Getting Out, Staying Healthy

GOSH

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Justice Health and Forensic Mental Health Network
NSW GOVERNMENT

CONNECTIONS PROGRAM

Case for change

The Connections program is an integral part of Justice Health and Forensic Mental health (JHFMHN) supporting patients when they are released into the community. Over 2000 referrals received in 2024, only 2 out of 10 people complete their journey with Connections. The program cannot meet current demand, leading to redundant care (perceived or actual), duplicate efforts, overservicing, and lack of prioritisation mean high-need individuals are missed. If we continue in the same way 39% of people who requested help from the Connections team were released into custody without ever having been seen.

Goal

To improve the accuracy, completeness, and timeliness of referrals to the Connections Program. High-risk patients are consistently identified, prioritised and linked to support, enabling staff to deliver coordinated care from the earliest point of engagement.

Objectives

- By December 2026, ensure that >85% of referred patients receive program information prior to referral and provide informed consent.
- Optimise referral processes so that at least 95% of referrals meet eligibility criteria and are complete by December 2026.
- Reduce the number of unable to assess patients from 33% (n - 667) to under 25% by June 2026.
- Decrease the number of patients who decline the program 29% to under 15% by June 2026.

Method

Interviews and focus groups with patients and staff

Surveys staff, steering committee and other relevant stakeholders

Process mapping

Power of three Traditional Brainstorming

File audit Data analysis

Diagnostics

CURRENT STATE

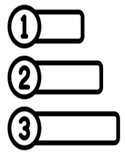
The eligibility for the Connection program is too broad. Meaning that patients who are referred to the Connections Program may not be suitable for the program as they do not require any Drug and Alcohol support. No strict eligibility and suitability criteria. Which includes evidence of those more at risk when returning to community e.g. overdose risk, complexity, and support needs.

Patient- "I had issues with D&A ages ago. Not now"

At the time of referral, not all patients are aware that they have been referred to the program. High number of patients reporting that they are unaware of Connections program, or its benefits at point of referral. This impacts the staff's ability to provide quality care to those at need.

He was released without his medication, no ID, no Centrelink, no follow-up. He relapsed and came straight back in

Staff - "What are we meant to focus on? Provide Drug and alcohol support or support people with getting clothes and ID? it is confusing!"



There is no priority system in place to identify high-risk patients. Due to high number of referrals, the Connections program may have missed the opportunity to support patients that are at higher risk when servicing patients who may not need the support. The impact of quantity over quality is evident.

Staff - "there is no priority of patients"

Staff - "Most of the time when they decline and don't come to the clinic, I'm unsure they know what they're declining".

Staff report that they are not aware of what the Connection programs focus is, making their scope and role unclear.

FUTURE STATE

Develop and implement strict eligibility and suitability criteria so that patients most at risk are seen and supported when they are released into the community.

The program is providing more quality patient care to those patients at high risk, which will reduce mortality and morbidity.

90% of patients are provided full detail of the programs support. This will support both patients and staff providing more clarity on what the program offers. This will limit the number of referrals of individuals that do not require the support from the program and all patients that are referred will have consented to the support.

Patients are consistently informed and consented to participate in a way that has been co-designed with them, ensuring cultural safety, respect, and autonomy.

Seeing high-risk patients on the Connections Program will; Reduce blood-borne virus transmission, reduce drug use and risk-taking behaviours, increased participation in opioid agonist treatment, increased community health linkages and lower the risk of overdose

Solutions

Develop a referral form that defines the risk priority for patients. The priority matrix (triage system) will assist the Connections management team and Connections Transition Coordinators to plan their workload more efficiently and effectively and determine the appropriate level of support required for each patient.
Referrals occur without patient involvement, under pinning principles of informed consent.
Inconsistent communication practices between custody-based staff and patients during release planning.

Develop and implement strict eligibility criteria and suitability criteria so that patients at risk are seen and supported when they are released into the community. This can lead to an enhanced patient experience by fostering a coordinated and collaborative approach among healthcare providers, improving communication and engagement with patients. To provide quality care to patients at high risk, which will reduce mortality and morbidity.

Results

Key benefits from the project are yet to realise as this project has been put on hold due to current organisational priorities within Justice Health. The project aims to address the following areas:

Improving the patient experience of care • Increase patient satisfaction with health care received • Patients experience a smoother transition, with fewer gaps or delays in accessing community supports after release.	**Improving the staff experience** • Staff feel more confident in the work they are undertaking, knowing that they operate within an efficient and effective system that supports the delivery of high-quality care to our patients, families, and carers.
Improving the health of populations • Reduced risk of patient overdose • Reduced transmission of blood borne viruses • Promotes equity by addressing unmet health needs and preventing deterioration after release.	**Reducing the per capita cost of health care** • Increased cost efficiency associated with less duplication of services • Our systems and processes are integrated across Justice Health NSW

Sustaining change

- Training package for all Connections staff
- Team huddles
- Communication strategy to the whole of Network along with external stakeholders
- Time series analysis
- Feedback and focus group sessions
- Staff wellbeing surveys
- Regular staff check-in
- Monthly performance monitoring of total number of unable to assess, declined and referred patients

Conclusion

Lessons learned:

- Ensuring that you have clear, effective and concise communication during the whole process.
- Ensure ongoing support at executive level to implement the change.
- Utilise your stakeholders at every stage – they provide valuable insight and knowledge.
- Changing the scope of the project is normal and okay!
- We can't fix everything.

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