Planning for death with an addiction

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KEYWORDS

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EXECUTIVE SUMMARY *(100 words maximum)*

People who use drugs and alcohol experience significant inequities in access to advance care planning (ACP) and palliative care, often engaging late and during crisis. This model embeds ACP early within routine D&A practice, supported by established therapeutic relationships and familiar care environments. The model was developed through a collaborative initiative with D&A services, the Aboriginal Supportive and Palliative Care team, and the Palliative Care team in South Eastern Sydney Local Health District (SESLHD). A key feature of the model is training clinicians on transference and counter transference which gives clinicians the tools to have difficult conversations and practice reflexively.

INTRODUCTION

Palliative care and ACP inequities for people who use drugs and alcohol remain poorly addressed, with many individuals experiencing stigma, fragmented care, and crisis-driven end-of-life trajectories. Traditional palliative models often struggle to engage this population early or meaningfully. In SESLHD, the D&A service supports a large Aboriginal population. Recognising their overrepresentation in the service and the importance of culturally safe, community informed approaches the model is designed to be inclusive and transferable.

HIGHLIGHTS

- We developed a model to embed ACP into D&A services, addressing an important gap in an underserved population.
- The model was developed in close collaboration with the Aboriginal Supportive and Palliative Care team to embed a culturally safe service.
- While most respondents of the workforce capacity assessment rated ACP as important or very important (84%), nearly half (47%) reported being not confident initiating ACP conversations.

METHODOLOGY / PROCESS

Workforce Capacity Evaluation

The project team developed a survey to assess the workforce capability. The survey captured staffs' willingness, confidence and training needs around ACP and palliative care.

Education and Promotion

The Service held a promotional event for ACP week which assisted in raising awareness and introducing end of life and ACP concepts to staff. Three online education sessions were facilitated for staff by the Palliative Care team, face to face education was delivered by the Palliative Care team to discuss case examples and the Advance Care Directive (ACD). A clinical psychologist provided education for staff on transference and counter transference to assist with normalising difficult conversations and emotional responses, which will be embedded into group supervision going forward.

Innovative Model of Care

The education program is designed to equip clinicians to have end of life discussions with patients. The model also provides access to resources and a process for documenting ACPs in the medical record along with referral pathways/service links.

RESULTS / OUTCOMES

A total of 44 of 94 (47%) eligible staff completed the workforce evaluation survey. Respondents were a mix of Nursing, Allied Health, Aboriginal Health Workers and Cadets, Consumer Representatives and Doctors. Three quarters (73%) reported no prior formal training in ACP, recognising the last year of life, end of life communication, or palliative care referral. While most respondents rated ACP as important or very important (84%), nearly half (47%) reported being not confident initiating ACP conversations. Despite low confidence, clinicians demonstrated strong readiness for change, with 76% indicating they were very willing to receive training, with a clear preference for interactive, case based, and clinically relevant education. These findings directly informed the blended education model implemented. Anecdotally, clinicians reported increased confidence and competence in initiating ACP and end of life discussions since receiving training. Post implementation data collection is underway and will be presented at the conference. Two Advance Care Directives have been completed since the training.

CONCLUSION

This model addresses an important gap in D&A services. It delivers education to address low levels of clinician knowledge and confidence and builds pathways to increased ACP, identification of need and referrals. The collaboration with Aboriginal Supportive and Palliative Care strengthens networks and culturally safe integrated practice. This approach offers a scalable model for palliative care engagement with marginalised populations.