



EMHSCA Shared Care Protocol 2016

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. This 4th revision maintains the original intent of supporting effective shared care arrangements for people with Mental Health illnesses and co-occurring concerns across the Eastern Metro Region of Melbourne.



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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.

- Anglicare
- Australian Government Department of Human Services
- Connect 4 Health (Community Health Services)
- Department of Health & Human Services – Eastern Metropolitan Region
- Dual Diagnosis Consumer and Carer Advisory Council & Working Group
- EACH
- Eastern Health Mental Health Services – Adult, Aged, and Child and Youth
- Eastern Homelessness Service System Alliance
- Eastern Melbourne PHN
- EMR Regional Family Violence Partnership
- **EMR Dual Diagnosis Response**
- Inner East Primary Care Partnership
- Inspiro
- MI Fellowship
- MIND Australia
- Mullum Mullum Indigenous Gathering Place
- NEAMI National
- Outer East Health and Community Support Alliance
- Outer East Primary Care Partnership
- RDNS
- SalvoCare Eastern
- Turning Point Eastern Treatment Services
- Uniting Care Prahran Mission

EMHSCA Shared Care Protocol

The EMHSCA Shared Care Protocol is an agreement between services in the Eastern Metropolitan Region of Melbourne to work together to help deliver consumers and carers, and impacted families and children the best possible service responses and outcomes. These services do this by working with the consumer, carer and all other agencies involved or needed by:

- Having open conversations about what is needed, who is involved and how we can all work together to deliver the best outcomes for the consumer, carers, impacted families and children.
- Making sure the consumer has consented to and has been included in service information sharing, collaborations and discussions.
- Making sure the consumer, carers/families and children, and all services involved are actively involved in all areas of assessment, planning and goal achievements (as active as they want or need to be), and in a timely manner.
- Sharing necessary information to reduce repetition, prevent duplication, confusion or crossed purposes, delay and improve the streamlining of services.
- Working together to identify an individual and their carer's/family's and children's needs and goals, and be able to address a wide range of needs.
- Collaboratively planning how these needs and goals will be supported or achieved.
- Making agreements about what all parties involved can and cannot do, and how they will do things they have agreed to in the plan.
- Providing one clear plan for the consumer, carer/ impacted family and children, and services to follow. A plan that has all the necessary information that everyone needs.
- Ensuring care planning is continuous across agencies/programs and shared at exit and transfer between services/programs.
- Sharing strategies that help someone manage and cope with difficulties or crisis situations.

Speak to your consumer, carer/family members and workers about making a shared care plan.



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.

AMHS: Adult Mental Health Service at Eastern Health.

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 person for whom they care. Children can be carers too.

Children: A daughter or son of a parent being below the age of 18 years - The United Nations Convention on the Rights of the Child.

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 2013.

Care Coordinator/Support Facilitator: Person 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.

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 person, 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.

Family: People have many different ways of defining a family and what being a part of a family means to them. Families differ in terms of economic, cultural, social, and many other facets, but what every family has in common is that the people who call it a family are making clear that those people are important in some way to the person calling them family. By Michelle Blessing, Mental Health Professional.

IRP: Individual Recovery Plan

MH: Mental Health

MHCSS: Mental Health Community Support Services. They provide non-clinical support for people with Mental Health illness throughout their recovery journey to manage and achieve a broader quality of life.

Planning Coordinator: the 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 but a Support Facilitator or Care Coordinator could take on this role where appropriate and available.

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

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

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



OVERVIEW

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 to better meet the consumer's individual recovery needs and goals.

Where there is shared care, member agencies/programs of the Eastern Mental Health Service Coordination Alliance (EMHSCA) have agreed to work with a consumer and their carers to:

- Establish agreed working practices with the shared consumer
- Consider the development of a Shared Care Plan.

This plan is to be owned by the consumer (copies to all other agencies/programs and persons involved). If the consumer is not directly involved in developing the agreement and plan, consent in writing should be obtained however, verbal consent is acceptable as long as it is clearly documented in case notes and shared care plans.

OBJECTIVE

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 PRINCIPLES

Organisations and their staff will:

- 1) Identify who is involved in the consumers care at intake/ assessment.
- 2) Ensure consent to collaborate is attained from the consumer and specifies all parties consented to and excluded.
- 3) Seek existing information about the consumer where relevant in order to develop a holistic view of the consumer and their circumstances, including a longitudinal history, in order to avoid unnecessary duplication.
- 4) Ensure that the following are completed in a collaborative manner:
 - a) assessment of each consumer's recovery and support needs, and
 - b) development of personal goals.
- 5) Work collaboratively with all relevant persons involved as a shared care team. The consumer must be an active participant of this team.
- 6) Ensure that the consumer and their needs, and the needs of any dependants, are at the centre of all processes and activities.
- 7) Provide the right services, at the right time and in the right place.
- 8) Provide seamless and supported access to each other's services.
- 9) Share timely and relevant access to information within the shared care team.
- 10) Respect the rights of the consumer and their family and children, including that of privacy and confidentiality.
- 11) Provide the consumer with all relevant options and information in an accessible format.
- 12) Facilitate supported decision making, individual choice and autonomy.
- 13) Support positive risk taking and individual dignity of risk.
- 14) Provide strengths based services and pro-actively support and identify positive change and new opportunities.



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)
- IRP development, review and content
- Significant changes in the consumer's level of needs or safety
- 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](#))

SHARED CARE PLAN

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

Individual Recovery Plan:

- 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.
- 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:

- Likely precipitating stressors, early warning signs, and protective factors such as strengths, self-management strategies, and supports.
- 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 Person ([s19 – s27 of MHS 2014](#))¹

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 person or others. This is a dynamic and ongoing process.
- 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.
- A family care plan may be useful if dependent children are involved <http://www.copmi.net.au/documents/product-downloads/32-family-care-plan/file>.

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.

¹ Advanced Statements and Nominated Persons are legal entities, specific to Mental Health Treatment. They express a person'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. Persons wishing to make an advanced statement or nominated person 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.



Note: Not all consumers will have identified safety issues. In that case a Safety Assessment & Management Plan communicates that fact.

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;
- Provide the consumer with the choice;
- 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 share information, agencies/programs cannot decline to participate or 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.

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. Impacted family members and children may be invited where appropriate. 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/person withdraws from the shared care arrangement or a different agency/program/person 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).



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 any agency/program or person 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.

These meetings should ensure currency of the plan by:

- Ensuring all details on the plan are kept current;
- Hold robust discussion on any proposed changes in goals, plans or service provision;
- Update information, 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.
- Consideration should be given to provision of care plan information to impacted family members and children.

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 at this meeting. All parties must be sensitive to the needs and requirements of the consumer, carers/families, children and withdrawing agency/program. Please note:

- All agencies/programs have a responsibility in providing support to the consumer, carers, impacted family and children during periods of transition.
- Agencies/programs should provide a reasonable amount of notice of exit to all parties.

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.

Sharing of Non-Share 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:

- Policies and processes of the agency/program who owns those documents;
- Freedom of information law; and/or
- The Mental Health Act 2014
- Privacy Act 1988



References:

Carers recognition Act 2012

[http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/023A825C23E20790CA2579C7000FB0BB/\\$FILE/12-010a%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/023A825C23E20790CA2579C7000FB0BB/$FILE/12-010a%20authorised.pdf)

Health Records Act 2001 (Vic).

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/f932b66241ecf1b7ca256e92000e23be/001F48EE2422A10CA257CB4001D32FB/\\$FILE/14-026aa%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/001F48EE2422A10CA257CB4001D32FB/$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>

Links:

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

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

Victorian Government Mental Health Website

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

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>

Family Care Plan

<http://www.copmi.net.au/documents/product-downloads/32-family-care-plan/file>

Developed by the Eastern Mental Health Service Coordination Alliance (EMHSCA)

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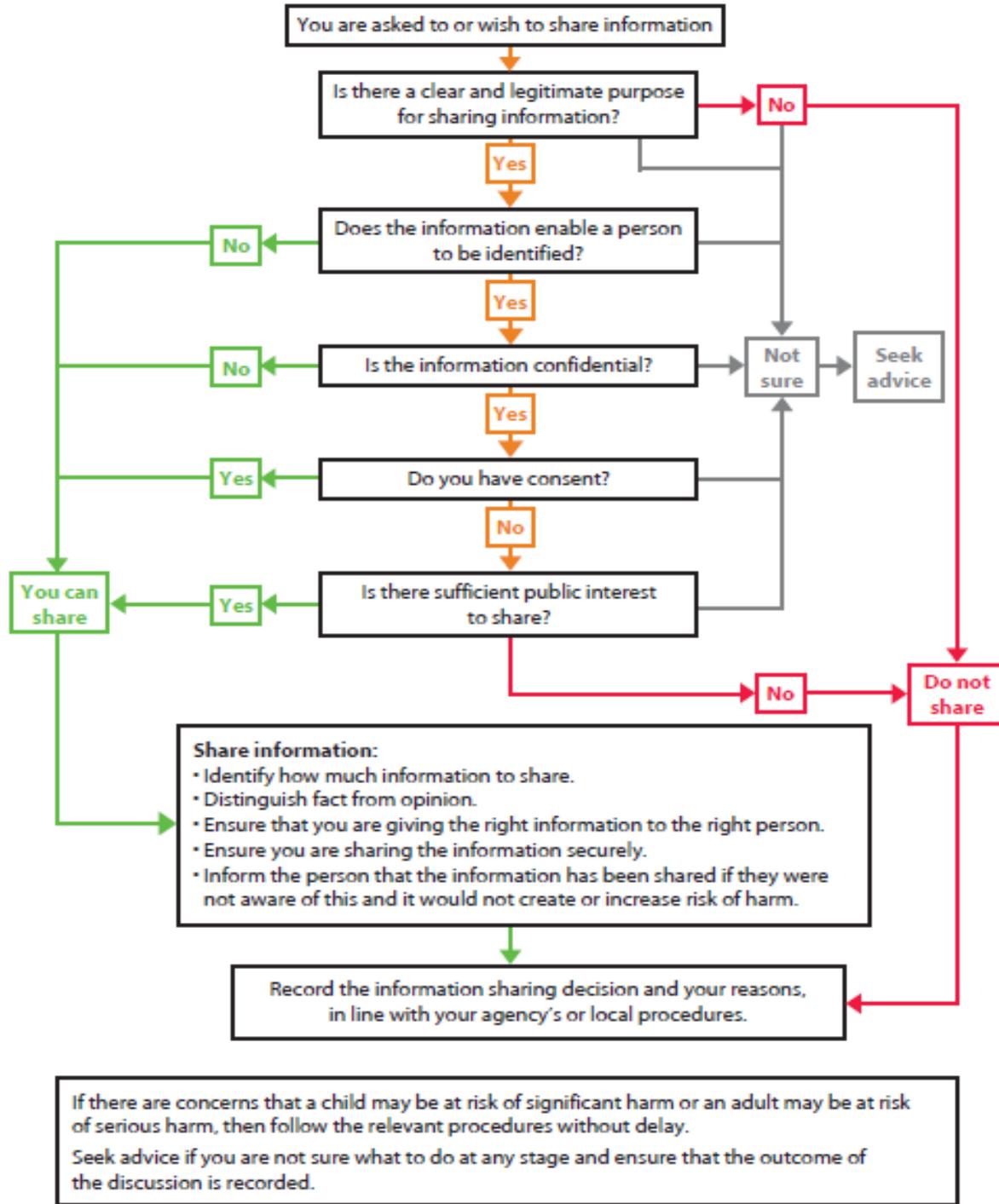
Important note: This information does not constitute legal advice. If more information is required, consult the relevant legislation or a legal adviser, as necessary.

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Appendix 1: Information Sharing Flow Chart

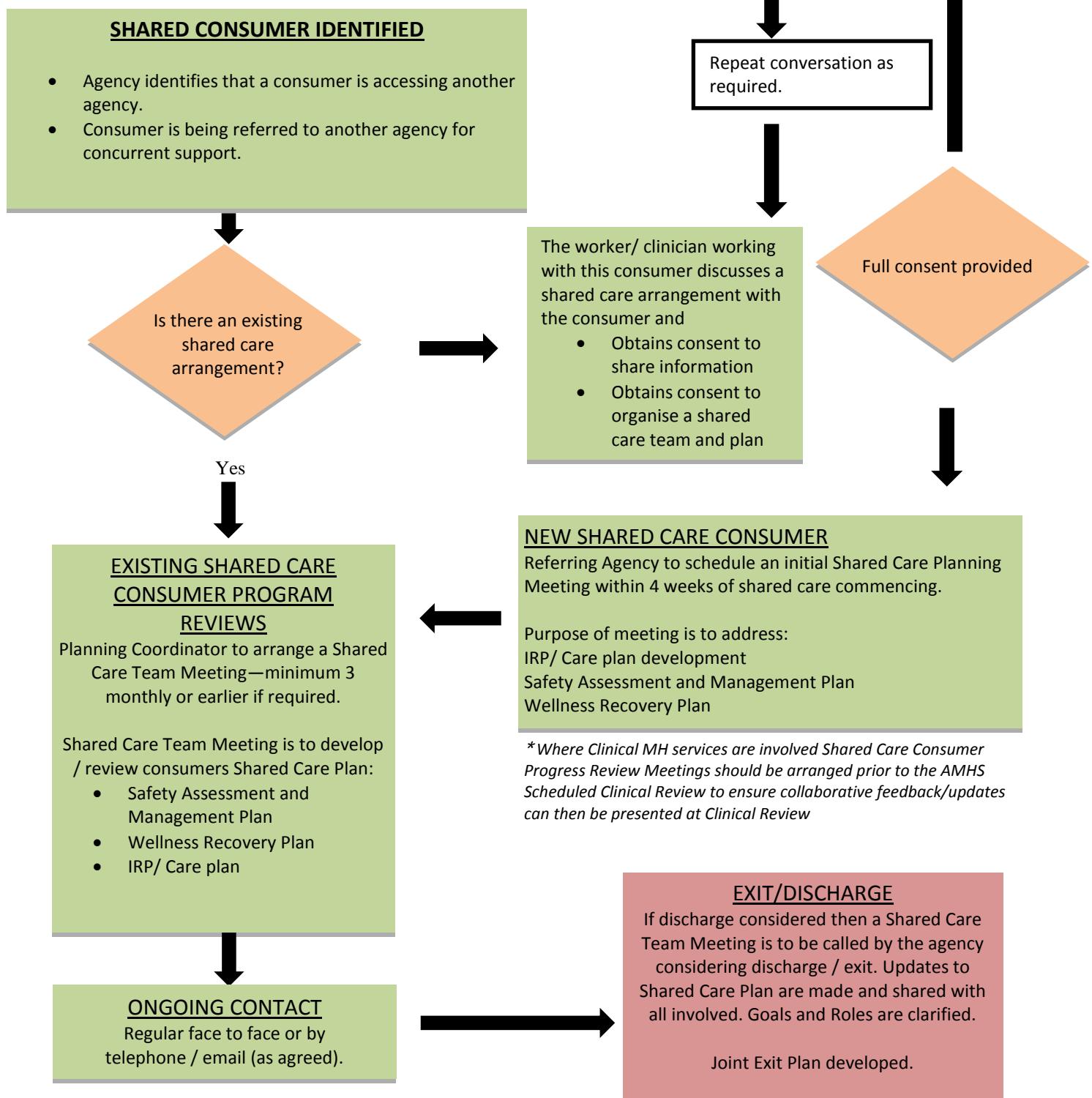
(an Extract from HM Government *Information Sharing: Guidance for practitioners and managers.*
www.ecm.gov.uk/informationsharing)



Note: Additional to the “Public Interest” mentioned, the existence of a “Duty of Care” is to be considered. At the 6th step consider whether the information is required to enable service providers to do their job effectively, prevent harms, and, in the case of a carer, to fulfil their caring role.



Appendix 2: Share Care Development Flow Chart



NOTE: To ensure the consumer is at the centre of the process, it is best practice to have consumer attend all Shared Care Meetings.