics, diagnosis, symptom needing PS, medications used and outcomes.

Methods Retrospective case-sheet study of a time period of 6 months (1/5/2023 to 30/11/2023)

Results During this time period, total 516 patients were admitted (with readmission); of which 16(3.1%) patients got palliative sedation. 8(50%) of 16 patients were having severe refractory dyspnoea, 6(37.5%) of them were with terminal restlessness, 2(12.5%) of them were with refractory pain. Out of 16 patients 2(12.5%) were admitted with non-cancer diagnosis. Only 1 patient discharged, 15(93.75%) of them passed away, all of them were peaceful death. Medications used will be discussed.

Conclusions A hospice relieves the burden of otherwise intractable suffering in EOL by means palliative sedation.

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P-6

DEMENTIA PALLIATIVE CARE IN AGED RESIDENTIAL CARE: A UNIQUE GRIEF

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Context Those living with dementia who require the specialist care environment of Aged Residential care find themselves facing loss, clinical challenges and relational complexities. Their reality results in a very unique grief. It is one that requires time and clinical acumen to help navigate. This presentation will explore both the complex and complicated grief associated with progressing dementia, and how our GP/NP shared care model with a team dedicated clinically to Aged Care alone can make a difference.

Objective To highlight the challenges of those living with dementia and emphasize the pivotal role the primary care provider has in patient outcomes and family grief experience during the disease and after their death. Using practitioners that focus only on Aged Residential Care, the palliative lense is stronger and addressed much earlier.

Discussion The dementia experience is one often mentioned but not talked about enough across all sectors of health. Navigating the significant and recurrent losses with the disease progression, with A known terminal end but unpredictable symptoms, palliative care provided in Aged Residential Care needs a specialist approach on a daily basis. Our model of care utilizes GPs and NPs who work primarily in Aged Care. This means we have been able to grow the palliative care support given across the trajectory of the dementia process. A comprehensive palliative care approach is required, but often