National Palliative Care Capacity-building Co-design Workshop Justice Health and Correctional Services: Report

Sydney, NSW

12 September 2023

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Recommendations

Thirteen recommendations emerged from the Co-design capacity-building workshop:

Multi-mode interactive education that champions palliative care excellence

1. To implement targeted palliative care education focused on 1) introductory ageing, recognising deterioration content for correctional personnel, and 2) complex ageing and advanced symptom management for justice health professionals.
2. To explore the acceptability and feasibility of using online spaced learning to deliver palliative care content for correctional personnel and more targeted symptom management for justice health professionals.
3. To support prisons to enable: 1) interested correctional personnel and justice health professionals to become local Palliative Care Clinical Champions; and 2) relevant personnel to input into the multi-disciplinary team meeting about managing a person's palliative care needs.
4. To create opportunities for interested corrections and justice health professionals to participate in the Program of Experience in Palliative Approach/Indigenous Program of Experience in Palliative Approach (PEPA/IPEPA) (e.g., observational placement at host site or reverse placement of palliative care specialist into the correctional site), including a program that builds correctional officers palliative care knowledge.

Strengthening links with local specialist palliative care teams

5. To map Australian prisons to local palliative care services and explore opportunities to build their understanding of people in prisons' palliative care needs and how they can better support their justice health colleagues to provide palliative care.
6. To strengthen collaborations with community palliative care teams to accelerate referral and engagement as required.
7. Establish or adopt existing palliative care referral and intervention triggers and pathways to ensure that people in prison with palliative care needs have timely access to appropriate care.
8. To support interested jurisdictions to co-design a 'dying on country' pathway to enable Aboriginal and Torres Strait Islander people in prison facing an expectant death to return home.

Foster national correctional services and justice health collaborations

9. To test the feasibility and acceptability of the National Interdisciplinary Justice Health and Correctional Services Extension for the Community Healthcare Outcomes (ECHO) program in 2024 to enhance service delivery, address the complex health needs of aging people in prison, and assist with building stronger interagency collaboration.
10. Establish National palliative care and ageing communities of practice inclusive of interested corrections personnel and justice health professionals in 2024.

Evaluating effectiveness

11. To continue to seek input from all stakeholders (e.g., people in prison and their families, correctional personnel and justice health professionals) via questionnaires and other means of feedback.
12. To consider establishing a combined correction and justice health mortality review to support strengthening corrections and clinical governance processes to prevent unexpected deaths in custody and better manage the palliative care needs of people in prison.
13. To consider the potential of facilitating the Stanford Palliative Care Medicine QI Initiative in 2024 to strengthen the provision of palliative care in Australian prisons.

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Background

People in prison experience an accelerated aging process and are considered 'older' from 45 years onwards [1]. Consequently, corrective and justice health services increasingly care for older people in a secure environment designed for fit and often aggressive young men. Traditionally, justice health services have provided screening, preventative healthcare, and chronic disease management around a variance of custodial management of the people in prison accommodation needs and program delivery [2]. But increasingly, they are now required to care for older people, many of whom have aged-related chronic and complex illnesses, with a growing number also requiring palliative care.

Palliative care is an approach that improves the quality of life of individuals and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, physical, psychosocial and spiritual [3].

These demographic and epidemiological changes require corrective and justice health services to consider how they will meet their charges changing healthcare needs, especially as the prison operating environment has been noted to complicate the provision of palliative care [4].

National Palliative Care in Prisons Project

The five-year National Palliative Care in Prisons (PiP) Project aims to address this need by strengthening access to the best evidence-based care for people with palliative care needs in Australian Prisons. We have partnered with Australian correctional and justice health services to co-design a national palliative care framework. This project aligns with the broader national palliative care landscape and the 2018 National Palliative Care Strategy [5].

The critical elements of this Project are to identify:

1) The palliative care needs of people in prisons – which is well underway.
2) Each organisation's capacity to provide palliative care.
3) The strategies required to build correctional personnel and justice health professionals palliative care capacity.

Aim:

To identify the capacity-building strategies that correctional personnel and justice health professionals require to strengthen palliative care in Australian prisons.

Methods:

Design and participants

Design: A co-design workshop was held on 12 September 2023 in Sydney, NSW. Co-design was selected as it was considered the best approach to determine priorities, barriers and facilitators and provide a deep understanding of stakeholders' experiences receiving and delivering services [6]. This co-design approach allows for a collaborative prioritisation of improvements, including a systems and perspectives approach with careful attention to governance and process [7]. Co-design provides a mechanism for redefining improvements into actionable strategies prioritised for implementation.

Participants: two nominated senior justice health and correctional services personnel invited to participate from each jurisdiction. The names and roles of the 23 participants who contributed to this co-design workshop are provided in Appendix 1.

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Key questions

This co-design workshop sought to answer the following key questions:

1) What are the minimal capabilities correctional staff require to better support people in prisons with palliative care needs?
2) What are the minimal capabilities justice health professionals require to better support people in prisons with palliative care needs?
3) What are the barriers to implementing palliative care capability-building strategies in Australian prisons?
4) What facilitators exist for implementing palliative care capability-building strategies in Australian prisons?
5) What would be the best strategies to build correctional officers' palliative care capabilities?
6) What would be the best strategies to build justice health professionals' palliative care capabilities?

Format

The co-design workshop involved four main activities:

- Pre-reading: Potential capacity-building strategies for consideration (Refer to Appendix 2).
- Co-design Program (Refer Appendix 3).
    - Questions to gauge the groups understanding of key palliative care concepts.
    - An overview of our current understanding of the palliative care needs of Australians in prison.
    - Global Café and establishing jurisdictional priorities.

Findings

This section details the findings to emerge from the workshop activities.

Mentimeter questions

The Mentimeter findings revealed that the participants (n=23) had a good understanding of palliative care principles and when palliative care ought to be introduced, as detailed below:

Palliative care principles

Participants had a sound understanding of palliative care principles, suggesting that it included holistic person-centred care, grounded in compassion and dignity, was inclusive of family and that delivery was supported by specialist input, as required.

Participants rightly acknowledged that palliative care should be initiated when people have unmet needs rather than their prognosis.

They also indicated that an ideal prison system ought to be able to care for people with palliative care requirements. However, to deliver on this ideal there needs to be timely access, adequate resourcing, in-reach multi-disciplinary specialist support, rapid assessment and response systems, better integration of services, appropriately trained clinicians, and correctional personnel with a better understanding of end-of-life processes/needs, including recognition of declining health.

Participants also suggested that integrating coronial recommendations, timely reclassification of people in prisons security levels and better integration of specialist external healthcare services was critical to delivery effective palliative care for people in the prisons. Along with culturally appropriate care and an opportunity for Aboriginal and Torres Strait Islander people to return to country to die if that this their and their families wish.

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Global café

Several factors underpinned prisons' ability to implement palliative care capacity-building strategies, which need to be considered, namely:

- That prisons are complex, risk-averse, and often reactive environments focused on security where every death in most jurisdictions, except Victoria[1] is a 'coroner's case.
- That there are multiple competing healthcare needs and priorities in prisons beyond palliative care.
- Balancing prison operational and security requirements impacts the organisations' ability to enable person-centred care.
- Collaboration, engagement, external connections, support, and delineated responsibilities are required to deliver person-centred palliative care in prison.

A summary of the key themes and considerations emerging from the global café questions is provided below:

Question 1- Key themes and considerations

Key considerations to emerge in response to the question related to correctional personnel's minimal capabilities to support people in prison with palliative care needs are as follows:

- As military principles underpin correctional officer training, any consideration of their minimal palliative care capabilities needs to be viewed from a safety, security and routine perspective and taking account of:
    - How correctional personnel roles and responsibilities are shaped by jurisdictional legislation, code of conduct and accountability.
    - What can be reasonably expected of correctional personnels in providing care.
    - The importance of person-centred care and that many correctional personnel are more familiar with people in prison and often unaware of the persons or families advance care planning wishes.

Question 2 – Key themes and considerations

The minimal knowledge and skills justice health professionals require to support people in prison with palliative care need centred around three key themes.

Providing person-centred care

Any palliative care capacity-building strategy needs to:

- Acknowledges that person-centred care is patient-focused and not prison-focused.
- Leverage justice health's professionals existing primary and mental healthcare knowledge and practices while acknowledging the healthcare needs of people in prison may differ across sites, especially regional sites.
- Be underpinned by:
    - The Nelson Mandela Rules and a working knowledge of local and state correctional systems, policies and procedures.
    - A trauma-informed approach to care
    - An understanding of diverse cultural, spiritual supports and the need for cultural safety within a multi-disciplinary team.

[1] Authorised Version No. 041. Coroners Act 2008, Authorised version incorporating amendments as of 11 October 2023.

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- Agreed co-designed models of palliative care, protocols and procedures including obtaining telephone orders, advice and accessing specialist support (i.e., managing Niki pump and Schedule 4 and 8 drugs).

Promoting collaborative care

To ensure that justice health professionals understand the:

- local and state corrections system and context and can access support from the local palliative care services.
- differences between creating relationships vs episodic care with support.
- risks recommended therapies can create for the rest of the prison population.
- collaborative care mechanisms that facilitate relevant referrals (i.e., specialist palliative care, Aboriginal and Torres Strait Islander Community Controlled Organisations, General Practitioners, Primary Care and community organisations)
- communication systems that need to be in place to facilitate the timely and secure transfer of information between people in prison, multi-disciplinary teams, corrections personnel, and justice health professionals.

Staff connections and support

To ensure that within the prison system that there is:

- Greater executive support for a team-based approach that enhances collaboration and communication between correctional personnel and justice health professionals supporting people in prison with palliative care needs.
- Greater acknowledgement of the moral distress experienced by correctional personnel and justice health professionals when the system 'fails' to facilitate responsive, compassionate care and of the critical importance of regular clinical supervision.
- Greater acknowledge that constructive feedback plays a key role in enabling opportunities for growth and improvement; and that a supportive environment that promotes reflective practice(s) especially in the context of coronial inquiry, is required to improve care outcomes.
- An opportunity to gain palliative care experiences, access clinical supervision, debriefing and promote wellbeing skills.

Question 3- Key themes and considerations

As summarised below, several barriers will likely impact the implementation of palliative care capability-building strategies in Australian prisons.

Lack of resources, meaningful connections and support

- A stretched prison workforce and high turnover make providing care as planned difficult.
- Inadequate resourcing is a major barrier, with the limited available resources primarily focused on primary healthcare and the needs of younger people in prison.
- Tensions between jurisdictional and Medicare-funding, can impact treatment and care options.
- Many Australian prisons in regional and rural communities, operate without an infirmary, so building their palliative care capabilities may not be indicated, as people with palliative care needs be transferred to a more suitable prison.
- Justice health professional cognisant of the need to provide best care and to prevent unwanted treatment side effects, which can be challenging. Their lack of access to regular debriefing and professional supervision contributes to compassion fatigue.

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- There is minimal support for disabled people in prison and minimal cultural support for Aboriginal and Torres Strait Islander and those from a culturally and linguistically diverse background.

Tensions between security vs. care

- Effective care is dependent upon managing the tensions between security and healthcare. Set unlocking and lock-up times can led to sub-optimal care (i.e., timely access to analgesic leading to unrelieved pain).
- The operational and individual needs of people in prison, such as those with combative, historical offences, need to be managed for the delivery of effective palliative care.
- There can be a struggle to work around restrictive practices, especially if the person in prisons wishes to stay on-site instead of being transferred to hospital for end-of-life care.

Organisational culture

- Person-centred care requires an opportunity for planned and meaningful reflection, taking account of prison processes to prevent closed thinking and desensitisation.
- Prioritising palliative care capacity-building requires high level executive support.
- Training in professional silos is a barrier, with cross-disciplinary learning deemed important to strengthening non-health personnel's understanding of palliative care, declining cognitive and/or physical capacities, and the care and strategies to manage these changes.
- As desensitisation reduces compassion and leads to less responsive care, there is a need to challenge existing norms and processes to ensure people in prisons with palliative care needs have access to more timely care for unrelieved symptoms (i.e., pain, breathlessness, fatigue).

Question 4-Key themes and considerations

Four main facilitators were identified that would support the implementation of palliative care capacity-building strategies in Australian prisons.

Resources

- Access to offsite learning opportunities is critical and allows for a more immersive learning experience away from work demands.
- Greater access to computers is required for effective online learning.
- Access to education across the various shifts, with out-of-cell hours to be factored into training time, and consideration given to weekly or half-day lockdown for mandatory clinical skill development.
- Better communication is required as correctional personnel often lack the necessary health information to effectively facilitate care.
- Opportunities to leverage and build upon existing activities involving correctional personnel and justice health professionals include collaborative risk assessments, engagement and liaison, handovers and case management.
- Ensure all correctional personnel and justice health professionals can access an Employee Assistance Program (EAP) debrief sessions.

Facilitators for variable learning

- Acknowledgement of the differing levels of health literacy within the prison workforce and multiple ways of learning.
- Flexible interactive learning models that are responsive to need, readily available and underpinned by the principles of adult learning are required.

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  - Monthly case management/clinic to build the capacity of staff. Combination of regional and metro and partnered with broader services (e.g., Extension for Community Healthcare Outcomes (ECHO)).
  - Combined palliative care learning sessions (i.e., correctional personnel and justice health personnel) may beneficial, dependent on service and utilising repetitive snap learning every month.
  - Train-the-trainer workshops, while not fully supported, are suitable for repetitive tasks and may be appropriate if the content is fit for purpose and the initial training is of a high-quality.
  - While e-learning has high initial attendance, it is often not completed.
  - A site 'champion' (sole or multiple) is important to increasing palliative care capacity within a prison or across prisons.
- External links with specialist services/providers are required to build palliative care capacity. Bringing in an outside agency provides global lessons and linkage to local networks. External links are viewed as patient-centred and holistic.
- The Program of Experience in the Palliative Approach/Indigenous Program of Experience in Pallliative Approach (PEPA/IPEPA) was a named strategy to support set up and placement.

Motivators for change

- Voluntary participation in capacity-building strategies that are linked to an individual's personal development is best for correctional personnel, while justice health maybe more open to mandated learning requirements.
- Need strategies that build an understanding of the value of relationships and roles, a willingness to listen to others, and leadership programs that share ownership and power across and between both correctional and healthcare services/providers.

External links, staff connections and support

- Clinical champion(s), either a solo or several team member(s) who are supported to build their palliative care capabilities and support others to deliver a palliative approach.
- Need to expand the psychosocial support available to people in prisons with palliative care needs family (i.e., bereavement support and counselling) and professional supervision and debriefing for correctional and health service personnel.
- Input from people in prison in the QI process about the level and quality of palliative care that ought to be available within the correctional environment.
- Advance care directives that promote individualised end-of-life care planning inclusive of input from relevant stakeholders (i.e., chaplain, family) and early identification of critical cultural considerations.

Question 5 – Key themes and considerations

Three main strategies considered most feasible and acceptable for building correctional officers' palliative care capabilities are detailed below:

Fostering collaboration and skill development between correctional officers and justice health personnel.

- Combined learning opportunities that foster meaningful collaboration and skill development for correctional personnel and justice health professionals tailored to their roles and scope of practice.

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Enabling Person-centred care

- Key considerations of person-centred care included an organisational attitudinal shift from prisoner to person in prison with palliative care needs, supported by prisoner perspectives and shared narratives.
- Building rapport and engagement via allocation of clinical champions with a recognised caseload.
- Ideally, the strategy of person-centred care should include patient and family perspectives within a pop-up model of palliative care initiated when needed and discrete.

Provision of tailored learning opportunities

Consideration of the following capacity building strategies:

- Extension for Community Healthcare Outcomes (ECHO) with an overlay of a custodial lens need and case selection of familiar local issues.
- Program of Experience in the Palliative Approach/Indigenous Program of Experience in Palliative Approach (PEPA/IPEPA) reverse pop-up model with a broader focus on principles and a hybrid of case and capacity building.
- Train the trainer may be suitable, although there were many who opposed this format primarily due to the infrequency of people in prison with palliative care needs. If adopted needs to include correctional personnel most likely to care for people with palliative care needs in prison.
- Spaced learning – received in principle support but noting it does require mobile device or computer access, which may limit its applicability in the prison setting.
- National council and prisons working party to convene with cyclic rostering.
- A national palliative care Quality Improvement (QI) program may foster networking and a collaborative approach to managing a small number of cases nationally.

In general, the implementation of specific strategies that foster practical, collaborative approaches nationally and locally was recommended. Considering that a significant portion of correctional personnel are new recruits (i.e., inexperienced), it is essential to provide them with fundamental palliative care knowledge so they can identify clinical changes and deterioration, distinguish between drug-seeking behaviours and symptom burden, conduct basic symptom assessments, recognise appropriate escalation referral pathways beyond calling for an ambulance, and comprehend their responsibilities in palliative care within the framework of non-healthcare professionals.

Question 6 – Key themes and considerations

Most of the capacity build strategies that were recommended to strengthen justice health professionals palliative care knowledge and skills were focus on systems and processes, as summarised below:

Core strategies to build justice health professionals palliative care capabilities.

- The intensity and approach of capacity-building strategies employed should be responsive to the frequency of palliative care patients within individual facilities, with centres who more regularly receive palliative patients undertaking ongoing training and upskilling.
- An in-reach team with expertise in navigating internal processes would help to prevent many points of difficulty. Establishing internal palliative care clinical champions at specific locations could provide timely, contextual and correct information and pragmatic advice to assist with managing the person in prison's palliative care needs.

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- All prison deaths are coronial cases and generate considerable distress and political agitation. Consider establishing combined corrections and justice health mortality reviews that examine the lessons learnt from each death and identify the QI opportunities.
- Palliative care education should be tailored for correctional and health personnel and focus on understanding disease progression, prognostic pathways, symptom management (e.g., pain, delirium, breathlessness), palliative care phases, physical and psychosocial end-of-life basic needs, when to triage or escalate, understanding internal prison support and cultural supports, how to work within a multi-disciplinary team, how to advocate for people in prisons' palliative care needs, referral pathways, ability to evaluate functional status, diagnosing dying and use of SPICT.

Better integration of specialist services through formalised processes

- Use existing annual health and chronic disease assessments processes to systematically identify people in prison with possible palliative care needs by routinely applying the Supportive and Palliative Care Indicators Tool (SPICT).[8]
- Relocation of the person in prison with palliative care needs from the general living unit to a more supportive setting; and refer them to the local specialist palliative care service.
- Establish a 'Pop-up model' of care which addresses the low volume but high complexity of people in prison with palliative care needs (Refer to Figure 1).
    - Such a model ideally would include a Palliative Care Nurse Practitioner and established links with the nearest specialist palliative care service. This model would facilitate real-time planning and address people's fears while concurrently building corrections and justice health palliative care capacity.
- Defined key escalation point to ensure timely and concise referral by corrections personnel and create a one-page care plan detailing the proposed approach which is shared with correctional personnel.

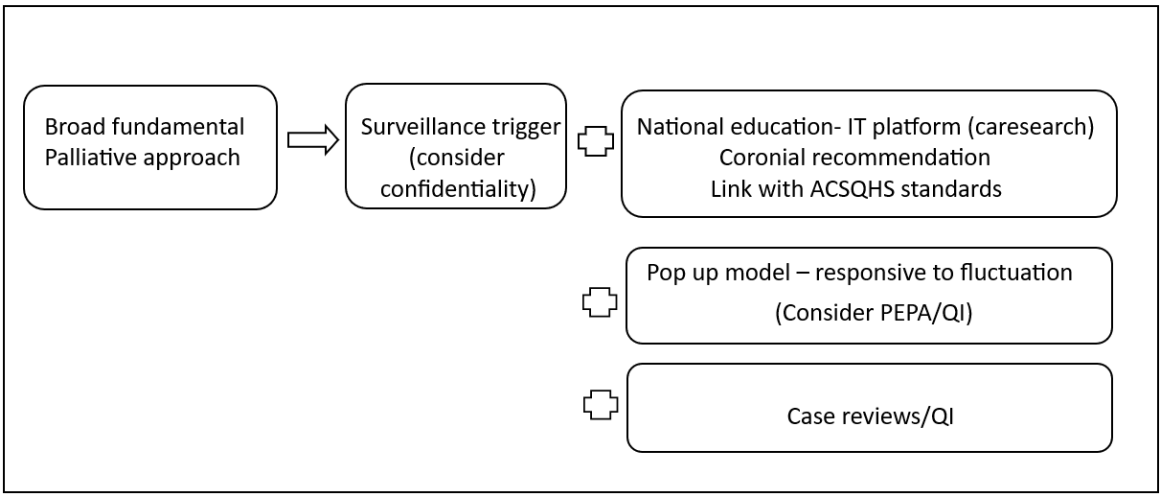

Figure 1: Proposed organisational changes to strengthening palliative care in prisons.

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Strategy ranking

The suitability and ranking of the proposed capacity-building strategies using a Mentimeter poll recommended the following strategies prioritised:

Correctional personnel:

1) PEPA/IPEPA placements
2) Spaced education
3) Community of practice

Justice Health professionals:

1. PEPA/IPEPA placements
2. ECHO
3. Community of practice – on focussed palliative care topic

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Jurisdictional priorities

Differing Jurisdictional capacity-building needs and priorities were identified, as detailed in Table 1.

Table 1: Identified priorities to build palliative care capacity in each jurisdiction

State	Interest and focus	Required from PIP Project
WA	Good base – conversation already underway	PEPA/IPEPA information for Corrections
	More meetings with Corrections	
	Provide in-house training	
	Integrate agencies' mental health, Aboriginal health, Multi-disciplinary Team meeting to address "Terminal List" 3+4 start planning.	
	Reverse PEPA/IPEPA for interested correctional officers.	Reverse PEPA/IPEPA for Correctional Officers
NSW	Focus on enabling Aboriginal people to die on country	IPEPA Communities of practice Joint corrections and justice health training
	Proactive screening to identify people with palliative care needs and established team responses to these needs	Implementation of SPICT screening into assessment and review
	Develop internal and external partnerships to strengthen palliative care.	
	How to refer? When to refer? Who to refer? Access	
	Move from a centralised model to a de-centralised	
VIC	Great start re-education/learning – need to expand	Establish a national group and share contacts for engagement
	Opportunity to grow PEPA/IPEPA across sites	PEPA/IPEPA Placements
	Project ECHO – sharing + connect with this	ECHO
	EOL policy suite in draft form – review and implement	
	Dreamtime journey policy – need to disseminate + implement this.	
QLD	National ECHO would be great. Fostering stronger in reach from specialist palliative care. Use national strategy as a lever. PEPA/IPEPA	National ECHO A forum with health/correction + pal care + consumers (esp. first nations)
NT	Indigenous focus – how can we ensure back onto the country	IPEPA
SA	Inspired by today. Info sharing. Plans – EOL wishes to approach. Continue PEPA/IPEPA + link to correctional officer.	Continue PEPA/IPEPA for Justice Health and tailored PEPA/IPEPA for Correctional Services.
TAS	EOL group identifies inmates who are > 55 years old with long sentences + 10 meds, including pal care needs.	PEPA/IPEPA linkage Establishing partnerships with specialist palliative care
ACT	Do more to engage and establish partnerships. Work is underway to establish specialist palliative care in reach.	All of the suggested strategies.

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Recommendations

The co-design workshop generated the following 13 palliative care capacity-building recommendations.

Multi-mode interactive education that champions palliative care excellence

1. To implement targeted palliative care education focused on 1) introductory ageing, recognising deterioration content for correctional personnel, and 2) complex ageing and advanced symptom management for justice health professionals.
2. To explore the acceptability and feasibility of using online spaced learning to deliver palliative care content for correctional personnel and more targeted symptom management for justice health professionals.
3. To support prisons to enable: 1) interested correctional personnel and justice health professionals to become local Palliative Care Clinical Champions; and 2) relevant personnel to input into the multi-disciplinary team meeting about managing a person's palliative care needs.
4. To create opportunities for interested corrections and justice health professionals to participate in the Program of Experience in Palliative Approach/Indigenous Program of Experience in Palliative Approach (PEPA/IPEPA) (e.g., observational placement at host site or reverse placement of palliative care specialist into the correctional site), including a program that builds correctional officers palliative care knowledge.

Strengthening links with local specialist palliative care teams

5. To map Australian prisons to local palliative care services and explore opportunities to build their understanding of people in prisons' palliative care needs and how they can better support their justice health colleagues to provide palliative care.
6. To strengthen collaborations with community palliative care teams to accelerate referral and engagement as required.
7. Establish or adopt existing palliative care referral and intervention triggers and pathways to ensure that people in prison with palliative care needs have timely access to appropriate care.
8. To support interested jurisdictions to co-design a 'dying on country' pathway to enable Aboriginal and Torres Strait Islander people in prison facing an expectant death to return home.

Foster national correctional services and justice health collaborations

9. To test the feasibility and acceptability of the National Interdisciplinary Justice Health and Correctional Services Extension for the Community Healthcare Outcomes (ECHO) program in 2024 to enhance service delivery, address the complex health needs of aging people in prison, and assist with building stronger interagency collaboration.
10. Establish National palliative care and ageing communities of practice inclusive of interested corrections personnel and justice health professionals in 2024.

Evaluating effectiveness

11. To continue to seek input from all stakeholders (e.g., people in prison and their families, correctional personnel and justice health professionals) via questionnaires and other means of feedback.
12. To consider establishing a combined correction and justice health mortality review to support strengthening corrections and clinical governance processes to prevent unexpected deaths in custody and better manage the palliative care needs of people in prison.
13. To consider the potential of facilitating the Stanford Palliative Care Medicine QI Initiative in 2024 to strengthen the provision of palliative care in Australian prisons.

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Summary

As the co-design workshop recommendations have revealed, there is an appreciation of the changing demographics within the Australian prison population and the need to address their healthcare needs. As the cohort of older people in prison with age-related chronic and complex illnesses, increases so too will the need for palliative care. The recommended four domains of action are designed to address and prepare the sector for the increasing number of people in prison with palliative care needs by focusing on:

- Multi-mode interactive education that champions palliative care excellence
- Strengthening links with local palliative care teams
- Fostering local and national correctional and justice health collaborations
- Evaluating effectiveness.

Partnering with jurisdictions to operationalise their preferred palliative care capacity-building initiatives is the next critical steps in the co-design process. During 2024, the National Palliative Care in Prisons Project will work to progress this agenda by exploring a range of capacity-building opportunities to develop and implement online spaced learning content, PEPA/IPEPA clinical placements, interdisciplinary palliative care champions, collaborative service delivery, cultural pathways, communities of practice, ECHO and quality improvement initiatives. Collectively, these initiatives offer the opportunity to strengthen palliative care provision in Australian prisons and improve care outcomes.

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Appendix 1: Co-design Workshop Attendees (n=23)

State	Attendee	Position
ACT	Dr Michael Chapman	Manager Palliative Care, Cancer, Aged & Chronic Care
NSW	Anne-Marie Martin	Deputy Commissioner of Security & Custody
	Thomas Chapman	Manager Palliative Care, Cancer, Aged & Chronic Care
	Phillip Snoyman	Director State-wide Services, Corrective Services New South Wales
	Jennifer Galouzis	Assistant Commissioner Offender Management & Programs
	Kathryn Lynch	Transitional Nurse Practitioner Palliative Care Operations and Nursing JH&FMHN
	Audrey Lazaris	South Eastern Sydney LHD
NT	Antony Clark	District Manager, Alice Springs Correctional Centre, Prison Health
QLD	Graham Kraak	Director, Office for Prison Health and Wellbeing
SA	Alyce Bolton	Manager of Offender Services & Case Management
	Adam Spicer,	Nursing Director
	Andrew Wiley	Director
	Stephanie Zulian	Manager, Accommodation Treatment Units
TAS	Cameron Brett	Prison Chaplain
	Deborah Siddall	Population Health & Special Projects Coordinator
	Sarah Peart	Assistant Director, Interventions and Reintegration Services
	Simon Kitto	Assistant Director of Nursing
VIC	Jackie Ashmore	Director Health Services and Clinical Governance
	Peter Foley	Operations Manager – Central Community
	Meg Parsons	Senior Clinical Governance Officer
	Amanda Smith	Offender Services and Integration Manager
WA	Dr Fermin Blanco Mayo	Medical Officer Casuarina Prison
	Jason Barnett	Deputy Superintendent, Casuarina Prison
	Amelda Doyle	Clinical Nurse Manager, Casuarina Prison

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Table 1b: Palliative Care in Prisons Team

Team	Prof Jane Phillips	Host, HoS – QUT School of Nursing
	A/Prof Michelle DiGiacomo	Investigator
	Monique Hooper	Investigator
	Dr Tim Luckett	Investigator
	Isabelle Shaefer	Investigator
	Prof Megan Williams	Investigator
Other	Dr Claudia Virdun	Investigator
	Dr Rebecca Bosworth	PhD Supervisor and NSW Justice Health Registered Nurse

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National Palliative Care in Prisons Potential Capacity Building Approaches: Pre-Reading

Sydney Co-design Workshop

12 September 2023

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Community of Practice

Definition: A group of individuals who share a common interest or concern and collaboratively improve their skills and knowledge through regular interactions, improving their collective expertise in a relevant field or activity [9].

Method: The three important elements of developing a community of practice include 1) an identity or membership connected to a shared interest, 2) a community of members engaging in discussion and activity, and 3) shared resources [9].

Advantages

- It is a strategy that facilitates communication and connections across various levels and divisions within formal organisations, such as healthcare or government [9].
- It allows space for cultural and professional knowledge to be recognised and considered [10].
- A low-cost, scalable peer-support approach that can be conducted virtually or fac-to-face.

Disadvantages

- A broadening definition means characterising what is or is not a Community of Practice becomes more challenging [11]
- Requires an organisational and individual commitment to ensure participation and a facilitator.

Evidence: In healthcare, Communities of Practice can serve several purposes, such as competency development, addressing organisational barriers, improving information sharing, implementing new technologies, increasing formal and informal communication within a team, and enacting behaviour change [12].

Further reading

https://pubmed.ncbi.nlm.nih.gov/31774401/

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Extension for Community Healthcare Outcomes

Definition: Extension for Community Healthcare Outcomes (ECHO) is a bidirectional tele-education practice model aiming at amplifying healthcare professionals' competencies in the management of complex and chronic health conditions [13].

Method: ECHO is a channel whereby specialist mentors can share best practices with local clinicians to reduce variation in care and improve outcomes through an established network between front-line healthcare professionals and a multi-disciplinary team of specialists [14]. Typically, the model includes a curriculum of regularly scheduled "ECHO clinics" of case-based discussion about a real patient situation and a short didactic presentation. Echo clinics combine brief didactic with case-based learning from specialists with embedded case material [14].

Advantages

- Patients in underserved areas receive best-practice care without travelling to urban centres [14].
- Continued no-cost medical education [14].
- Professional interaction with colleagues and access to specialists [14].

Disadvantages

- Clinician time requirement [14]
- Organisational and individual commitment to participate and to present a de-identified patient case [14].
- Requires a facilitator and input from relevant specialist providers [14].

Evidence: The ECHO model was first launched in 2003 to support primary care providers in rural and prison settings in managing patients infected by the Hepatitis C virus. Evidence shows the ECHO Model increases healthcare professionals' perceived knowledge and confidence in their ability to perform new behaviours in practice [13].

Further reading

https://www.tandfonline.com/doi/abs/10.1080/08897077.2021.1941518

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Indigenous/Program of Experience in the Palliative Approach

Definition: The Program of Experience in the Palliative Approach/Indigenous Program of Experience in Palliative Approach (PEPA/IPEPA) is a national program funded by the Australian Commonwealth Government as part of the National Palliative Care Strategy. It provides opportunities and funding for education in palliative care for health professionals through clinical placements and interactive workshops [15].

Method: One element of the program is the "reverse placement", which allows a specialist palliative care clinician, supported by PEPA/IPEPA mentors, to attend a workplace to provide palliative education and mentorship to the workplace over 2-4 days [15]. The aim is to improve the skills and confidence of an entire team to work with those affected by life-limited illnesses.

Advantages

The advantages of a reverse placement include [15]:

- Cost-efficiency of educating more than one participant at a time.
- Strengthening relationships between specialist palliative care services and the unit.
- The ability of the specialist palliative care clinician to recognise facility-specific issues.
- On completion, participants will have the confidence and skills to implement a palliative approach in their usual role.

Disadvantages

- Specialist Palliative Care providers must travel and remain on-site for a period, which may limit the availability of these placements as they have existing clinical responsibilities [10].

Evidence: Evidence suggests that a reverse PEPA/IPEPA placement provides appropriate support for Indigenous healthcare professionals, as the facilitator can tailor learning to the group's specific needs [10].

Further reading

https://www.proquest.com/docview/2645225668/fulltextPDF/C199C72C245A4416PQ/1?accountid=13380

https://search.informit.org/doi/epdf/10.3316/ielapa.958237219642955

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Spaced education – via the Qstream Platform

Definition: Spaced education harnesses the pedagogical benefits of spacing and testing effects to deliver small quantities of educational content in repeating patterns over time while concurrently 'testing' learners' understanding of the content [16].

Method: Educational content that is spaced and repeated over time (spaced distribution) increases the acquisition and retention of knowledge compared to content delivered at a single time point (mass or bolus distribution)[17, 18]. Spaced and repeated test-enhanced learning promotes better recall and retention than long single or back-to-back consecutive testing [19-21]. Qstream takes advantage of the psychological finding that education encounters that are 'spaced' and 'repeated over time result in more efficient learning and improved retention compared to a bolus distribution learning format [22]. It 'pushes' clinical questions or case-based scenarios to the participant's email, which takes less than 5 min to answer, and provides immediate feedback upon submitting a response. When delivered prospectively, it can generate significant topic-specific learning [23]. In several RCTs, 'Qstream' has been shown to improve knowledge acquisition, boost knowledge retention from 3 months and out to 2 years, and positively impact on entrenched clinical practice and outcomes [24-27].

Advantages

- A cost-effective, scalable online delivery platform underpinned by good evidence.
- Addresses the learning retention curve, where 70% of knowledge is forgotten within 30 days.
- Qstream's short scenario-based assessment format:
- Increase knowledge retention and reinforcement by up to 170%
- Cement knowledge in the minds of healthcare professionals so they can apply this new knowledge to their role to improve job performance and patient care.
- Its bite-sized micro-learning and delivery method accommodates busy healthcare professionals' schedules and increases learner engagement by 90% or more.
- Each authentic case-based scenarios question takes 7 minutes to complete.

Disadvantages

- Per head user licence and access to a mobile phone or desktop computer.
- Requires an organisational commitment for participants to attend to learning using their mobile phone and an individual commitment to engage in the learning content.

Evidence>It is the only microlearning technology with evidence of changing healthcare providers' knowledge and behaviours (add previous references).

Further reading

https://qstream.com/industries/qstream-healthcare-education-and-training-solutions/

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Stanford Palliative Care Medicine QI

Definition: The Stanford Palliative Medicine QI program (PAICE) teaches collaborative evidence-based Quality Improvement methodology during 7 interactive sessions to multi-disciplinary teams so that they can address inefficiencies and unique problems in complex healthcare environments in diverse global settings.

Method: The Stanford Palliative Medicine QI Team have discovered effective methods for applying quality improvement tools and creating a learning environment where clinical leaders can redesign how care is delivered in their local areas.

Advantages

- Online and scalable
- Proven model that delivers quantifiable results in improving patient outcomes and engaging local leaders.
- Bring diverse disciplines together to address a locally identified problem.
- A structured program that builds QI capabilities through defined deliverables and timelines.

Disadvantages

- Requires an organisational and individual commitment to allocate the time to complete the tasks – approximately an hour a week.

Evidence: Between 2017 and 2020, the Palliative Care—Promoting Access and Improvement of the Cancer Experience Program conducted three QI capacity-building courses with 22 Indian palliative care and cancer programs. This work has demonstrated that it is a feasible model of international collaboration and capacity-building in palliative care and cancer QI. It is one of the several networked and blended learning approaches with the potential for rapidly scaling evidence-based practices [28].

Further reading

https://globalhealth.stanford.edu/programs/paice-global/

https://globalhealth.stanford.edu/education/improving-cancer-care-in-india.html/

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Train-the-trainer

Definition: An organised activity is provided by a trainer to improve the trainees' learning and behaviour (Poitras et al., 2021).

Method: An outside consultant or specialist facilitates initial training for the selected internal trainers. Standardised training ensures that all trainers receive the same instruction and format. The skills and practical exercises taught in training can be tailored to specific industries or workplaces, with the course format and process remaining the same [29].

Advantages

- Ability to reach larger audiences via subsequent training activities.
- More direct access to understand contextual issues affecting application and training.
- Potential for enhancing networking and collaboration amongst trained.

Disadvantages

- Other staff/peers lack of training (Poitras et al., 2021)
- Funding required for continued training (Poitras et al., 2021)

Evidence: Train-the-trainer is an effective method for broadly disseminating evidence-based public health principles that is less costly than traditional methods and allows for tailoring to local issues [30].

Further reading:

https://pubmed.ncbi.nlm.nih.gov/34292260/

https://www.twi-institute.com/train-the-trainer-model/

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Appendix 3: Co-design Program

National Palliative Care in Prisons

Capacity-building Co-Design Workshop with Jurisdictional Justice Health and Correctional Services

Mercure Sydney 818-820 George Street, Sydney, NSW.

Tuesday 12 September 2023

Facilitator – Professor Jane Phillips

Time	Presenter	Content
09:30	Jane Phillips	Welcome and introductions, housekeeping
09:35	Monique Hooper	Acknowledgement of Country
09:40	Jane Phillips	Introduction to palliative care and co-design workshop objectives
09:50	Isabel Schaeffer	What do we know about the palliative care needs of people in prison
10:10	Jane Phillips	Global Café Round 1 - Defining the needs
11:00		Morning tea
11:15	Jane Phillips	Global Café Round 1 - Feedback and conversation
12:00	Monique Hooper	Capacity-building overview - What do we know, and what are the options?
12:00	Jane Phillips	Capacity-building Reading Pack and Reflections
13:00		Lunch
13:45	Jane Phillips	World café Round 2 - Co-designing the solutions.
14:30	Jane Phillips	World café Round 2 – Feedback and conversation
15:00	Jane Phillips	Ranking exercise
15:10	Jane Phillips	State-based Groups - preferred capacity-building strategy
15:45	Jane Phillips	Next steps
16:30	Jane Phillips	Close

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