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APSAD 2025

# Optimising the patient journey:
People with opioid dependence transitioning to palliative care

10 November 2025


Date of preparation; Nov 2025 AU-NPR-2500098

# Acknowledgement of Country

We acknowledge the Gadigal people of the Eora Nation, Traditional Custodians of the land on which we meet tonight.

We pay our respects to their Elders past, present, and future. We extend that respect to Aboriginal and Torres Strait Islander peoples here today.

## Chair

# Dr Marianne Jauncey

Dr Marianne Jauncey is a public health physician who has worked at the pointy end of harm reduction for decades. She started work in Kings Cross in 1998 and has been the Medical Director of the Uniting Medically Supervised Injecting Centre (MSIC) since 2008.

Marianne is proud of the influence that she and her service have had not only within Uniting, the services and advocacy arm of the Uniting Church in NSW/ACT that holds the licence to operate the MSIC, but more broadly. Marianne knows that to effect attitudinal and policy change, the narrative about people who use drugs needs to be framed by fairness, equity, and compassion. To this end Marianne has conducted countless media interviews and community led conversations to improve understanding about harm reduction and the nature drug use. She is passionate about improving the lives of people who use drugs and is always keen to get people taking about ways to make this happen.

# Disclosure

Dr Marianne Jauncey has nothing to declare.

# Agenda

| | | |
|---|---|---|
| 6.15PM | **Introductions** | Dr Marianne Jauncey, Chair |
| 6:25PM | **The Situation in Australia** | Dr Grace Fitzgerald |
| 6:40PM | **The Reality for Clinicians** | Dr Peter Allcroft |
| 6:55PM | **The Reality for Patients** | Sione Crawford |
| 7:10PM | **Panel Discussion** | |
| 7:25PM | **Close** | |

# Housekeeping

Roving mics are available – please be sure to use a microphone when asking questions to ensure all delegates can listen.

At the conclusion of the event, please take a moment to complete an evaluation form – your feedback is valuable!

**Speaker**

# Dr Grace Fitzgerald

Dr Grace FitzGerald is an Advanced Trainee in Addiction Medicine and General and Acute Care Medicine, based in Naarm

# The Situation in Australia

Dr Grace Fitzgerald

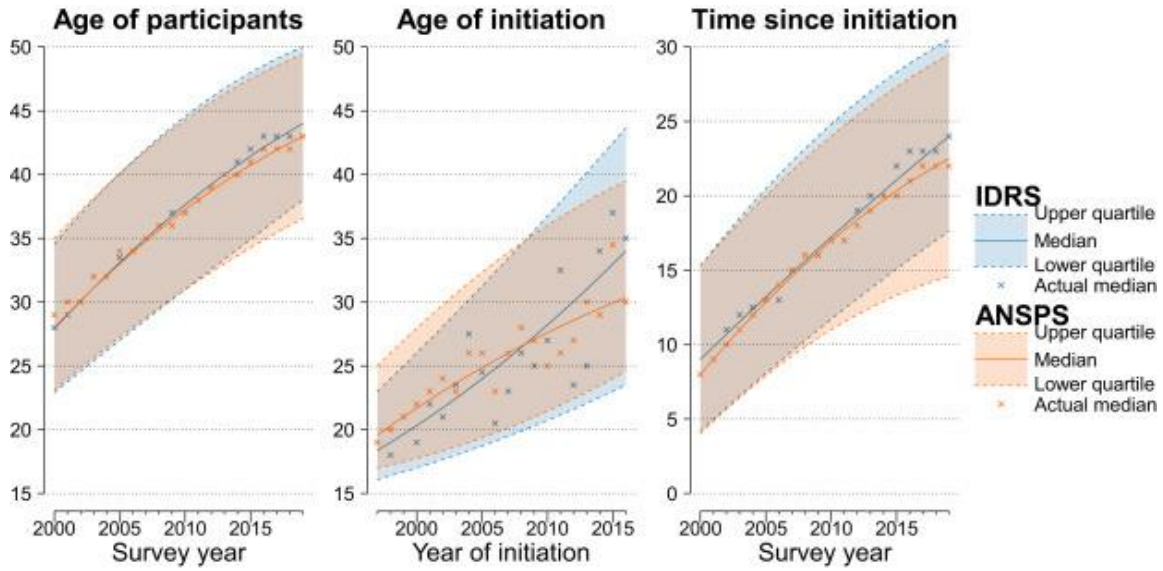
# Disclosure

Dr Grace Fitzgerald has nothing to declare.

# More people who use drugs and alcohol are living long enough to require palliative care

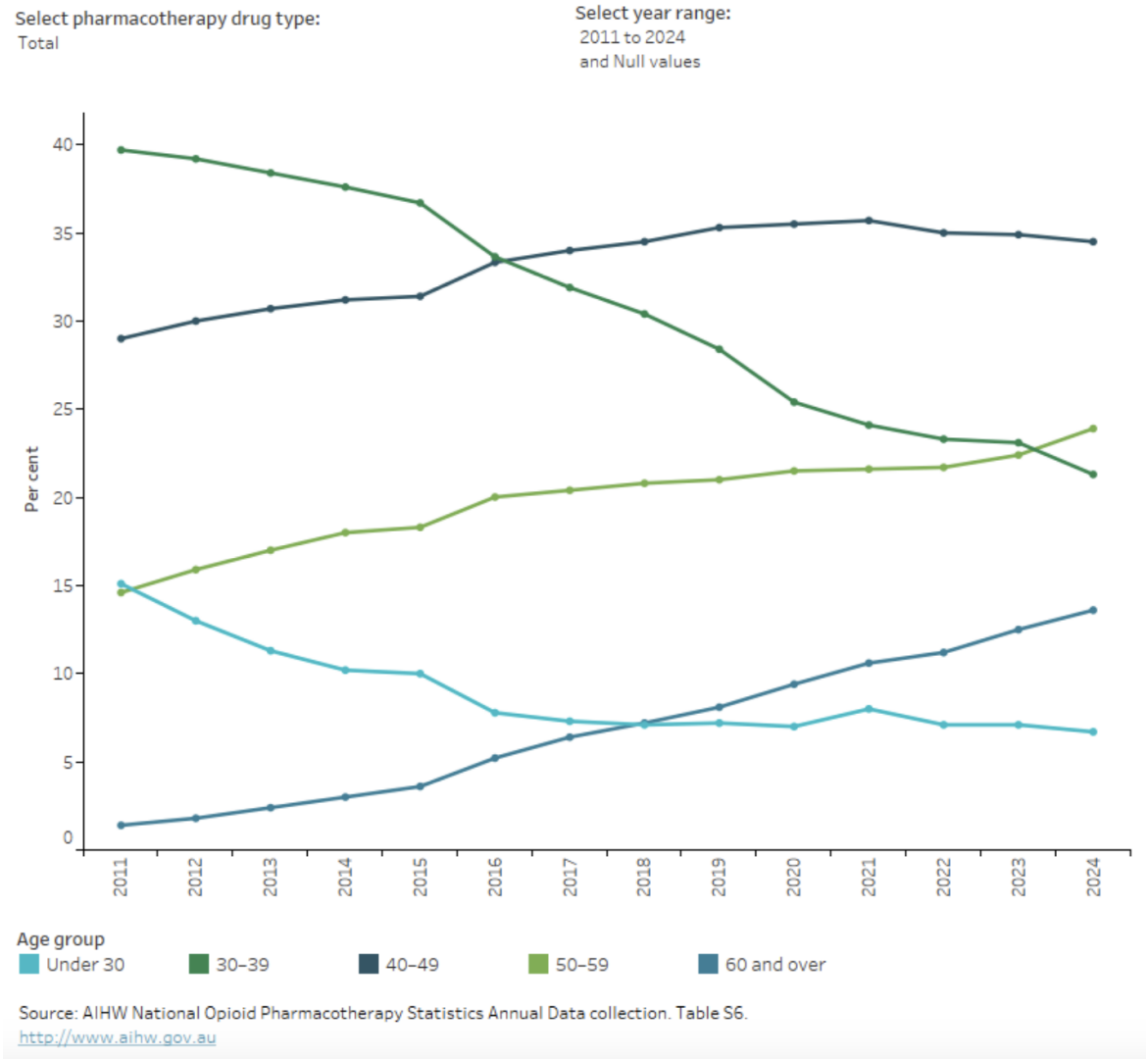
- An increasing number of older people use drugs and alcohol – and harm reduction interventions mean people who use drugs are living longer
- People who use alcohol and other drugs experience accelerated age-related declines in functioning compared with non-drug using persons of similar age, and often have complex care needs
- This means some people who us alcohol and other drugs are living long enough to develop illnesses that would benefit from the contributions of palliative care services

# Ageing among people who use alcohol and other drugs




Age of IDRS and ANSPS participants (by survey year), age of injecting drug use initiation (by year of initiation), and time (in years) since injecting drug use initiation (by survey year).

- In 2022-2023 people in their 50s were the most likely age group to smoke daily
- People in their 60s were more likely to consume alcohol at risky levels
- People aged 45-54 had the highest age-specific rate of drug induced-deaths




Sources: Price et al, 2025
AIHW, 2024

# Older people who use substances live with significant burden of disease

**Key challenges for older people, the community and the health system**

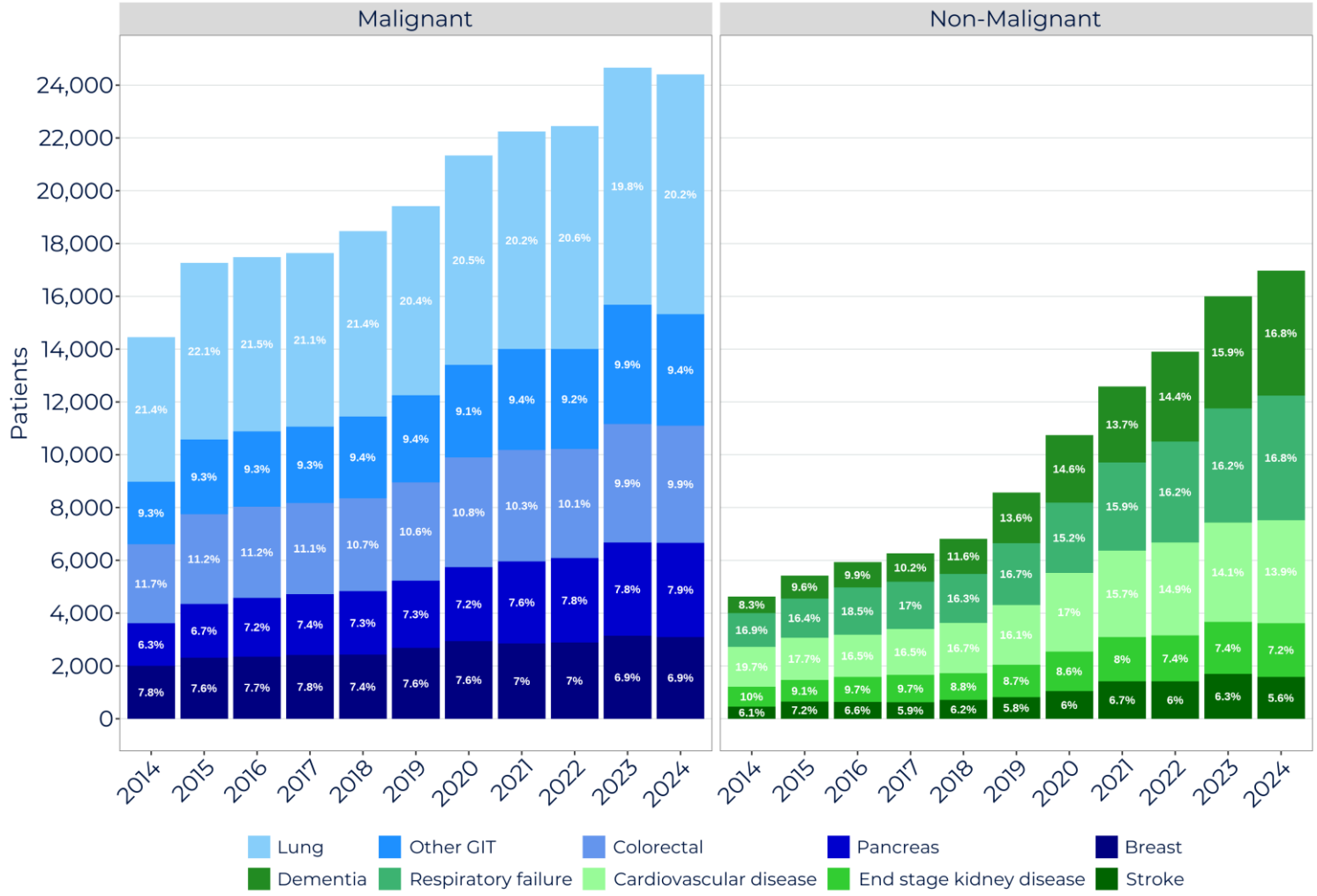
| | |
|---|---|
| **Comorbidities and physical health issues** | ■ Mental health and/or physical health comorbidities are common. Ageing-related health issues are relatively new for drug and alcohol services. |
| **Cognition** | ■ There are risks for and high rates of cognitive impairment among older people with substance misuse issues. This means services need to work differently. |
| **Recognition, stigma and ageism** | ■ *"I'm not a junkie."*<br>■ *"I've had this many drinks for years and never had a problem before."*<br>■ *"They've been using for 40 years; what difference will I make?"*<br>■ *"It would be cruel to take away the last pleasure in life."* |
| **Pain** | ■ Rates of chronic pain have been shown to increase with age.<br>■ High rates of opioid prescription, and low use of non-pharmacological ways of managing pain, contribute to substance misuse in older people. |
| **Social isolation** | ■ Social isolation can play a part in initiating substance misuse, or be an outcome of it.<br>■ Alcohol can promote social inclusion, adding to the complexity of the issue. |
| **Accommodation, finances and transport issues** | ■ Financial difficulties often arise due to low income and/or the cost of using substances. This can impact on the older person's ability to participate in the community, and on access to appropriate treatment and/or care.<br>■ There are limited appropriate accommodation options. |
| **Carers** | ■ Carer presence can create issues with disclosure and stigma. However, carer engagement can also improve access to services. |
| **Relevant resources for older people** | ■ Available health promotion resources and activities tend to be targeted towards younger people.<br>■ More needs to be done to promote clear messages to older people around safe use of alcohol and 'risky' drinking levels. |
| **Issues with services** | ■ There are some barriers to older people accessing existing drug and alcohol services and programs. Additionally, other services and sectors may not recognise and/or provide appropriate responses to older people's substance misuse problems. |

Among 99 people aged ≥50 years (M = 55, SD = 4.5; 77% male) attending specialist AOD treatment in Sydney

- Half self-reported lifetime liver disease (59%), head injury and/or loss of consciousness (52%)
- Other conditions included circulation problems in legs (31%), respiratory problems (22%), other gastrointestinal problems (21%), hypertension (18%), other cardiac problems (15%), seizures (14%), cancer (9%), diabetes (7%), stroke (3%)
- Many reported sleep problems (67%), lack of energy (74%), shortness of breath (60%), limb pain (58%) and back pain (55%) in the preceding 4 weeks
- The mean Addenbrooke's Cognitive Examination-R score was 82.4 ± 9.6,with 40% performing at a level consistent with severe cognitive impairment

Sources: AIHW, 2016
Lintzeris et al, 2016
NSW Ministry of Health, 2015

# Among people who use alcohol and other drugs there are high rates of the disease processes that often require palliative care




Sources: Palliative Care Outcomes Collaboration, 2025
Larney et al, 2019
Darke et al, 2023
AIHW, 2021

# Improving palliative care for people who use alcohol and other drugs

Grace FitzGerald, Jon Cook, Peter Higgs, Charles Henderson, Sione Crawford and Thileepan Naren

Med J Aust 2025; 222 (4): 164-167. || doi: 10.5694/mja2.52585

Published online: 3 March 2025

Common themes in the available literature:

- Late diagnoses with challenging or terminal medical conditions, relatively late referrals to palliative care services
- Expressions of guilt, shame and internalized stigma by patients
- Difficult to manage pain, anxiety, distress
- Clinician discomfort with taking a substance use history
- Clinician discomfort with prescription of high-dose opioids and benzodiazepines
- Ongoing substance use presenting a barrier to access to palliative care interventions
- Compounded challenges for individuals who are unhoused or deemed to be unsuitably housed

Gaps in literature include management of non-malignant terminal conditions, provision of care to First Nations or culturally and linguistically diverse people who use alcohol and other drugs

Sources: Tayba et al, 2025
Cook et al, 2022
Witham et al, 2019
Ulrick et al, 2023
McNeil et al, 2012

# Person-centred approaches to improve palliative care for people who use alcohol and other drugs

- Improved pathways for people who use alcohol and other drugs to participate in shaping their palliative care journey, including accessing timely care
- Having some understanding of and empathy for reasons why people use or have used alcohol or other drugs
- Identification and management of a patient's goals with regards to their substance use
- Incorporation of accurate, contemporary substance use histories into clinical assessment and treatment planning
- Consideration of the best environment for a particular individual to receive palliative care and involvement of people with lived experience in co-design of environments for delivery of care
- Considering risks related to palliative care for people who use alcohol and other drugs as individuals, and considering these risks through the lens of harm reduction
- Creation of an evidence base to guide best practice delivery of palliative care to people who use drugs and alcohol, prioritising the perspectives of people with lived and living experiences of substance use

Source: Fitzgerald et al, 2025

## 4 Examples of risks identified when providing palliative care to people who use alcohol and other drugs

| Risk | Potential implications | Possible mitigation strategies |
|---|---|---|
| Unsanctioned use of palliative care drug delivery devices/ equipment | • Delivery of lethal doses of intravenous substances<br>• Line-associated infections<br>• Impaired ability to deliver prescribed medications in event of line malfunction | • Dignity of risk<br>• Open and transparent discussion about the intended role of certain devices and equipment, and the risks of their malfunction |
| Oversedation and respiratory depression | • Morbidity or mortality relating to interactions between prescribed and non-prescribed drug use | • Dignity of risk<br>• Clear discussions about the goals of care, outlining circumstances where an individual wants resuscitation<br>• Provision of naloxone to interested patients |
| Experience of intoxication from use of prescribed medication | • Staff anxiety about potential medication misuse is often high, but an intoxicating experience is a low risk outcome | • Focus on key risks of sedation, oxygen saturation and respiratory rate and modify subsequent doses of medication based on these measures |
| Development of opioid use disorder or benzodiazepine use disorder | • Development of a new substance use disorder might be less significant at the end of life than at other life stages | |
| Insecure storage of large volumes of sedating medications or diversion to others | • Harm to non-tolerant individuals | • This is generally a poorly understood phenomenon without evidence-based responses<br>• Provision of safes, staged supply where practicable |
| Occupational insecurity for clinicians | • Clinician exposure to environments where people are using drugs, where clinicians may worry about exposure to sharps, to people with altered conscious states and unpredictable behaviour | • Context-specific risk assessments rather than blanket organisational positions<br>• Provision of sharps-disposal units |

Source: Fitzgerald et al, 2025

## Speaker

# Dr Peter Allcroft

Dr Allcroft is a Senior Staff Specialist at Southern Adelaide Palliative Services in South Australia and is a Clinical Adviser for Voluntary Assisted Dying (VAD) for the South Australian Department of Health and Wellbeing, Chairs the Board of Directors for Palliative Care Australia, and has been a member of MND South Australia Board for 10 years. He completed Physician training through Flinders University School of Medicine, initially specialising in Thoracic and Sleep Medicine. He has since completed his Masters in Palliative Care and is currently undertaking a PhD exploring models of palliative care for people with advanced heart failure.

Dr Allcroft cofounded the Motor Neurone Disease Clinic in South Australia 25 years ago. This clinic is a multi-disciplinary clinic and cares for 150 patients on average living with MND and has been awarded South Australian and International Awards for clinical care.  He has a special interest in the palliative care approach for people living with advanced neuro-degenerative disease and is a member of the EAPC Neuro-palliative Care Special Interest Group. He is a strong advocate for teaching and research for all health care professionals and is a Senior Lecturer in the College of Medicine Flinders University, and a member of the Research Centre for Palliative Care, Death, and Dying (RePaDD) hosted at Flinders University.

In 2024 he was awarded a Gold Medal by MND Australia to recognise his contribution to Australians living with MND.

# The Reality for Clinicians

Dr Peter Allcroft

# Disclosure

I am planning on donating my honorarium for this talk to MND SA

# Palliative Care for People Who Use Drugs (PWUD)

Dr Peter Allcroft

Southern Adelaide Palliative Services

Southern Adelaide Local Health Network

Clinical Advisor VAD South Australia DHW

Chair Palliative Care Australia

Flinders University

Flinders University | Research Centre for Palliative Care, Death & Dying

Government of South Australia
SA Health

Palliative Care Australia
Matters of life and death

# It doesn’t happen often but when it does…..

Emma Foreman[1], Georgia Salamon[1], Angela Robinson[1], Tim To[1,2], Peter Allcroft[1,2]

[1]Southern Adelaide Palliative Services, Southern Adelaide Local Health Network

[2] Flinders University Research Centre for Palliative Care, Death, and Dying (RePaDD)

Flinders University
Research Centre for Palliative Care, Death & Dying

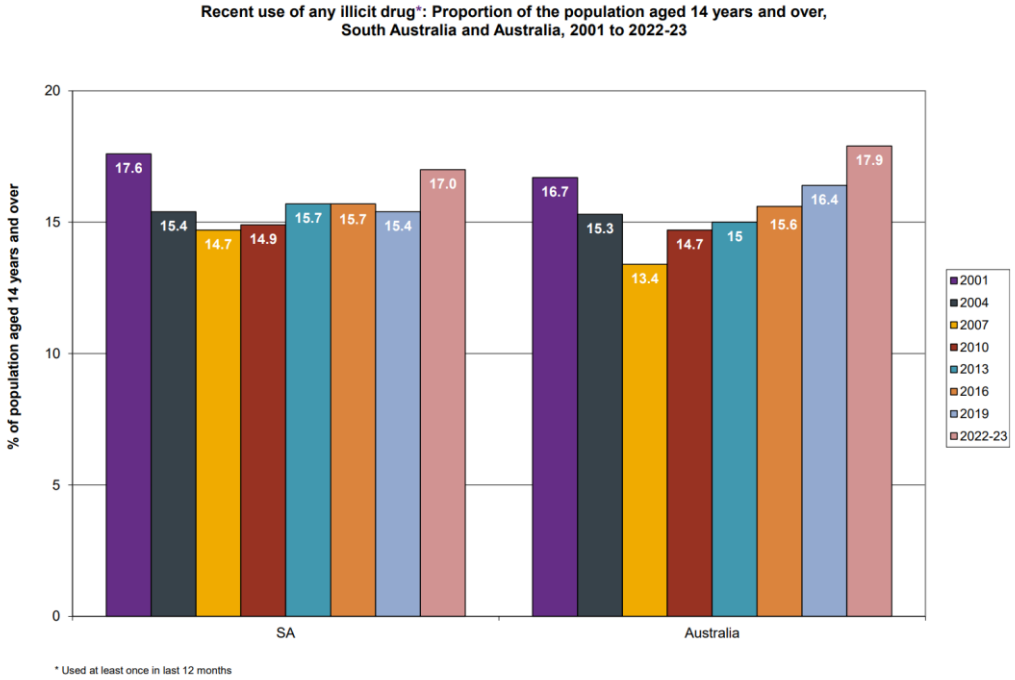
Government of South Australia
SA Health

# Andy

- 38 year old man; lives with partner; 2 children (different partners)
- Stage 4 NSCLC
    - Lung, adrenal, weight loss,  left radial nerve injury, AKPS 50
- Significant substance misuse disorder
    - Now predominantly cannabis
    - Recent urine screen Cannabis, opioids
- Severe pain
    - Background medication (twice weekly pickup)
        - Oxycontin 30 mg BD
        - Olanzapine 5 mg tds
        - Amitriptyline 75 mg nocte
        - Pregabalin 300 mg BD
        - Methadone 10mg TDS
        - Diazepam 5 mg BD
        - Oxycodone 20 mg up to 6 per day
    - Repeated admissions for pain crisis every 10-12 days
    - “If you can’t get my pain any better I want VAD”

# Background

- Substance use increasing
  - Older people; past or present use
  - Associated complexity, comorbidities
- Challenge in delivering care
  - Symptom management
  - Setting for health care delivery
  - Ongoing drug use
  - Concurrent comorbidities
    - Physical, psychological, psychosocial
- Limited evidence to guide management
  - Medication use, dose, dose increments




Australian Institute of Health and Welfare (2025) Illicit drug use, AIHW, Australian Government

# Substance use during hospitalisation requiring an urgent clinical response: an opportunity for intervention

Emily Nash [1,2] Andrew H. Dawson,[1,2] Paul Haber,[1,2] Robert Gribble[1,2,3] and Anastasia Volovets[1,2]

[1]Drug Health Services, and [3]Department of Psychiatry, Royal Prince Alfred Hospital, Sydney, and [2]Sydney Medical School, University of Sydney, Sydney, New South Wales, Australia

**Table 1** Patient demographics for 30 episodes of drug use

| Characteristic | Number ($n = 30$) |
|---|---|
| Female, *n* (%) | 17 (57) |
| Median age, years (IQR) | 42 (30–49) |
| Mental illness, *n* (%) | 28 (93) |
| Substance use disorder, *n* (%) | 23 (77) |
| Previous self-harm, *n* (%) | 16 (53) |
| Previous suicide attempt, *n* (%) | 9 (30) |
| Day of hospitalisation where drug use occurred, days (IQR) | 1 (1–8) |
| Admitted to hospital at the time of drug use, *n* (%) | 28 (93) |
| Admitting service | |
| Drug Health Service, *n* (%) | 18 (60) |
| Orthopaedics, *n* (%) | 5 (17) |
| Psychiatry, *n* (%) | 3 (10) |
| Other, *n* (%) | 4 (13) |

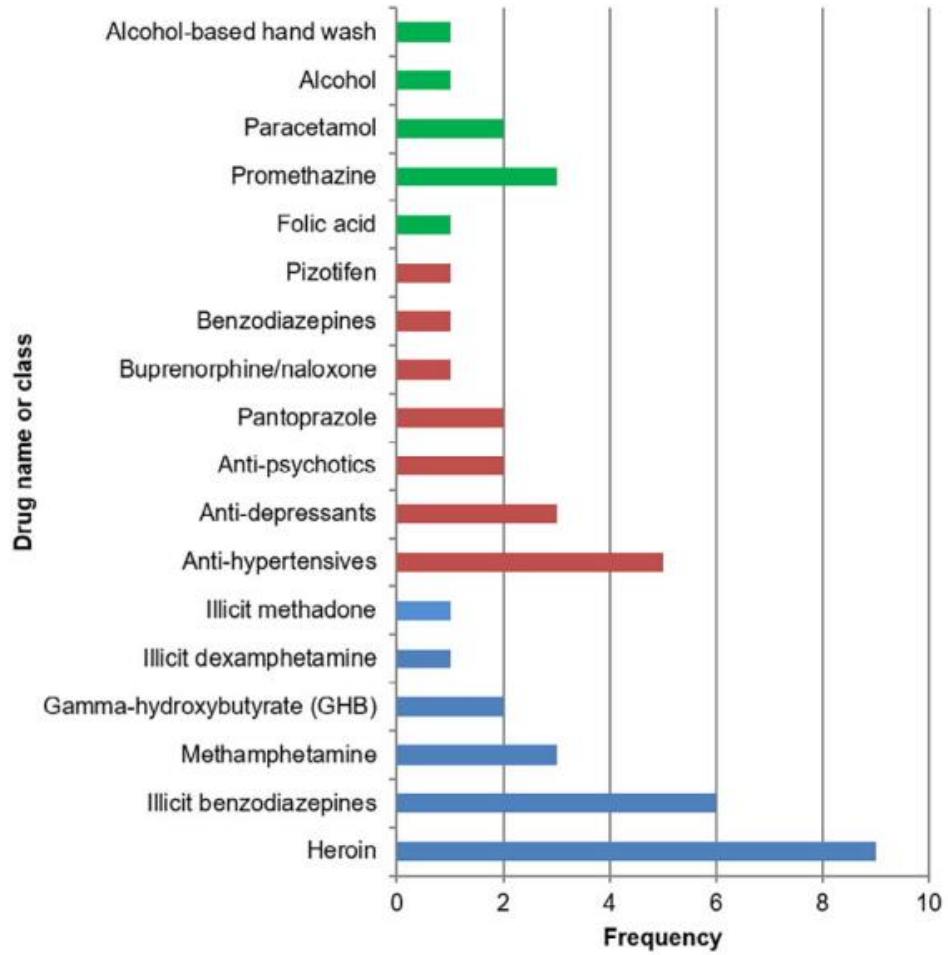



**Figure 1** Drugs used during admission, reported as illicit (blue), prescribed (red) and over the counter (green) ($n = 45$).

# Characteristics and clinical challenges in patients with substance use disorder in palliative care—experience from a tertiary center in a high-income country

**Case study 3—lack of compliance**

*REPORT NOTE:*

- *18:30 o'clock: patient has not been seen on ward since noon.*
- *Cannot be reached by phone and had not been seen in her home residence.*
- *Security service and police are informed.*

**Later that evening…**

- *The patient has called that she has no more money left to take a cab to the hospital.*
- *The police finds her, and she seems to be under the influence of drugs but can give clear answers.*
- *3:40 o'clock: the patient is back on ward.*
- *She's sitting on the edge of the bed and has very large pupils (consistent with cocaine use), anamnesis shows that she smoked crack; she sometimes talks incoherently; multiple abrasions on her neck are visible, crusted with blood.*

# People Who Use Drugs

- Vulnerable
- Significant Sx burden
  - Pain, dyspnoea
  - Tolerance, hyperalgesia
- Maladaptive coping skills
- Reduced compliance
  - Missed appointments
  - Difficulty in contacting patients
  - Institutional distrust
  - Overloaded with decision making
- Comorbid illness: anxiety, schizophrenia, liver disease, infections
- Significant histories of trauma

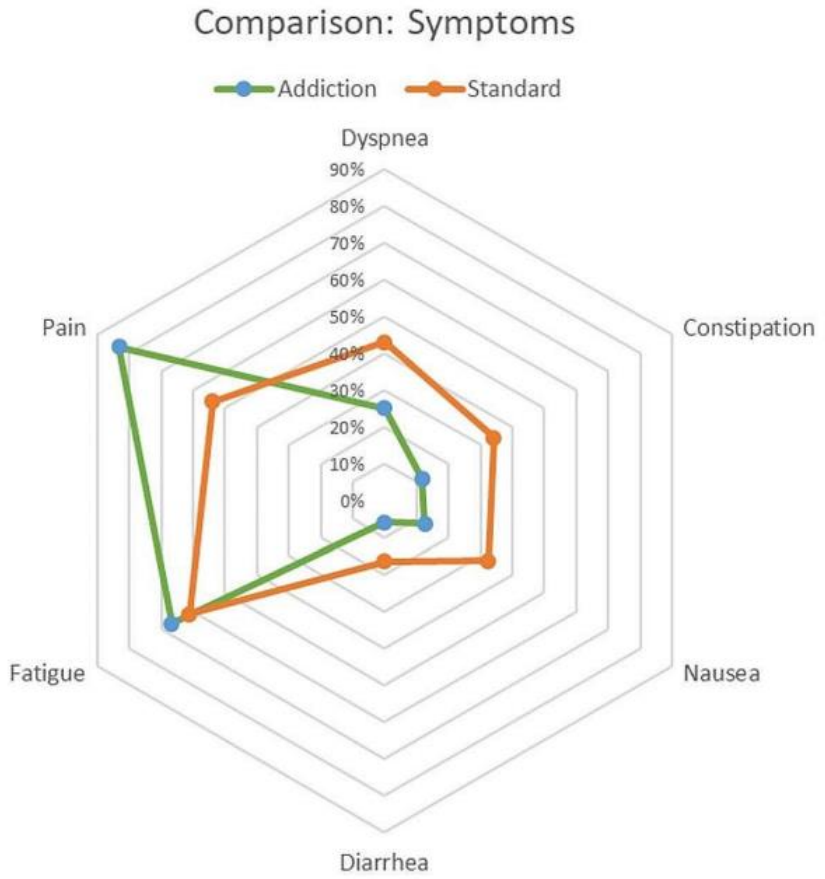



**Fig. 2** Symptom burden—comparison chart

Marti *et al. BMC Palliative Care* (2024) 23:28

# Issue

- Nurse in Laurel Hospice discovered used syringe in the bed from self injecting non prescribed substances
  - Severe drug dependence and an advanced malignancy
- Nurse response
- What would your response be?
- How was it handled?
- Could we have done better?

# CASE SYNOPSIS

**PROFILE**
45-year-old man, unemployed
Supported by mother

**ONCOLOGIC DIAGNOSIS**
- Metastatic melanoma BRAF +
    - Diagnosed 2015
    - Variable compliance with systemic therapies
    - Recurrent disease 2022 with intracranial leptomeningeal disease
    - WBRT

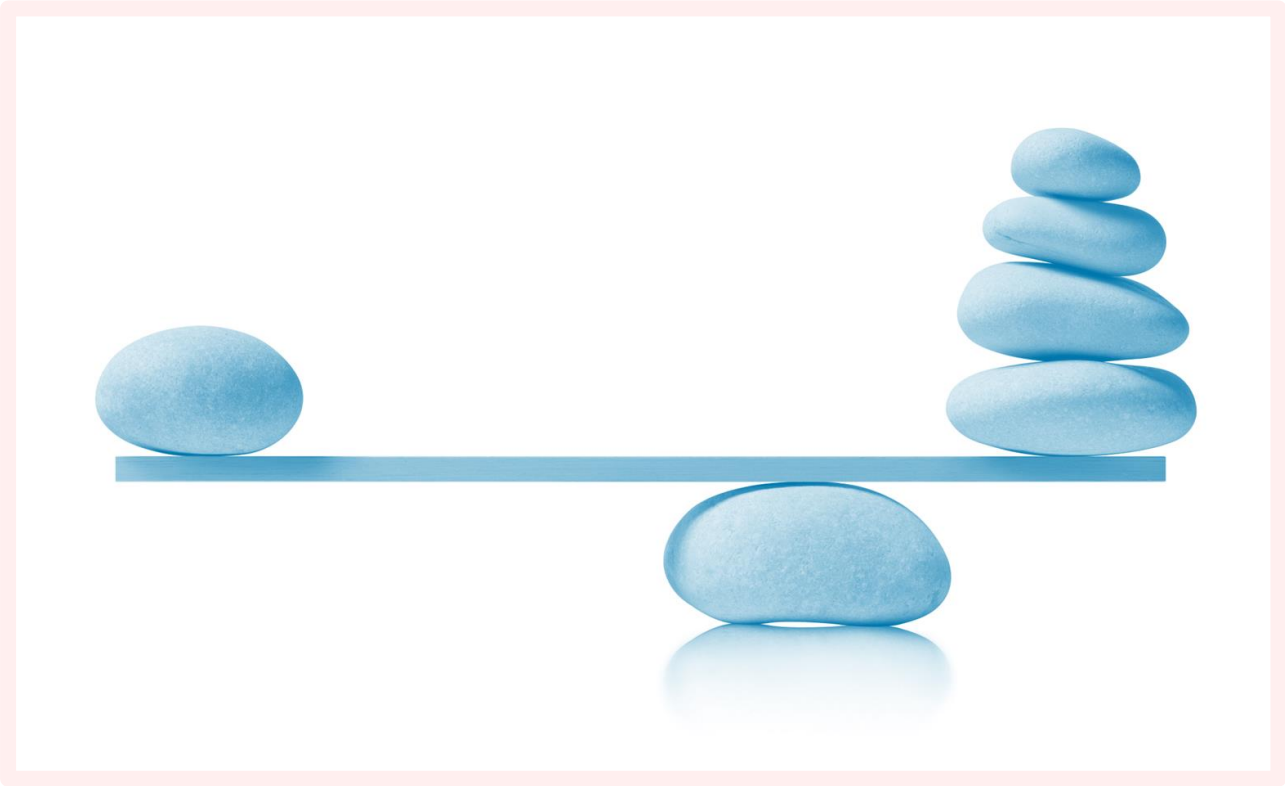
**COMORBIDITIES**
- Cluster B personality traits
- Chronic Pain
- Previous drug induced psychosis
- Past IVDU (abstinence > 6 months)
- Smoker:  cigarettes and marijuana

# Case synopsis

- Admitted to hospice with neurological deterioration due to recurrent melanomatous leptomeningeal involvement
    - Symptom management and likely EOLC
- Terminal 2-week admission became fraught with ethical, legal and moral challenges
- Eventual disclosure of active IV drug use during admission
- Disclosure of regular outpatient drug use and likely dealing
- Sourcing and injecting home supply of prescribed Kapanol capsules whilst being prescribed the same dose by hospice
- Probable co-administration of IV methamphetamine and pregabalin
- Threatening behavior towards mother
- The feel of the needle was important
    - preference and need to prioritise intravenous route

# KEY ISSUES

- How to balance the conflicting drivers for compassionate care and respect for patient autonomy with safety and legal requirements?



## INDIVIDUAL

- **IDENTIFYING THE ISSUE**
  **ORGANIC ADVANCED ILLNESS**
  **COVERT AND DRUG AFFECTED BEHAVIOUR**
  **LYING/MISLEADING/MANIPULATING**
- **BALANCING INDEX OF SUSPICION WITH GIVING PATIENTS THE BENEFIT OF THE DOUBT**
- **PATIENT AUTONOMY/DIGNITY OF RISK**
- **CHALLENGING BEHAVIOR OF PATIENT AND FAMILY/FRIENDS**
  **MALADAPTIVE COPING STRATEGIES**
  **ALCOHOLISM OF MOTHER**
  **CODE BLACKS**

## SYSTEM

- Legality
  - Active drug use is illegal
  - Potential for forensic investigation
- Safety
  - Risk of needlestick injuries
  - Aggressive behavior
  - Suicidality

# STRATEGIES

- Boundary setting
  - Contracts
  - Agreements
  - Consequences
- Multi-disciplinary input
  - DASSA
  - Leadership
  - Executive
  - Security
- Safety Huddle
- Debriefing
- Legal drug prescription

# Drug & Alcohol Services SA (DASSA)

- Significant Risk in any location
- Not an abstinence service but ultimately behaviour cannot be accepted
- Priorities:  Safety of patient and staff plus symptom management
- Boundary setting including consequences
- Legal implications including potential forensic investigation
- Ongoing attempt to engage patient and family
- **Emphasise that treatment of opiate and amphetamine dependence is prioritised**
- Practical measures
- Liaison with risk management

# FINAL DAYS

- Aim was to provide the additional drug requirement plus anxiolysis to reduce craving
- Overall opioid was >3x original dose prescribed

Regular

- CSCI 1:  Morphine 300mg, Midazolam 35mg, Ketamine 300mg/24 hrs
- CSCI 2:  Levomepromazine 300mg/24 hrs
- CSCI 3:  Phenobarbitone 750mg/24 hrs
- Clonazepam 2mg subcutaneously/12 hrs

Breakthrough

- Morphine 30-40mg sc 1/24 (300mg)
- Midazolam 10-20mg sc 1/24 (100mg)
- Levomepromazine 50mg sc 4/24 (100mg)
- Phenobarbitone

# Risk assessment for drug use in hospital

**TABLE 1** Risk assessment framework for people who use drugs in hospital settings.

| | Risks associated with ongoing substance use | Mitigation strategies | Risks associated with early discharge |
|---|---|---|---|
| Risk to patients | Overdose | Access to naloxone, adequate staff training, open communication allowing for post use monitoring | Undertreated medical/surgical condition<br>Loss of opportunity to assist with substance use<br>Increased mortality<br>Potential loss to follow-up care<br>Increased perception of stigma leading to reduced help seeking |
| | Infection | Access to sterile equipment, alcohol swabs, sterile water for injection, etc. | |
| | Drug interactions | Open communication allows for interactions to be checked | |
| | Delirium | Open communication means intoxication may be able to be distinguished from delirium | |
| | Cardiovascular risks | Knowledge about substance use allows risks to be monitored appropriately | |
| Risks to staff | Needle stick injuries | Provision of sharps container and education | Potential increased behaviours of concern prior to discharge |
| | Managing difficult behaviours | Increased awareness, adequate management of pain and withdrawal symptoms, improved engagement and communication, peer support worker advocacy | |
| Risks to other patients | Needle stick injuries | Provision of sharps container and education | Potential increased behaviours of concern prior to discharge |
| | Potential witnessing behaviours of concern | Adequate management of pain and withdrawal symptoms, improved staff awareness, engagement and communication | |
| | Impact of intoxication on behaviour towards other patients | Increased awareness and recognition amongst staff, improved communication about concerns and engagement with patient, mitigation and de-escalation strategies, peer support worker engagement | |

*Drug Alcohol Rev.* 2023;42:1529–1533.

# CONCLUSIONS

- Ultimately our aim was to provide the best possible care for a person suffering, and ultimately dying, from advanced metastatic melanoma coupled with an intractable drug addiction
- Hopefully, this experience will guide proactive management of similar situations
- Hope to improve the care for this small but complex group of patients with terminal illness and substance use disorder
- How to manage people living with cancer as a chronic disease/survivorship and high dose opioid use?



## Speaker

# Sione Crawford

Sione Crawford has been working in peer-based organisations of people who use drugs since 2004.  He has worked as a peer-educator, in community development and in policy and leadership positions.

Sione has lived and living experience of hepatitis C treatment, injecting drug use, opioid dependence treatment and the stigma and discrimination that attaches to these experiences.

Sione is currently the CEO of Harm Reduction Victoria: the organisation representing people who use drugs in Victoria, Australia. HRVic works with their community to ensure access to health care and human rights for people who use drugs. HRVic also provides peer- based services from festival harm reduction to needle and syringe programs to system and peer navigation and is instrumental in developing the lived and living workforce in Victoria.

# The Reality for Patients

Sione Crawford

# Disclosure

Sione Crawford has nothing to declare.

# How did we get here?

Let’s face it – many people who use drugs don’t expect to get old.

If we thought about it we’d assume we would die very early… like Sid

# Instead….

A combination of harm reduction, pharmacotherapy, peer education and a growing drug & alcohol sector and awareness means we are living longer…

# Things to remember - Stigma

- Most of us don’t feel like healthcare is for us

- In one series of reports, consistently high proportions (72 per cent in 2023) of people reported negative treatment by healthcare workers due to injecting drug use.[1]

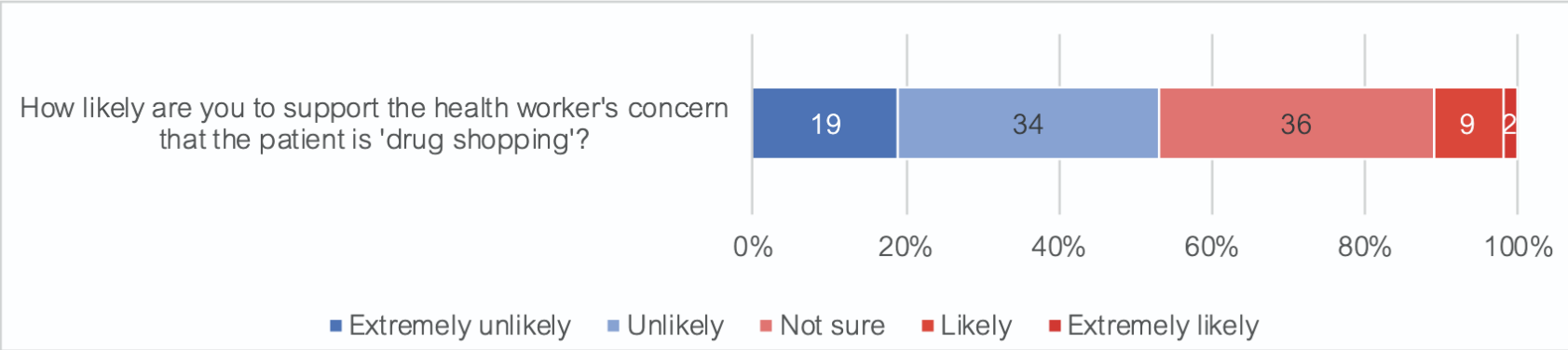
- This stigma often transforms into direct discrimination


1. https://www.unsw.edu.au/research/csrh/our-projects/annual-report-of-trends-in-behaviour

# Things to remember – Stigma II (and some hope)

**Figure 11. Health care workers' responses to injecting drug use related scenario (n=353)**

Scenario: A health worker is treating a patient who injects drugs and also suffers a painful medical condition. The patient insists on pain relief but the health worker worries that the patient does not actually have bad pain but is 'drug shopping'.




Approximately half of participants reported being unlikely to believe that this hypothetical patient was 'drug shopping' (53%), and only 11% indicated they would support this view. More than one in three (36%) were unsure, highlighting the potential complexity of these situations.

2. https://www.unsw.edu.au/research/csrh/our-projects/annual-report-of-trends-in-behaviour

# Things to remember – distrust

- Telling the truth about our drug use seldom has positive outcomes for us
- It is an act of bravery to do so and it's usually rewarded with what feels like punishment – even if you don't see it that way
- Many years of these experiences leads to lack of trust
- If we've not been 100% honest initially it's difficult to backtrack and often leads to fulfillment of cliches that we are dishonest – when often that is all we want to be

# Fear

- Experience tells us we will be given less pain relief not more
- We have spent 50 or more years dosing ourselves! Loss of control is scary
- We often minimize due to internal stigma. In hospital I was afraid to use my pain relief in case it was taken away from me, for example.
- Many of us have seen friends die without dignity or struggle to convince their carers to optimize treatment and pain relief.
- This haunts most of us

# What can we do?

- Explain medico-legal risk and any other fear you have
- Understand and be prepared to explain how pharmacotherapy and pain interact and be prepared to hear how it feels to us
- Be open and accept we have choices and dignity of risk
- Listen without assumptions
- Don’t make the last few weeks of our lives a judgement on the preceding 60 or 70

# Panel Discussion

Your feedback is important to us.

Please complete the evaluation form provided.

# THANK YOU

Date of preparation; Nov 2025 AU-NPR-2500098