



# EMHSCA

Eastern Mental Health Service Coordination Alliance

## Shared Care Protocol 2020

This protocol was initiated between clinical and community mental health services in 2007 and expanded to include AOD, Housing/Homelessness, Community Health, Primary Health, Human services, and Family Services in 2013. A 4th edition was provided in 2016 in line with the introduction of the new Mental Health Act and the National Recovery framework. This 5th revision reflects the strategic objectives of EMHSCA in ensuring that Shared care practices are embraced by all health and community service providers and the people who access them across the Inner- and Outer Eastern Areas of Melbourne. This protocol maintains the original intent of supporting effective shared care arrangements for people who experience mental ill-health and co-occurring concerns

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## Eastern Mental Health Service Coordination Alliance (EMHSCA)

The EMHSCA is a collaborative group of services who are signatories to the EMHSCA MOU and who participate in activities aimed at promoting and enhancing service coordination across the Eastern Metro Region of Melbourne in relation to Mental Health illness and co-occurring concerns. The following is a list of the various services involved in this alliance.

- Access Health & Community Services
- Anglicare Victoria
- Australian Government Department of Human Services
- Campbell Page
- Carrington Health
- Department of Health & Human Services – Eastern Metro Region
- Dual Diagnosis Consumer & Carer Advisory Council
- EACH
- Eastern Community Legal Centre
- Eastern Health Mental Health Services – Adult, Aged, CYMHS
- Eastern Health Turning Point
- Eastern Homelessness Service System Alliance
- Eastern Melbourne PHN
- EMR Regional Family Violence Partnership
- Independent Mental Health Advocacy
- Inner East Primary Care Partnership
- Inspiro
- JobCo.
- Knox City Council
- Link Health & Community Services
- Maroondah City Council
- Mentis Assist
- MIND Australia
- Mullum Mullum Indigenous Gathering Place
- NEAMI National
- NEXTT
- Outer East Health and Community Support Alliance
- Outer East Primary Care Partnership
- The Salvation Army
- Wellways
- Whitehorse City Council

### EMHSCA embraces diversity

EMHSCA welcomes and celebrates diversity, as we reflect the variety of cultures and communities we serve. Our Alliance strives for true collaborative practice and a spirit of inclusivity for all. EMHSCA recognises that poorer health outcomes are associated with experiences of discrimination and marginalisation. EMHSCA challenges inequities in the development and delivery of health and community services.

### Acknowledgement of country

We acknowledge the traditional custodians of the land upon which we are meeting, the Wurundjeri people of the Kulin Nation, and pay our respects to their elders past and present and to aboriginal people present here today.

### Recognition of Lived Experience

EMHSCA recognises those individuals and their supporters who have a lived experience of mental ill health and the important contribution that they make to the development and delivery of health and community services.

## DEFINITIONS

**Accessible Format (Information):** the provision of information to a consumer that is in a language and a format that the consumer can use in their decision making processes.

**AOD:** Alcohol and Other Drugs

**AOD Practitioner:** a clinician or worker who is employed by an Alcohol or Other Drug service to provide specific alcohol and other drug treatments, interventions and support.

**Carer:** family members or friends of a consumer who provide care to the consumer within their relationship as defined by the Carers Recognition Act 2012. Carers may not necessarily live with the consumer for whom they care. Children can be carers too.

**Eastern Mental Health Service Coordination Alliance Services (EMHSCA):** All Eastern Metropolitan Region of Melbourne services involved in the provision of care to people with a mental health concern and who have signed the EMHSCA Memorandum of Understanding 2016.

**Care Coordinator/Support Facilitator:** Service provider specifically employed to support and co-ordinate the provision of timely and appropriate care to people with multiple and complex needs.

**Clinical Case Manager/Clinician:** a clinician employed by a public Mental Health service who provides direct clinical services to a consumer.

**Clinical Services:** a public Mental Health service or a Mental Health Nurse (MHN) in private practice. These are governed by the Mental Health Act 2014.

**Collaborative:** All parties to the plan participate as equals in all processes of coordinated shared care required. This includes all EMHSCA agencies/programs, non-EMHSCA agencies/programs and practitioners, consumers, carers and others deemed relevant to the planning process., \*Consent must be sought from the consumer in most circumstances (see page 8).

**Community Mental Health Worker:** an employee of a Mental Health Community Support service providing direct non-clinical services and support to a consumer.

**Consent** Consumer agreement based on an understanding of the implications of a particular activity or decision and the likely consequences for the consumer.

**Consumer:** a consumer, who has been diagnosed with a mental health illness, has direct experience of Mental Health Services or identifies as a consumer [VMIAC's definition]. The term "consumer" refers to people who directly or indirectly make use of mental health services.

**Duty of Care:** the legal obligation to safeguard others from harm while they are in your care. This extends to those potentially affected by any harms of those in your care.

**NDIA:** The National Disability Insurance Agency (NDIA) is an independent statutory agency, whose role is to implement the National Disability Insurance Scheme (NDIS).

**NDIS:** The National Disability Insurance Scheme provides community linking and individualised support for people with permanent and significant disability, their families and carers.

**LAC:** Local Area Coordinator – local organisations working in partnership with the NDIA, to help participants, their families and carers access the NDIS.

**Planning Coordinator:** the support person identified by the consumer (or otherwise by consensus) as the most appropriate to liaise with other services, manage the contributions of all parties involved and coordinate the care planning process. Note: This role may be held by any member of the care team.

**Public Interest:** A matter that is capable of affecting the general public and that they may have legitimate interest in being informed of.

**Personal Plan:** A consumer's plan that articulates what is important in their life and includes their goals, hopes and dreams, and identified supports (Glover 2013).

**Service Plan:** The service commitment offered to a consumer after hearing their need and negotiating the available supports with the consumer (Glover 2013).

**Shared Care Planning team:** The various parties to the Shared Care Plan.

**Specialist Family Violence Advocates (SFVA):** a practitioner who is employed by a Specialist Family Violence service to provide specific family violence risk assessment, needs identification, safety planning and case management support.

**Support Coordination:** NDIS specific role – Support coordination is a capacity building support to implement all supports in an NDIS participant's plan, including informal, mainstream, community and funded supports. This is best provided independent of other supports to avoid bias in service selection.

**Support Worker:** an employee of services providing direct non-clinical support to a consumer. E.g. Homelessness outreach

## EMHSCA SHARED CARE PROTOCOL

Shared care refers to one or more agencies/programs who are working with a particular consumer to facilitate appropriate, collaborative, consistent and coordinated service delivery. Services should establish a shared care agreement with the consumer to better meet their individual recovery needs and goals.

The EMHSCA Shared Care Protocol is an agreement between services across Inner- and Outer Eastern Melbourne to work together to help deliver consumers and carers the best possible service responses and outcomes.

This protocol describes expectations, requirements and processes for shared care by EMHSCA member agencies/programs, with the objective of improving outcomes for consumers, their carers, impacted families and children.

The protocol includes guidelines on the collaborative practices:

1. For service providers when working together with shared consumers.
2. For the development of Shared Care Plans.
3. For appropriate and effective sharing of information between parties to the Shared Care Plan.

## SHARED CARE PRACTICES

The protocol supports the following practices when working collaboratively to support people along their mental health journey:

### Know who is involved

- Taking a holistic view, identify all of the person's existing supports at intake assessment and seek consent to collaborate, being mindful of potential safety issues for all concerned.

### Take care when you share

- Respect the rights of the person and their family and children, including that of privacy and confidentiality. Know when you can share, when you cannot, and when you must. Always put safety first and check in with your colleagues when making decisions.

### Look at the whole picture

- Seek existing information about the person in order to develop a holistic view of their individual circumstances, resilience factors and relapse signature. Gather a longitudinal history and seek to avoid unnecessary duplication and misunderstandings.

### Work as a shared care team

- Work collaboratively with all relevant formal and informal supports involved as a shared care team, providing timely and relevant access to information. The person must have opportunity to be an active participant of this team and information should be provided in an accessible format. Keep carers in the loop.

### Keep the person and their family at the centre

- Ensure that the identification of the person's recovery, safety and support needs and the identification of personal goals is a collaborative process and that the person and their needs, and the needs of any dependents, are at the centre of all processes and activities. Acknowledge the role of carers (including young carers) and provide clear and timely information and advice.

## Case Example

Jamie is an energetic young person who loves adventure and music. Jamie “mixes beats” and spends most of the time with a few close friends. Jamie lives at home with mum, dad and a younger sister. Jamie’s mental ill-health makes it hard to concentrate and communicate with most people in the community. Jamie uses substances in large quantities and whatever and whenever they are available. Jamie has collapsed due to heavy substance use on a number of occasions and received treatment in the emergency department of the local hospital. Whilst there, Jamie’s behaviours have been challenging to manage. Jamie is no longer welcome to live at home with the family due to aggressive outbursts and drug use behaviours.

Mental Health services want Jamie to work on the substance use issues. AOD services want Jamie to be treated for psychotic features and to receive a clear Mental Health assessment and diagnosis. Homelessness services have no suitable housing options and need Jamie to actually have left home to provide support. Jamie

### Jamie’s care plan

*Jamie was not keen on seeing the clinical mental health case manager because Jamie said “they hassle me about my drug use and want me to take my meds”. Jamie preferred to work with the AOD counsellor who spent time listening to Jamie’s concerns and interests and paced the work around Jamie’s motivation to change. The AOD counsellor did not feel equipped to manage Jamie’s erratic and psychotic presentations and encouraged Jamie to consider developing a Shared Care Plan. Jamie was reluctant at first but later agreed and consented in writing for the AOD counsellor to make contact with the clinical case manager. An initial meeting was arranged and the clinical case manager expressed relief to have specialist AOD support.*

### Jamie’s goals

*Jamie needed some support to explore short-term and long term goals. Moving out of home had not been possible due to lack of financial stability. Jamie understood the need to engage with Centrelink to apply for the Disability Support Pension (DSP). Getting off the Community Treatment Order (CTO) was a clear goal and involved the need to stabilize mentally. This led to exploration of substance use issues with subsequent harm reduction goals included in the plan. Jamie mentioned an interest in a music course to improve ability to mix beats and record tracks. This was recorded in the plan as a longer term goal when things became more stable. Jamie identified that attending school would require a more stable mental state and more controlled*

has not been engaging with Centrelink due to unstable mental state and has not qualified for the Disability Support Pension. Jamie is headed for forensic involvement, emergency services and has the potential to die at any time.

## SHARED CARE PLAN

A Shared Care Plan will consist of the following core components:

### Recovery Plan:

A Recovery Plan brings together the person’s goals and desires with clear articulation of the various support services’ ability to support the person on their Recovery journey.

- An overview of the consumers’ current situation, strengths and their personal values, vision and goals.

- Goals are as prioritised by the consumer.
- The strategies and supports to be employed to achieve stated goals.
- A clear outline of what the service can provide and a commitment to what will be provided.
- Articulation of the roles, responsibilities and contact information of all parties involved in the Shared Care Plan.
- Identification of a Planning coordinator (see Definitions, p.2).

**Wellness Plan:** Includes the following

- The consumer's likely precipitating stressors, early warning signs, protective factors and personal strengths.
- Strategies and responsibilities for maintaining wellness and responding to crisis
- Support plans pertaining to those who may be dependent upon the consumer in times of relapse e.g. children, pets etc...
- Details of any Advance Statement and Nominated Consumer ([s19 – s27 of MHS 2014](#))<sup>1</sup>

**Safety Assessment & Management Plan** (previously referred to as Risk assessments and plans):

- Safety assessment is a tool which identifies any potential and/or current safety issues and risks to the consumer or others. This is a dynamic and ongoing process.
- The plan should be developed with the consumer (wherever possible) and self-management and mastery of safety is to be encouraged and supported.
- All parties, including the consumer can and should contribute information and insights relevant to safety.
- The plan should include strategies, responsibilities and supports required to manage any safety issue.
- The safety of children, dependent elderly and animals are paramount in safety management planning.
- Collaborative safety management involves appropriate and timely communication of all relevant parties.

Tools used should be at the discretion of and owned by the consumer, and be used to inform any documentation requirements of the individual agencies/programs. The consumer should ideally be spared from repetition where ever possible. **Note:** Not all consumers will have identified safety issues. In that case a Safety Assessment & Management Plan communicates that fact.

## SHARING OF INFORMATION

All staff are responsible for and expected to maintain effective, open and timely communication. This includes but is not limited to information on:

- Entry into and exit from services (including any inpatient admissions and referral information)
- Assessment outcomes (including risk assessments)
- Recovery Plan development, review and content
- Significant changes in the consumer's level of needs or safety

### Sharing information

*Jamie did not want family to know about the substance use. This right to privacy was upheld and Jamie was encouraged to explore honest communication with family as part of the care plan. The family were provided with support and education by the clinical case manager in spite of consent issues as they were the closest support people in Jamie's life and needed skills to manage Jamie's behaviours.*

*When Jamie talked about plans to hurt a family member, the family were immediately informed and a safety plan developed with Jamie and with the family.*

<sup>1</sup> Advance Statements and Nominated Consumers are legal entities, specific to Mental Health Treatment. They express a consumer's preference at a time where they are under a Mental Health Act order and do not have capacity to make decisions. They must be witnessed, signed and recorded on Mental Health's CMI system to be identified and have legal status. Consumers wishing to make an advanced statement or nominated consumer who is not engaged with a mental health service at present, will need to send copies of the relevant documents to their local (or last mental health service they had contact with) to be registered.



- Triggers, stressors and/or significant changes in mental state or associated behaviour
- Medication and/or treatment changes that may have an effect on support needs
- Significant changes to appointment frequency or non-attendance at scheduled appointments
- Critical incidents
- Change of clinician, worker or treating team

Consent to share information must be provided by the consumer, and sharing of information must at all times adhere to local agency/program policies and all relevant legal frameworks.

(For further information on the sharing of information refer to *s346 Subsection 2 of the [MHA 2014](#)*)

## Sharing of non-shared care documentation with the consumer

The Shared Care Plan must be provided to the consumer at initial development, at each review and upon request by the consumer.

The sharing of all other agency/program documentation is subject to the following:

- Policies and processes of the agency/program who owns those documents;
- Freedom of information law
- The Mental Health Act 2014
- Privacy Act 1988
- Family Violence Protection Act 2008/FV Protection Amendment Act 2017
- Child Safe Standards

## Consumer consent to shared care and/ or the sharing of information

When an agency/program identifies a consumer that is or will be using multiple agencies/programs, the agency/program should;

- Discuss the opportunity and benefits of developing a shared care arrangement and plan;
- Discuss the benefits and needs for sharing information between agencies/programs and practitioners;
- Discuss any constraints of confidentiality relating to the information sharing scheme where family violence is indicated;
- Provide the consumer with the choice to consent to a shared care arrangement;
- Obtain consent (as per individual organisations policy requirements) from the consumer to discuss this potential with the other agencies/programs, practitioners or carers, or to share information; and,
- If information only is to be shared, the consumer must specify what information, with whom and for what time period it may be shared.

**Note:** A consumer may withdraw consent at any time. Consumer consent should be reviewed at least 12 monthly or as requested by the consumer.

Where consent has been provided to share care or to the sharing of information, agencies/programs cannot decline to participate, or to share the required information if it is relevant to and required by the agency/program making the request.

Where a consumer **does not consent** to a shared care arrangement and/ or the sharing of specific information, this should be documented in the consumer's notes. It can be revisited at any time by the agency/program or the consumer. Some information may still be shared as per *s346 Subsection 2 of the [MHA 2014](#)*. Ensure the consumer is aware of their rights and where information may be shared without consent under the law. Information that may be shared under these circumstances is that which enables service providers and carers to perform their necessary functions and where information is required under certain orders and/or Acts.



## Family violence and information sharing

The Royal Commission into Family Violence found that there can be catastrophic consequences when information is not shared. Special provisions have been made to improve the sharing of information in order to keep victim survivors safe and hold perpetrators to account. The requirement by law that a serious threat to an individual must be imminent before information can be shared is to be removed from the Privacy and Data Protection Act 2014 and the Health Records Act 2001. These amendments will apply generally (not just for Family Violence). For further information go to the Victorian Government's family violence reform website at <http://www.vic.gov.au/familyviolence/family-safety-victoria/information-sharing-and-risk-management.html>.

## INITIATING A SHARED CARE ARRANGEMENT AND PLAN

It is the responsibility of the identifying agency/program to coordinate the initial shared care meeting. The meeting should be conducted within 4 weeks of shared care being identified. Consumers and carers should be present at this meeting. Prior to this meeting all agencies/programs involved should have meaningful discussions with consumers and their carers about the service offered, the consumers recovery, personal recovery goals, safety and the collaborative process.

A member of the Shared Care Planning team will need to be identified as the Planning Coordinator. This should be based on:

- Consumer preference
- Agency/program knowledge and engagement with the consumer
- Frequency of contact with the consumer
- Capacity of the agency/program

The Planning Coordinator may be changed by agreement if for example the consumer's circumstances change, the coordinating agency/program/consumer withdraws from the shared care arrangement or a different agency/program/consumer is better suited to perform the role at a later date.

The Shared Care Plan should be initiated at the first meeting. It must clearly define the roles and activities of everyone involved in the plan. When completed all plans should be signed by the consumer, planning coordinator and the carer if party to the plan. Copies should be provided to all parties with which the consumer provided consent to share information.

Shared care planning is an ongoing activity involving initiation; development; review and transfer (see appendices).

## Aboriginal and Torres Strait Islander peoples

Due to the ongoing impacts of colonisation, Aboriginal and Torres Strait Islander peoples require a trauma informed and community focussed approach to collaborative care.

They refer to Social & Emotional Wellbeing rather than Mental Health. The concept of disability does not resonate with Aboriginal communities generally. The focus is on what people can do, and the Community provides the support. Collaborative care should focus on engaging with the Community (including the family) first and providing support as they identify their needs.

## Culturally and Linguistically Diverse (CALD) communities

A person centred and trauma informed approach aims to identify the person and their community's and families unique preferences. Application of a trauma informed lens is also recommended.

## MAINTENANCE AND REVIEW OF SHARED CARE ARRANGEMENT AND PLAN

Shared care meetings should be held at least every three months and involve the consumer, carer/s, and all identified shared care agency/program representatives. Meetings may be more frequent if deemed necessary by the consumer or any agency/program involved in the agreement. Individual agencies/programs may have requirements to update and review plans at different intervals. These agencies/programs may invite other agencies/programs to these internal review meetings.

Any party who is involved in the Shared Care Plan may initiate a review of the plan. The consumer and their carers should be involved in this decision and process. Cross sectorial best practice, as outlined in this protocol, must also be maintained. Remember to recognise the consumer's progress on their Recovery journey.

These meetings should ensure currency of the plan by:

- Ensuring all plan details are kept current;
- Hold robust discussion on any proposed changes in goals, plans or service provision;
- Update information, consent, goals, responsibilities and activities outlined in the plan; and,
- Ensuring details of how, where and frequency of contact from each agency/program is discussed, agreed on and recorded.
- All parties to the plan should be provided with amendments to the plan, whether present at the planning meeting or absent.

## EXIT OF CONSUMER FROM AN AGENCY/PROGRAM INVOLVED IN THE SHARED CARE ARRANGEMENT

All people involved in the shared care agreement should be made aware of and be included in the planning of a service withdrawal or graduation. Where possible a review meeting should be convened and a collaborative exit plan (of that agency/program) be developed, and the remaining agencies/programs review the Shared Care Plan. The consumer and carers should be invited to attend this meeting. All parties must be sensitive to the needs and requirements of the consumer, carers and withdrawing agency/program. Please note:

- All agencies/programs have a responsibility in providing support to the consumer during periods of transition.
- All agencies/programs will inform the Shared Care Plan team about which services the consumer will be transitioning to, and provide contact information of new services where possible.
- Agencies/programs should provide a reasonable amount of notice of exit to all parties.
- Exit from a service can be used as one opportunity to celebrate the consumer's progress on their Recovery journey.
- Consumers should be made aware of re-entry pathways or options should they need a new episode of support.

### Reviewing Jamie's plan

*Together, Jamie, the AOD counsellor, and the clinical MH case manager decided that it was time to apply for the Disability Support Pension (DSP). A Centrelink social worker was engaged and included in Jamie's Shared Care Plan.*

*A housing worker was temporarily involved and an application for public housing made. Jamie was able to stay at home as the behavioural issues were managed by a Shared Care team approach and the family felt supported and included.*

*The financial stability offered by the DSP enabled Jamie to consider applying for a TAFE music course. This meant involving the music program director and a student service counsellor in the plan. Jamie was registered for student disability support and a tailored program of support was developed to enable Jamie to participate at TAFE.*

## CONFLICT RESOLUTION BETWEEN SERVICES

If any questions, differences of opinion or disputes arise that are not able to be negotiated by the workers, consumers and carers directly involved in the Shared Care Plans, the issue should be escalated to the relevant agency/program manager/supervisor in the first instance. These managers will:

- Resolve the given issue, or
- Refer the issue to the Eastern Mental Health Service Coordination Alliance Committee if a resolution has not been reached.

Where an agreement cannot be reached by the Eastern Mental Health Service Coordination Alliance Committee the Chief Executives/ Directors of the organisations/sector representatives that are party to the Agreement will agree on a method of resolution to apply to the question, difference or dispute.

### **Managing transitions**

*Jamie had achieved the goal of stability in mental health and reduced the harmful substance use. The CTO was removed and Jamie prepared for discharge from the clinical mental health service. The case manager communicated with the other Shared Care team members, including the family, and a transition plan was developed with all involved. Non-clinical community Mental Health services were engaged to support ongoing psychosocial needs for Jamie. The clinical case manager met with Jamie and the new worker before discharge from the clinical service.*

## REFERENCES:

### **Fifth National Mental Health Plan**

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-fifth-national-mental-health-plan>

### **Victorian 10 year Mental Health plan**

<https://www2.health.vic.gov.au/mental-health>

### **Carers recognition Act 2012**

[http://www.legislation.vic.gov.au/Domino/Web\\_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e9200e23be/023A825C23E20790CA2579C7000FB0BB/\\$FILE/12-010a%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e9200e23be/023A825C23E20790CA2579C7000FB0BB/$FILE/12-010a%20authorised.pdf)

### **Children Legislation Amendment (Information Sharing)**

[http://www.legislation.vic.gov.au/domino/Web\\_Notes/LDMS/...nsf/.../581377bi1.docx](http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/...nsf/.../581377bi1.docx)

### **Family Violence Protection Amendment (Information Sharing) Act 2017**

[http://www.legislation.vic.gov.au/Domino/Web\\_Notes/LDMS/PubStatbook.nsf/51dea49770555ea6ca256da4001b90cd/750DDA187664F2BBCA25813F000F7BE7/\\$FILE/17-023aa%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/51dea49770555ea6ca256da4001b90cd/750DDA187664F2BBCA25813F000F7BE7/$FILE/17-023aa%20authorised.pdf)

### **Health Records Act 2001 (Vic).**

[www.health.vic.gov.au/hsc/downloads/hppextract.pdf](http://www.health.vic.gov.au/hsc/downloads/hppextract.pdf)

### **Mental Health Act 2014,**

[http://www.legislation.vic.gov.au/Domino/Web\\_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e9200e23be/0001F48EE2422A10CA257CB4001D32FB/\\$FILE/14-026aa%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e9200e23be/0001F48EE2422A10CA257CB4001D32FB/$FILE/14-026aa%20authorised.pdf)

### **Privacy Act 1988 (October 2015 update)**

<https://www.comlaw.gov.au/Details/C2015C00534>

### **Victorian Service Coordination Manuals**

<https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination>

## USEFUL LINKS:

Checklist for Sharing Personal Information – Commissioner for Privacy and Data Protection

<https://www.cdp.vic.gov.au/images/content/pdf/Checklist%20for%20Sharing%20Personal%20Information.pdf>

National Standards for Mental Health Services 2010 Commonwealth of Australia, 2010

[https://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/\\$File/servst10v2.pdf](https://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf)

Partnership Tools

<https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships/strengthening-partnerships-tools-resources>

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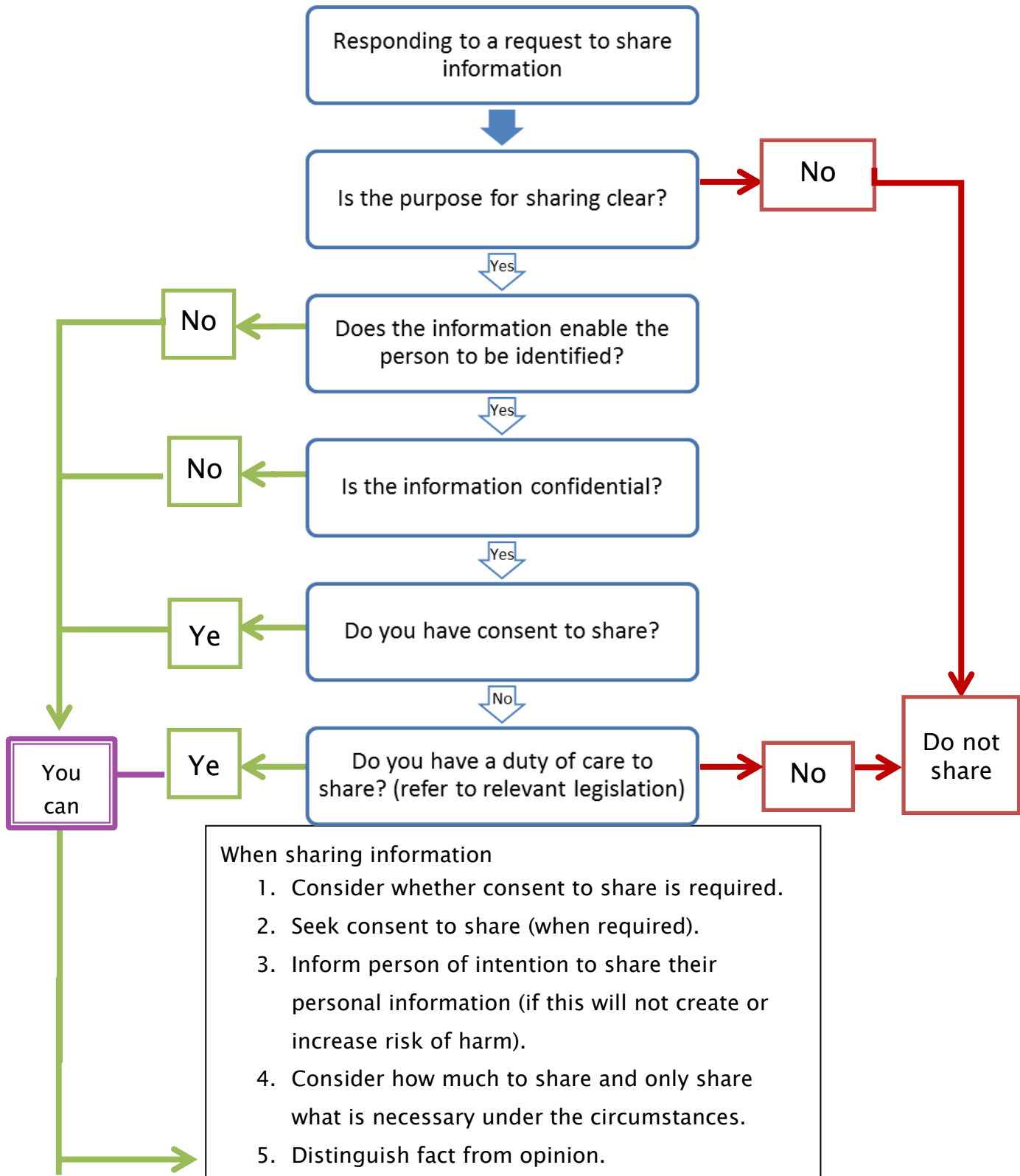
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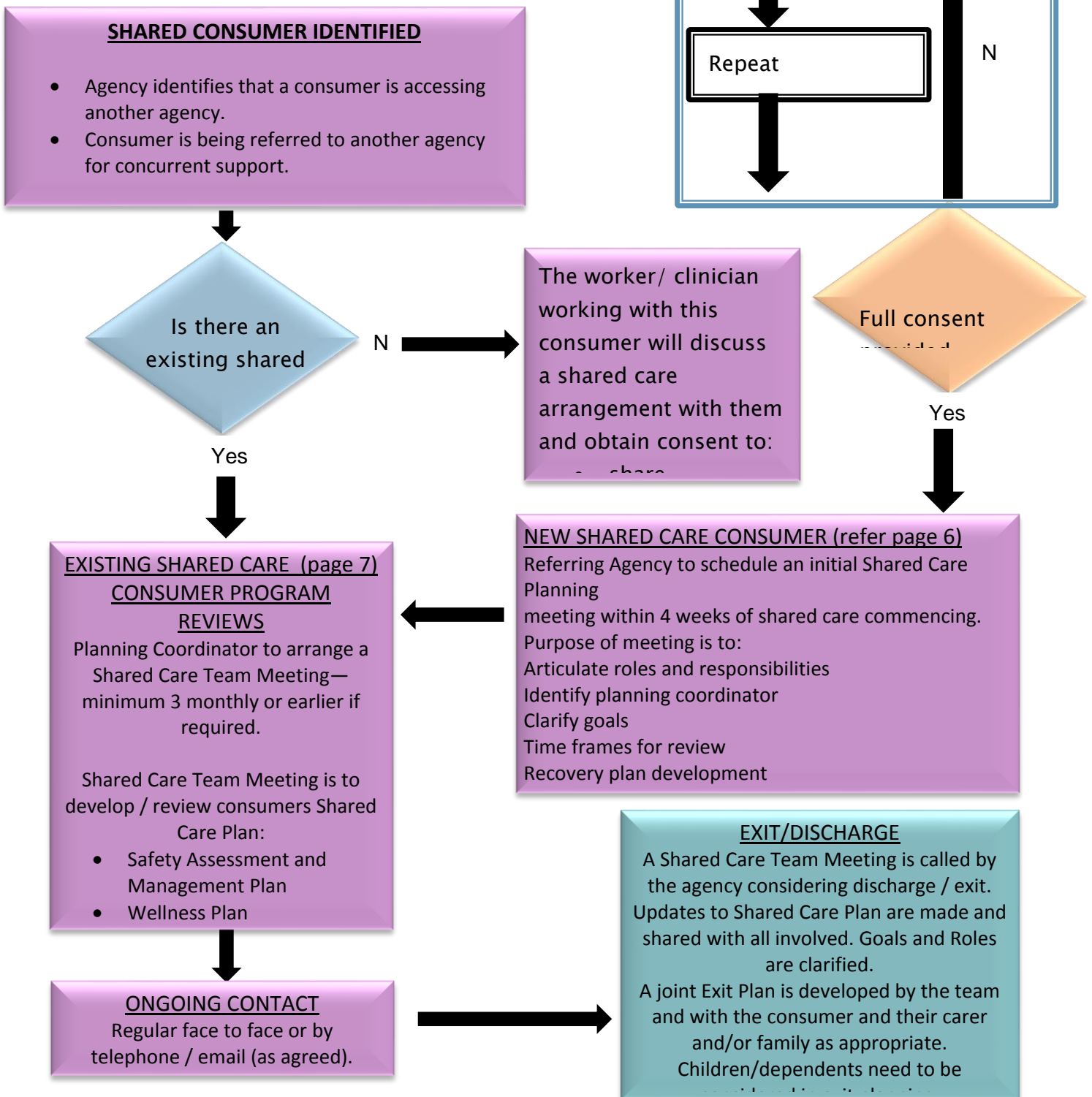
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## Appendix 1: Information Sharing Flow Chart



Failing to share information can lead to significant safety issues. If there are concerns for the safety of a child, an adult or an animal/pet, then follow relevant procedures without delay. Seek advice from your line supervisor and record the outcome of discussions.

## Appendix 2: Shared Care Development Flow Chart



**NOTE:** To ensure the consumer is at the centre of the process, it is best practice to have the consumer input into all Shared Care Meetings (bv attendance or correspondence. as