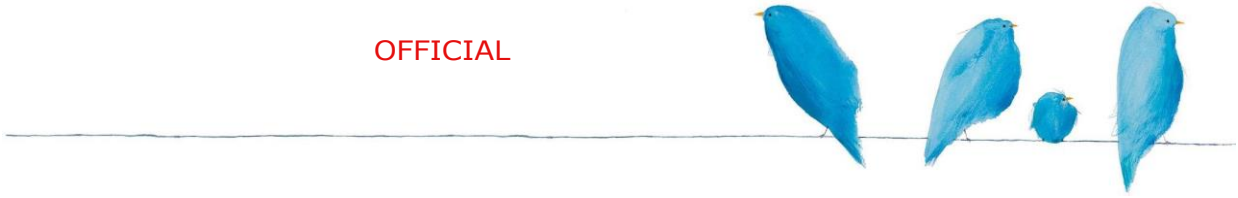
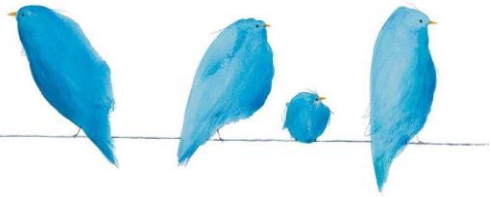


Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS): An implementation guide for hospitals and integrated health services



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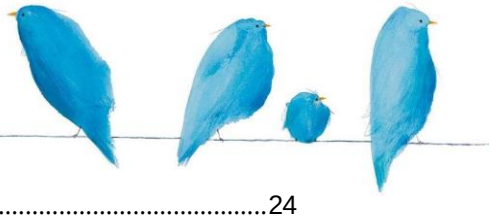
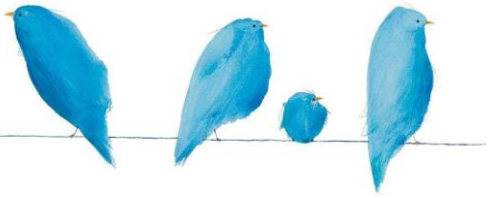




Introduction

The Victorian government has implemented three interrelated reforms that are integral to reducing family violence and promoting child wellbeing and safety.

1. Family Violence Information Sharing Scheme (FVISS)
2. Child Information Sharing Scheme (CISS)
3. Multi-Agency Risk Assessment and Management Framework (MARAM)

For many people, a visit to a health professional is the first, and sometimes only, step they can take to access support and healthcare when their safety and wellbeing is at stake. The health sector provides a critical entry point to the family violence service system and provides important opportunities to promote child wellbeing and safety. It is important for the health sector to align with Victoria's information sharing reforms so we can collaborate within the health sector, and with other services, to address family violence, child wellbeing and safety.

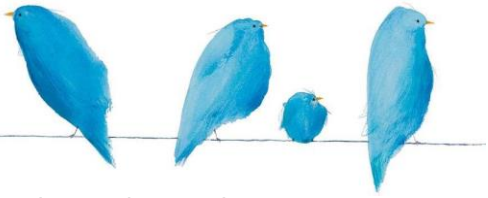
Health services overall responsibilities are outlined in detail in Victoria's Health Services Act and Victoria's Public Health and Wellbeing Act. While the Health Services Act addresses development and ongoing operations, the Public Health and Wellbeing Act sets out our duties to protect and promote life and health and reduce health and wellbeing inequalities, including in safety and wellbeing.

In addition, key public health services are legally prescribed to share information on family violence under Victoria's Family Violence Protection Act 2008 (FVPA), and to share information to promote child wellbeing and safety under Victoria's Child Wellbeing and Safety Act. That means that from 19 April 2021 the Child Information Sharing Scheme (CISS), the Family Violence Information Sharing Scheme (FVISS) and Multi-Agency Risk Assessment and Management Framework (MARAM) commenced for health and hospital services, as funded organisations in Phase 2 of prescription to the reforms.

Since then, the Royal Commission into Family Violence emphasised, in its 2016 report, that services need to share family violence information as part of their collaborative practice. The report found this was necessary to keep the victim survivor safe and the perpetrator in view of the public system and accountable to the community. The McClellan Royal Commission into Institutional Responses to Child Sexual Abuse (2017) also identified that the lack of information sharing had contributed to negative outcomes for the wellbeing and safety of Victorian children. These inquiries have shown that integrated and timely provision of service and access to information is essential in:

- promoting the safety of victim survivors and their families
- holding perpetrators of family violence to account
- the broader wellbeing and safety needs of children.

Since then, the MARAM framework and information sharing schemes have been found to have improved collaboration within and across sectors overall. However, we recognise that it is important that this approach continue to mature and be refined with guidance and through reflective practice. In 2023, the MARAM legislative review stated that it was critical, for instance, that information be shared in a timely manner to protect victim survivors. Its report cautioned against new processes and forms contributing to delays in the transmission of critical information, as that undermines services' work to assess risk and prepare safety plans. It also found that voluntary, 'proactive' information sharing was not occurring as often as it should.



MARAM outlines the responsibilities of different workforces in identifying, assessing, and managing family violence risk across the family violence and broader service system. Information sharing to assess or manage family violence risk is a responsibility under the MARAM Framework (Responsibility 6), and MARAM will guide information sharing under both Schemes wherever family violence is present. Further resources for hospitals and integrated health service alignment to MARAM can be found within the SHRFV Toolkit – MARAM Alignment Resources.

The CISS five-year review 2024 found that while the scheme had been implemented collaboratively and effectively, we need to monitor inherent risks, including: misuse or oversharing of information, the need to follow the CISS legislative framework and guidelines for Aboriginal cultural safety, and to realise that there are information gaps when not all services are prescribed.

- promoting the safety of victim survivors and their families
- holding perpetrators of family violence to account
- the broader wellbeing and safety needs of children.

About the guide

This guide forms a part of the SHRFV Toolkit and includes:

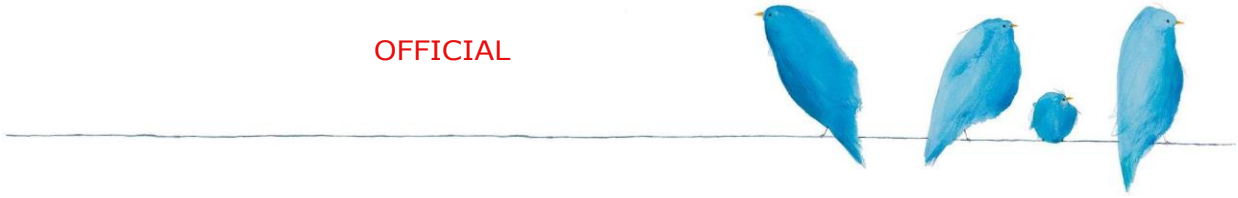
- An Introduction
- Background on the Information Sharing Schemes
- A checklist to prepare for application of the Schemes
- Guide to sharing under the Information Sharing Schemes
- Documentation
- Relevant legislation and overview (Appendix 1)
- Examples of resources (Appendix 2)
- Examples of case studies for staff training (Appendix 3)

Purpose

This implementation guide is designed to assist public hospitals and integrated health services to ensure they have the appropriate systems to safely and ethically implement FVISS and CISS ('Information Sharing Schemes' or 'Schemes') and to share information under the Schemes. It suggests processes that could support your services' implementation of the Schemes in a step by step approach.

It provides a:

- background to and description of the Schemes
- checklist to prepare for application of the Schemes
- guide to sharing information under the Schemes.



Background: The Information Sharing Schemes

Background knowledge about the Information Sharing Schemes (Schemes) is essential before hospitals and integrated health services can implement the Schemes and appropriately share information.

Overview of the Schemes

The two Schemes have been introduced to enable a range of authorised organisations to collaborate and share information for the purpose of assessing and managing family violence and promoting children's wellbeing and safety.

Organisations and services authorised to share and request information under the FVISS or CISS are known as Information Sharing Entities (ISEs). An ISE (for example a public hospital or integrated health service) can share information with other ISEs from across the service sector. This could include other public hospitals/integrated health services, Child Protection, Youth Justice, Maternal and Child Health, and Victoria Police.

Family Violence Information Sharing Scheme (FVISS)

> The FVISS enables ISEs to share information with other authorised professionals to facilitate assessment and management of family violence risk to children and adults.
>
> (State Government of Victoria website: Family Violence Information Sharing Scheme)

FVISS seeks to facilitate better information sharing to assess and manage family violence through the timely sharing of relevant information between ISEs. The scheme therefore supports ISEs to:

- keep perpetrators in view and accountable
- promote the safety of victim survivors.

FVISS represents a shift – moving the focus *from victim survivors* being responsible for their own safety, *to a shared accountability* between victim survivors and the broader service system in both managing victim survivor safety and holding perpetrators of family violence to account.

Services and organisations that are able to share information under the FVISS are prescribed in the *Family Violence Protection (Information Sharing and Risk Management) Regulations 2018*. Guidance on the operation of the FVISS is provided in the legally binding Family Violence Information Sharing Guidelines: Guidance for Information Sharing Entities.

Child Information Sharing Scheme (CISS)

> The CISS allows information sharing between ISEs to promote the *wellbeing or safety* of a child or group of children.
>
> (State Government of Victoria website: Child Information Sharing Scheme)

CISS helps services work together to identify children's needs, risks and improve outcomes. It was established under Victoria's Child Wellbeing and Safety Act to promote earlier, effective intervention and integrated service provision.

CISS allows authorised organisations to share and request information to support child wellbeing or safety. This ensures that professionals working with children can gain a complete view of the situation of the children they work with, making it easier to identify their wellbeing and safety needs earlier, and to act on these concerns sooner.

The Child Information Sharing Ministerial Guidelines: Guidance for Information Sharing Entities outlines the requirements and application of CISS.

An example of information sharing under CISS

Tim is a thirteen-year-old boy who has been admitted to a Victorian public hospital after presenting with severe abdominal pain – query appendicitis. Hospital staff have some concerns about him and are uneasy about discharging him back to the care of his parents, but they don't believe these meet the threshold for a report to Child Protection. Allison, a hospital representative, decides to contact Child Protection to see whether they have a history of involvement.

Under CISS – if there are wellbeing or safety concerns Child Protection can share relevant information about the child's wellbeing and safety with the hospital given both are ISEs.

How does MARAM inform the Schemes?

The family violence Multi-Agency Risk Assessment and Management (MARAM) Framework "creates the system architecture and accountability mechanisms required to establish a system-wide approach to and shared responsibility for family violence risk assessment and management" (State Government of Victoria (2018), Family Violence Multi-Agency Risk Assessment and Management Framework: A shared responsibility for assessing and managing family violence risk).

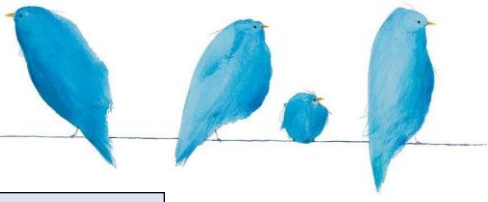
MARAM is a prescribed framework that provides a best practice model for family violence risk assessment and management. The MARAM guide sets out responsibilities for prescribed services and supporting workers to better understand their responsibilities to undertake family violence risk assessment and management. (For further information concerning MARAM see MARAM practice guides and resources; resources regarding hospitals and integrated health service alignment to MARAM are available on the SHRFV Toolkit – MARAM Alignment Resources).

FVISS is a mechanism for fulfilling the responsibility under MARAM of information sharing to assess or manage family violence risk – Responsibility 6.

MARAM should be used to guide services in identifying when family violence may be present and help the service determine what information is relevant to share under FVISS and CISS.

What is the relationship between FVISS and CISS?

CISS preceded MARAM and is a stand-alone scheme. While FVISS and CISS have been designed to *complement* each other since, they are *not* the same.



FVISS authorises the sharing of information to assess or manage *family violence risk* to both adults and children.

CISS relates to information sharing to promote the *wellbeing or safety* of a child or group of children in a range of contexts.

Both FVISS and CISS aim to remove barriers to information sharing on their respective issues, thus enabling greater collaboration and coordination between (authorised) organisations and services and across the service system.

Importantly FVISS and CISS have different purposes for sharing information but should be used together where the wellbeing or safety of children is impacted by family violence (further details available on State Government of Victoria website in fact sheet titled How do the information sharing schemes work together?).

What does it mean to be prescribed under the Schemes?

Organisations and services are prescribed as ISEs by *either or both* the Family Violence Protection (Information Sharing and Risk Management) Regulations 2018 and the Child Wellbeing and Safety (Information Sharing) Regulations 2018.

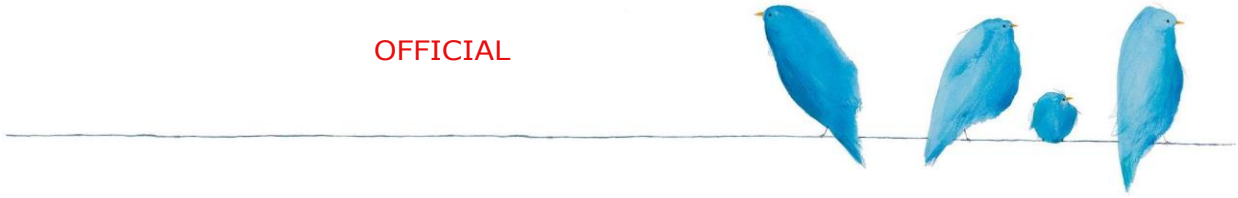
ISEs are authorised to share and request information for a family violence protection purpose to manage family violence risk, including through ongoing assessment (FVISS) or to promote the wellbeing or safety of a child or group of children (CISS). A subset of ISEs are *also* Risk Assessment Entities (RAEs) and may request information for a family violence assessment purpose under FVISS.

A phased approach has been taken to implementing the two Information Sharing Schemes.

> Phase 1 commenced on **September 2018** and included key frontline family violence services, some health services including Designated Mental Health Services, human services, justice, and police.
>
> *Phase 2* commenced on **April 2021** and expanded information sharing permissions to several universal services including Ambulance Victoria, Alcohol and Other Drug services, Bush Nursing Centres, Community health services, Community-managed Mental Health Services, Early Parenting Centres, General Practice Nurses, General Practitioners, Health Services, Maternal Child Health and State funded Aged Care Services.

Information concerning which organisations/workforces are prescribed under the Schemes (and MARAM) is available via the following resources:

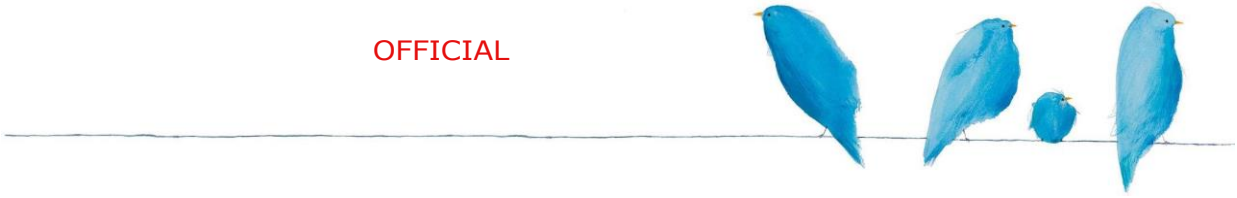
- Child Information Sharing Scheme and Family Violence Information Sharing Scheme Fact Sheet (Nov. 2020) – provides a list of Department of Families, Fairness and Housing and Department of Health organisation/workforces prescribed in Phase 1 and Phase 2
- Report on the implementation of the Family Violence Risk Assessment and Management Framework 2019-20 includes:
  - Appendix 3: Currently prescribed organisations (Phase 1) – reviewed 18 Feb. 2021
  - Appendix 4: Proposed prescribed organisations (Phase 2) – reviewed 18 Feb. 2021
- The Victorian Government website About the information sharing and MARAM reforms provides a list of prescribed organisations (reviewed 4 Jan. 2021) which will be updated after 2021 to include all of Phase 2 workforces/services



- The Victorian Government ISE List which can be used to identify individual prescribed organisations/services – this will include Phase 2 ISEs as of 19 April 2021.

As part of Phase 2 prescription of FVISS and CISS (and MARAM), public hospitals are prescribed in their entirety, i.e., as an organisation, and are therefore ISEs. However, funding, particularly Commonwealth Government funding, may mean there are other obligations to consider, including privacy laws and other permissions to share information, including contractual obligations.

ISE List
A full list of prescribed organisations is provided by the Victorian Government and this can be used to identify individual prescribed organisations/services.
See: https://iselist.www.vic.gov.au/ise/list/



A proposed checklist to prepare for application of the Schemes

Hospitals and integrated health services are currently prescribed under the information sharing schemes and need to have a system to receive, request, and share information under the Schemes.

1. Determine governance structure

A governance structure to guide planning for, and support implementation of, the Schemes is recommended with consideration given to:

- appointing an Executive Sponsor as overseer – who will also provide accountability and communicate with the hospital or integrated health service Board as required.
- deciding which position, program or working group is best placed to progress work in Phase 2 of the Schemes. This may sit with one primary position or program, or be shared between a working party or committee with representatives from several areas such as Legal and Health Information Services.
- using relevant existing governance committees (established to monitor MARAM alignment and Strengthening Hospital Responses to Family Violence (SHRFV)) for the information sharing schemes.

To inform this process, also consider:

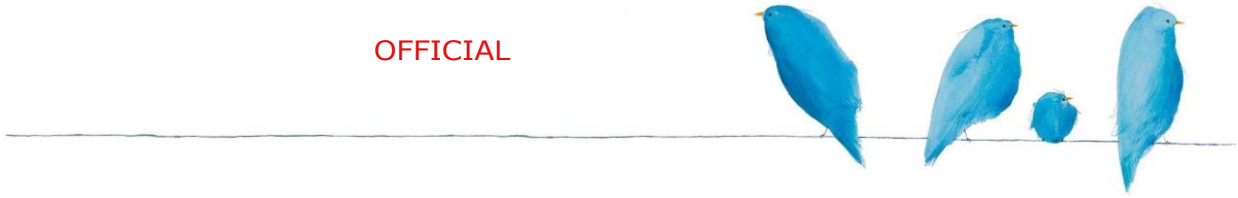
- reviewing any existing programs (if applicable) that are authorized under Phase 1 as ISEs within the hospital or integrated health service (e.g., designated Mental Health, Alcohol and Other Drug services and Centres Against Sexual Assault). This could inform what processes or policies are already in place and what gaps exist.
- conducting discussions with primary departments or personnel behind Phase 1 implementation (e.g., Specialist Family Violence Advisors for designated Mental Health or Alcohol and Drug services). This will offer insights into what procedures are currently operational, and what successes and/or challenges have been experienced – existing process could be used as a foundation, alternatively a new approach to best suit an all-of-hospital model could be adopted.

2. Develop a project brief

Outline the scope of the project, who is to be involved, and outline the project including the governance structure, timeframe, products to be developed, the approval process. Ensure this is approved by the hospital's/integrated health service's Executive Sponsor and Family Violence Governance Committee. As the legislation changes have implications for privacy compliance and potentially increased work demands in some areas, the hospital's executive team need to have an understanding of the changes and the organisation's approach taken by the organisation.

3. Engage leadership and communication

Clear briefings and communication should occur with the hospital/integrated health service executive leadership team. This communication may take the form of briefings, utilising any appropriate memos or products. Further information can be found on https://www.vic.gov.au/training-for-information-sharing-and-maram.



4. Consider establishing an Information Sharing Scheme Working Group

Consider establishing an Information Sharing Scheme Working Group with Terms or Reference; alternatively, an already established group could assume this function.

The introduction of the Schemes has compliance and workload implications that need to be considered by the leadership of the hospital or integrated health service. Representatives from the programs and departments that are likely to change their practice as a result of the information sharing schemes could be part of the Working Group. These departments will vary according to the hospital/integrated health service structure but may include:

- Legal Counsel
- Health Information Services
- Freedom of Information team
- Social Work
- Emergency Departments
- Paediatric wards and clinics
- Women's Health Unit
- Information Technology and Management
- Community Health (including counselling, family programs and children's services).

5. Define the internal system

Whilst the information sharing reforms do not require a centralised sharing process within ISEs, it is recommended that in order to manage information sharing under FVISS and CISS, hospitals and integrated health services establish an internal system. This ought to include guidance on how to:

- make a request for information
- respond to requests for information
- voluntarily sharing information
- record information sharing requests.

This internal system should include instructions that ensure that both verbal and written requests can be managed effectively, and that they meet record keeping requirements under FVISS and CISS.

It is important, however, that the internal system does not detract from proactive and timely information sharing by hospital/health service departments as required or perceived to be appropriate by authorised staff under the Schemes. This is particularly relevant when information sharing is deemed urgent – for example, authorised staff need to be able to appropriately respond to an urgent request for information from police under FVISS or CISS (noting that record keeping obligations still apply).

A standard request form

The development of a standard request form for external ISEs to complete when they make a request for information to the hospital/integrated health service pursuant to FVISS or CISS will assist hospital/ integrated health service staff in:

- determining whether the threshold to share information has been met
- recording that a response was provided i.e., information shared, or request denied (if the requirements of the Schemes have not met).

Ideally the form should cover both FVISS and CISS requests (see 'Resources to assist' section below and Appendix 2 for an example) and cover the following key information:

- name and organisation of the requester
- date of the request
- subject of the request
- whether it is under FVISS/CISS
- consent details, where applicable.

(Further information is also available in the Family Violence Information Sharing Guidelines – 'Appendix A: Information sharing process checklist when making a request' and 'Appendix B: Information sharing process checklist when responding to a request'.)

It is preferable to have fields with fixed choice or drop-down options where appropriate.

The Request Form should be easily located by other ISEs and made available online through the hospital website if possible. Completed forms should be sent via email or facsimile to the appropriate/designated hospital department.

Directing a request

To ensure received requests for information are directed appropriately, a central phone contact, along with an assigned fax line and designated email address (e.g. infosharing@ourhospital, or ISS@yourhospital.vic.gov.au) that are regularly monitored by a small group of identified staff is suggested. Hospitals/integrated health services will need to determine which group will monitor the fax and email inbox, with the knowledge that requests will pertain to a wide range of program areas and departments – an option is the Freedom of Information (FOI) team, who already receive similar requests from organisations such as Child Protection.

It is important that requests for information are prioritised and responded to in a timely manner. In doing this hospitals/integrated health services need to consider the level of risk in relation to the person on whom the information is shared when requests are received, and ensure there are provisions for the urgent sharing of information where there is a serious threat (see Timeframes for responses section below).

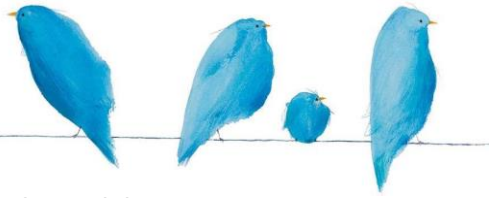
Resources to assist

Resources for implementation of the Information Sharing Schemes have been developed for hospitals and integrated health services as outlined below.

Resources providing example (for full outline of Resources see Appendix 2)	
Resource One:	'Family Violence and Child Information Sharing Request' *(request form)*
Resource Two:	'Process for Requesting Information'
Resources Three, Four and Five:	Workflow processes
Resource Six:	'Information Sharing Reforms: Implementation Plan (example)' *(can be used to identify gaps, and determine actions and timeframes)*

6. Policy development

Hospitals and integrated health services will need to develop policy and procedure documents relevant to their operational setting and may use the information provided in this guide to assist in



this. An organisation-wide policy will outline to staff the expectations for their roles and departments, and the workflow process that are to be followed. The policy should have clear information and links to the legislative requirements to ensure appropriate procedures are followed.

7. Staff training and capability development

Within prescribed ISEs, all staff should undertake MARAM training according to the responsibility level that their organisation has mapped them to. It is recommended that staff undertake information sharing training in both FVISS and CISS before they undertake MARAM training. The level of training that each staff member undertakes will be dependent on their roles within the organisation and the part their organisation has assessed that they play in the information sharing process.

Recommended staff training includes:

- MARAM training as appropriate to role i.e. to match the structure of the workforce mapping for MARAM alignment as detailed within the SHRFV MARAM Alignment Resources:
    - SHRFV Foundational Practice*
    - SHRFV Sensitive Practice*
    - SHRFV Antenatal Family Violence Screening and Response Model
    - SHRFV Brief & Intermediate*
    - MARAM Comprehensive – for details see Safe & Equal's MARAM Training

  (Detailed on the SHRFV Training resources page of the SHRFV Tool Kit and available as eLearning modules*.

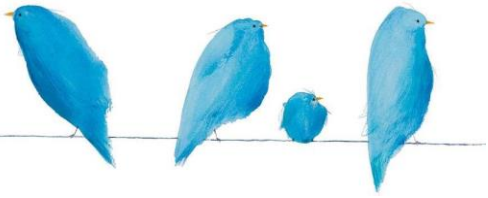
- **OR** Department of Families Fairness and Housing Information Sharing Schemes Online training for Health and Community Services Professionals (as appropriate for role) – eLearning Modules 1-3 available on the Information Sharing and MARAM Online Learning System. Hospital/ integrated health service staff mapped at an Intermediate or Comprehensive Level, or mapped at Responsibility 6 (responding to information sharing), are required to undertake this training (see Workforce Mapping for MARAM Alignment available on the SHRFV webpage MARAM Alignment Resources.

Localised support and information sessions may also be required to assist staff in understanding their role. It is important to include reception and client services in these information sessions or briefings as they may receive requests from external ISEs and need to know how and where to direct the enquires.

In addition, hospitals/integrated health services may need to provide appropriate staff training concerning how FVISS and CISS sit within other legislation, for example:

- existing information sharing and privacy frameworks
- child protection requests
- mandatory reporting
- FOI requests.

There are three example case studies provided in Appendix 3 that can be used for staff training and capability building.



8. Maintaining records

It is a requirement that any written or verbal requests for information, and any response provided, should be stored in each of the medical records of those identified. This means that if the request for information relates to multiple subjects (for example a group of siblings), a file note or copy of the request and response should be placed in each subject's (child's) medical record.

For organisations with an electronic medical record, at a minimum any written requests or responses should be scanned and filed within the record. It is recommended that a template be developed and built into the infrastructure of the electronic medical record. This allows entries to be made directly by relevant staff. A template also allows staff to enter necessary details when receiving a verbal request, ensuring that the key aspects of the request are obtained and recorded.

Access to encryption software, such as Liquid Files, is also recommended. This ensures that email communication with external addresses is kept secure through encryption processes.

According to the Family Violence Information sharing Guidelines, ISEs are encouraged to ensure that they have appropriate processes in place to safeguard against privacy breaches. This includes taking steps to ensure that perpetrators cannot access information about a victim survivor or that those workers requesting information or working with a client do not have a conflict of interest (e.g. that the worker does not have a personal or familial relationship with a victim survivor or perpetrator). To effectively implement this, it is recommended to collaborate with internal resources such as Health Information Service (HIS) and Freedom of Information (FOI) teams and revise the relevant procedures as required.

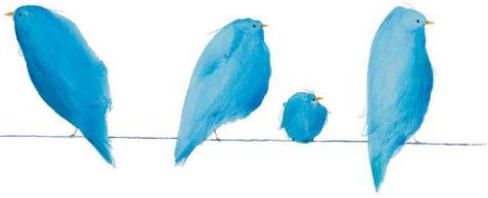
9. Managing access to information and Freedom of Information requests

People may seek access to their medical and personal information under privacy and Freedom of Information (FOI) laws. It is important that hospitals/integrated health services consider how such requests are addressed where the Information Sharing Schemes have been used. This may need to be done in consultation with relevant hospital/health service staff (for example Legal Counsel, Health Information Services, Freedom of Information team) and be clearly addressed in relevant documentation (such as relevant Health Information policies and procedures). Particular attention should be paid to the potential impact on the safety of victim survivors (under FVISS) and the safety of a child or group of children (under CISS).

Under FVISS

Accessing information and FOI requests are detailed in Chapter 10 of the Family Violence Information Sharing Guidelines – note that these guidelines state:

- "ISEs have the right to refuse a perpetrator's (or alleged perpetrator's) access to information if the ISE reasonably believes that giving access would increase risk of family violence to the victim survivor. Perpetrators also cannot access their child's information, or the information of another person they are authorised to access, if giving access to this information would increase the level of risk" (p.114).
- "When deciding whether a disclosure to an alleged perpetrator or a perpetrator would meet this exception, a Minister or the relevant agency (where it is also an ISE) must take into account whether a disclosure of that information would increase the risk to a victim survivor's safety from family violence" p.115).



Under CISS

Accessing information and FOI requests are detailed in Chapter 4 of the Child Information Sharing Scheme Ministerial Guidelines – note that these guidelines state:

- "An information sharing entity may refuse to give an individual access to their own confidential information if they believe on reasonable grounds that giving the individual access to the information would increase a risk to the safety of a child or group of children" (p.31).
- "A request for information from a child or family member may be refused if the disclosure could put a child at risk" (p.31).

10. Consideration outside of standard business hours

A process for managing and responding to urgent requests or the voluntary sharing of information that occurs outside of standard office/business hours needs to be developed. This will vary according to the structure for out of hours operations and existing escalation procedures at different hospitals. Furthermore, it should be clear to external ISEs, so that urgent requests can be accommodated.

Staff with after-hours responsibilities should have completed the necessary training and have a sound understanding of both Schemes in order to make independent decisions around sharing information.

11. Communication

Communication with patients

Consumers of the hospital or integrated health service and the public including relevant family members should have access to details about the Schemes. This should cover information about consent, when it is and is not required (detailed in section headed Understand when consent is required in this document) and include examples of instances when information may need to be shared with another ISE in accordance with the law. This can be achieved through:

- written brochures available for patients and their families (existing brochures may be expanded to cover the Schemes)
- the hospital's external website
- conversations with health professionals when engaging with a service.

Examples of providing patients information about the Schemes

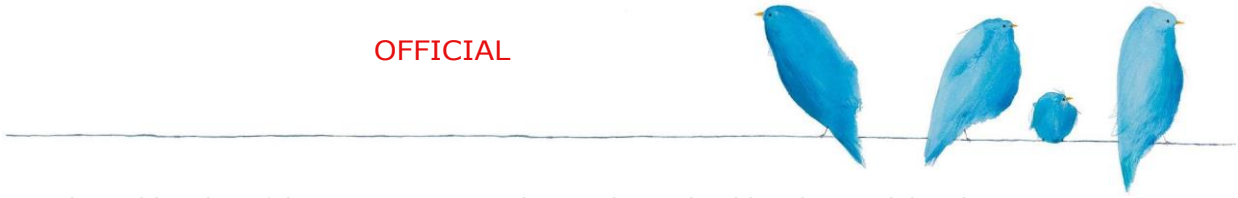
A Community Health nurse would provide a new patient with information, both written and verbal, about privacy and confidentiality and the limitations of this.

It is helpful to:

- facilitate a discussion about examples of when information may need to be shared and what purpose this would serve
- ask about any concerns the patient has around potential information sharing and document in the patient's medical record.

Importantly *consent should not be sought from a perpetrator or alleged perpetrator* (it is not required under the Schemes and may compromise the wellbeing and safety of victims), however, they should be advised of these information sharing permissions when they engage with services through the avenues outlined above (i.e. brochures, websites, and conversations).

Otherwise, if a situation arises where information may be shared without consent, these concerns can be considered and potentially passed on to the requester so that further actions can be developed



with knowledge and consideration of these concerns. Further, patients should understand that they should be notified if their information is shared and their views sought, both when it is appropriate and practical to do so.

Communication with ISEs

Hospitals and integrated health services should develop a communications plan which clearly outlines to other ISEs the processes that should be followed when requesting information from the service under the FVISS and CISS. Communication should include:

- any request form that has been developed
- where to direct any requests
- what response they should expect.

This information should also be included on the hospital/ integrated health service website.

Existing partnerships and networks can be utilised to distribute information about how ISEs can collaborate with the hospital/ integrated health service and share relevant information under both Schemes.

A feedback mechanism would also be valuable to determine whether the process is effective, and if any changes are required.

Monitoring and review

- For monitoring and compliance, an internal escalation process needs to be established which includes: prompts and follow up for instances where requests are not actioned within a timely manner (hospitals/integrated health services may indicate timeframes), or (under FVISS) urgently where a serious threat has been identified
- regular auditing systems to ensure:
    - processes are being followed as set out in the policy
    - practices are in line with legislation.

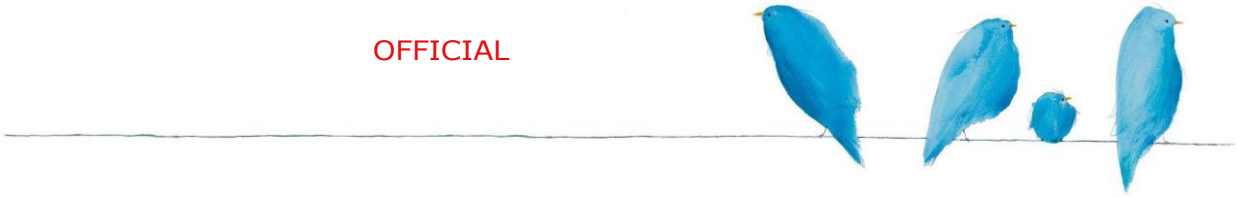
This monitoring will also highlight any gaps in staff capability or the system, allowing the opportunity for internal workflow procedures to be improved and refined.

12. Data collection

There are no specified requirements for ISEs to collect data in relation to sharing information under the Schemes. However, the SHRFV team recommends that an organisation can develop a data collection tool to:

- assist with monitoring internal compliance
- determine where requests are originating from
- ascertain purposes of requests.
- Monitor demand from FVISS and CISS
- Have identifiers or indicators of actual or potential risk
- Monitor follow up

It is important to note that the MARAM Implementation Review Guide suggests three ways (qualitative review, case file checklist, and quantitative review) to review the success of implementation activities which requires collection of Information-sharing data.



Guide to Sharing Information under the Information Sharing Schemes

Hospitals and integrated health services prescribed as ISEs need to share information in accordance with the two Information Sharing Schemes which will include:

- responding to a request from another ISE
- requesting information from ISEs
- receiving information voluntarily shared from ISEs
- voluntarily sharing information with other ISEs where appropriate.

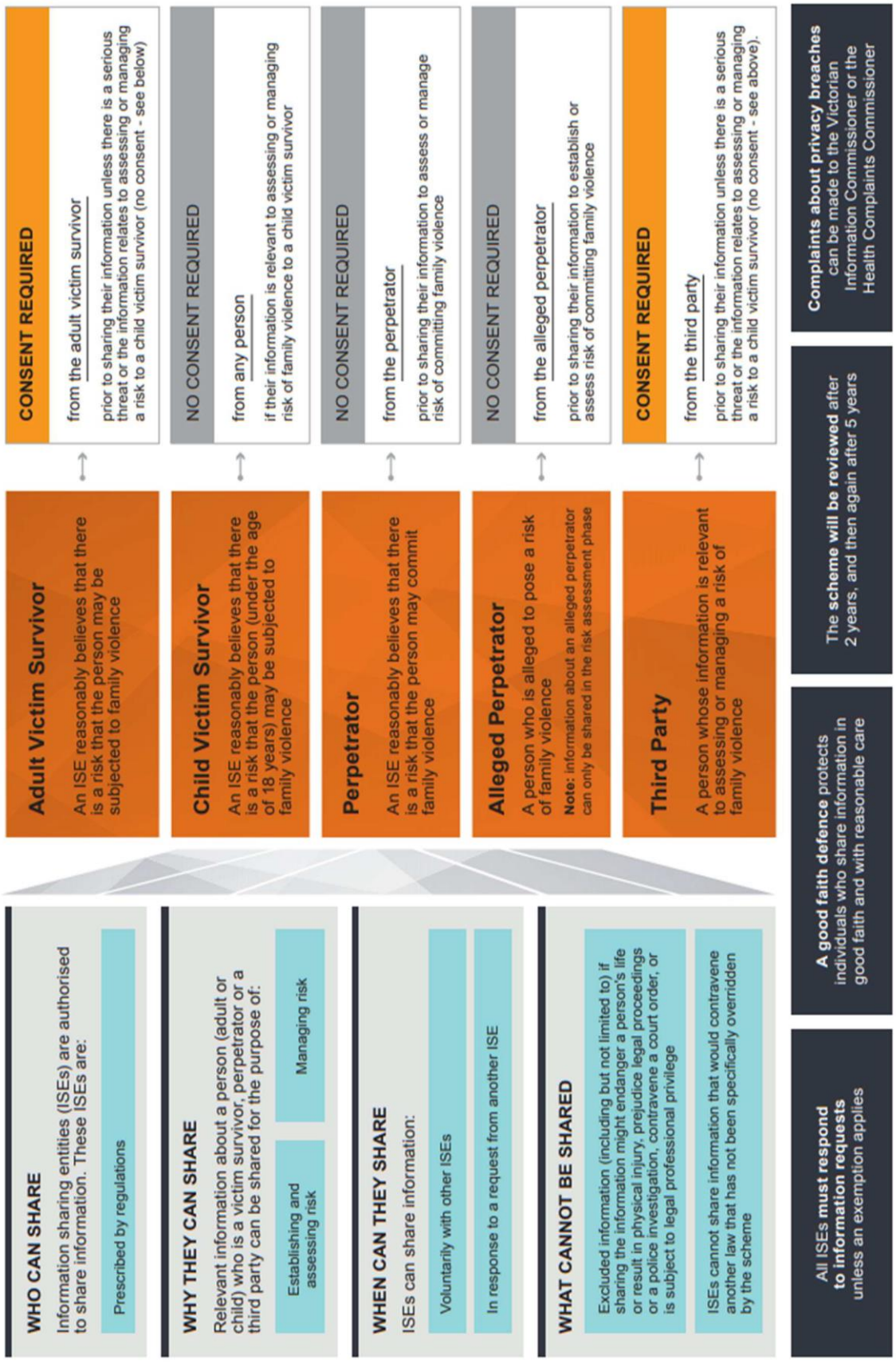
Considerations when sharing or requesting information

Applying the threshold tests

Before using the Schemes to share information the requirements for sharing must be met and these differ between the FVISS and CISS.

Under FVISS

ISEs are bound by the guidelines set out in the Family Violence Information Sharing Guidelines: Guidance for Information Sharing Entities which detail the sharing of information to assess or manage family violence risk to adults or children. These can be summarised as follows.



Source: 'Figure 1: Overview of the Scheme' (Family Violence Information Sharing Guidelines: Guidance for Information Sharing Entities p. 23).

In addition, the Department of Education and Training has developed a three-point requirement schema which summarises the circumstances in which ISEs can share information under FVISS for Victorian education and care workforces sharing information about child wellbeing or safety – see below.

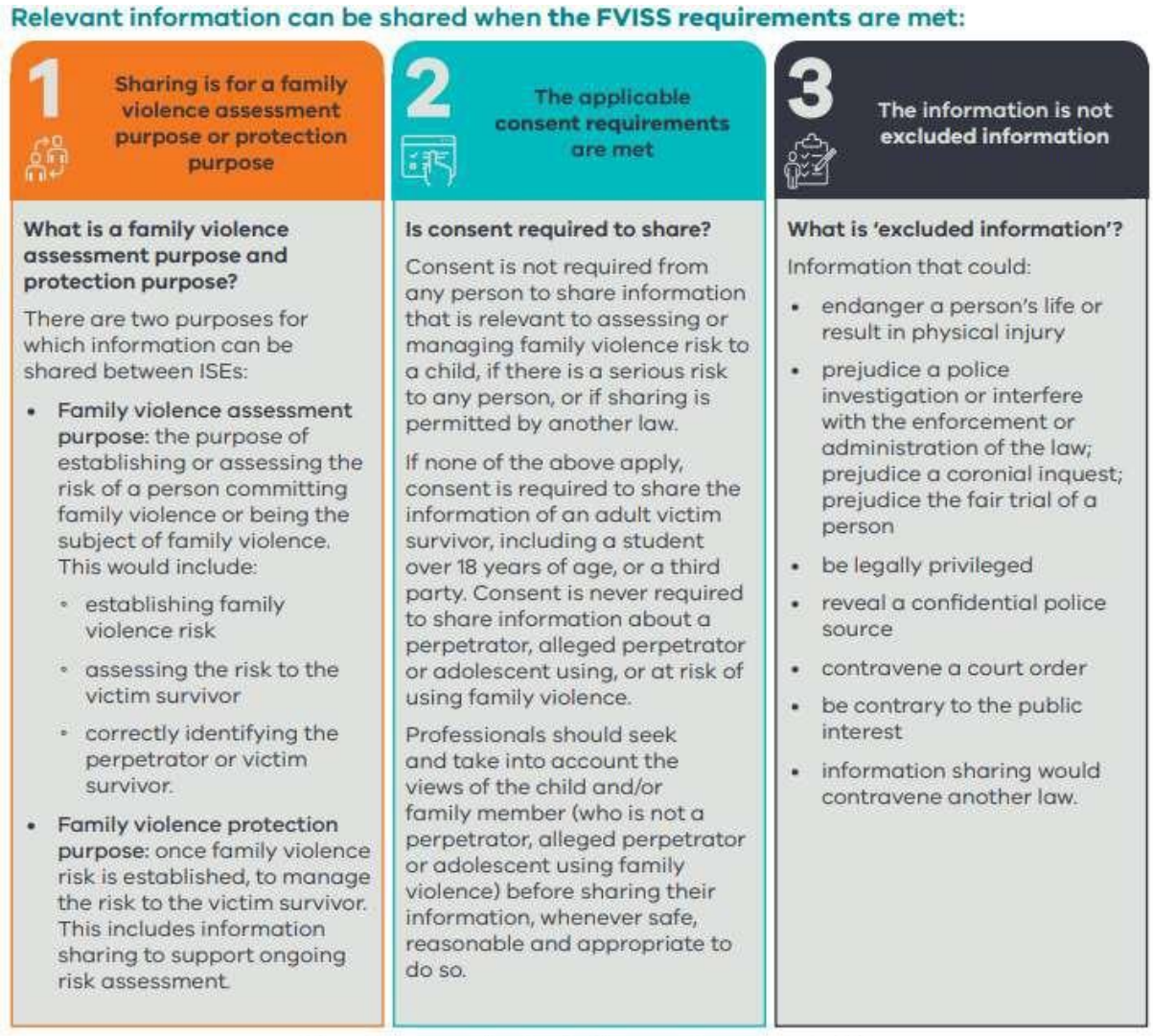


Figure 2. Diagram showing the three requirements for FVISS

Source: 'Figure 2: Diagram showing the three requirements for FVISS' (Information Sharing and Family Violence Reforms Toolkit: For centre-based education and care services; government, Catholic and independent schools; system and statutory bodies; and education health, wellbeing and inclusion workforces p.13).

Under CISS

Detailed guidance concerning information sharing by ISEs under CISS is provided in the Child Information Sharing Scheme Ministerial Guidelines. These can be summarised as follows.

Child Information Sharing Scheme summary

Who

Who can share information

If the scheme's threshold is met, prescribed information sharing entities can request and disclose confidential information about any person with each other.*

Why

Threshold part 1: Promoting child wellbeing or safety

An information sharing entity can **request** or **disclose** information about any person for the purpose of promoting the wellbeing or safety of a child or group of children.

What

Threshold part 2: Sharing to assist another information sharing entity

The **disclosing** information sharing entity must reasonably believe that sharing the information may assist the receiving information sharing entity to carry out one or more of the following actions:

i. making a decision, an assessment or a plan relating to a child or group of children
ii. initiating or conducting an investigation relating to a child or group of children
iii. providing a service relating to a child or group of children
iv. managing any risk to a child or group of children.

Threshold part 3: Excluded information

The information being **disclosed** or **requested** is not known to be 'excluded information' under Part 6A of the *Child Wellbeing and Safety Act 2005* (and is not restricted from sharing by another law).

When

When should information be shared

If the threshold of the scheme is met, an information sharing entity:

- can **share proactively** with other information sharing entities
- can **request information** from another information sharing entity
- must **respond to requests for information** from another information sharing entity and provide relevant information.

Principles

Legislative principles to guide sharing

1. Give precedence to the wellbeing and safety of a child or group of children over the right to privacy.
2. Seek to preserve and promote positive relationships between a child and the child's family members and people significant in the child's life.
3. Seek to maintain constructive and respectful engagement with children and their families.
4. Be respectful of and have regard to a child's social, individual and cultural identity, the child's strengths and abilities and any vulnerability relevant to the child's safety or wellbeing.
5. Promote the cultural safety and recognise the cultural rights and familial and community connections of children who are Aboriginal, Torres Strait Islander or both.
6. Seek and take into account the views of the child and the child's relevant family members, if it is appropriate, safe and reasonable to do so.
7. Take all reasonable steps to plan for the safety of all family members believed to be at risk from family violence.
8. Only share confidential information to the extent necessary to promote the wellbeing or safety of a child or group of children, consistent with the best interests of that child or those children.
9. Work collaboratively in a manner that respects the functions and expertise of each information sharing entity.

*The Child Information Sharing Scheme also permits information sharing entities to share information with a child, a person with parental responsibility for the child or a person with whom the child is living, for the more limited purpose of managing a risk to the child's safety.

Source: Child Information Sharing Scheme summary factsheet (2018)

The Department of Education and Training has developed a three-part threshold test that must be met before there is any information sharing under CISS – see below.

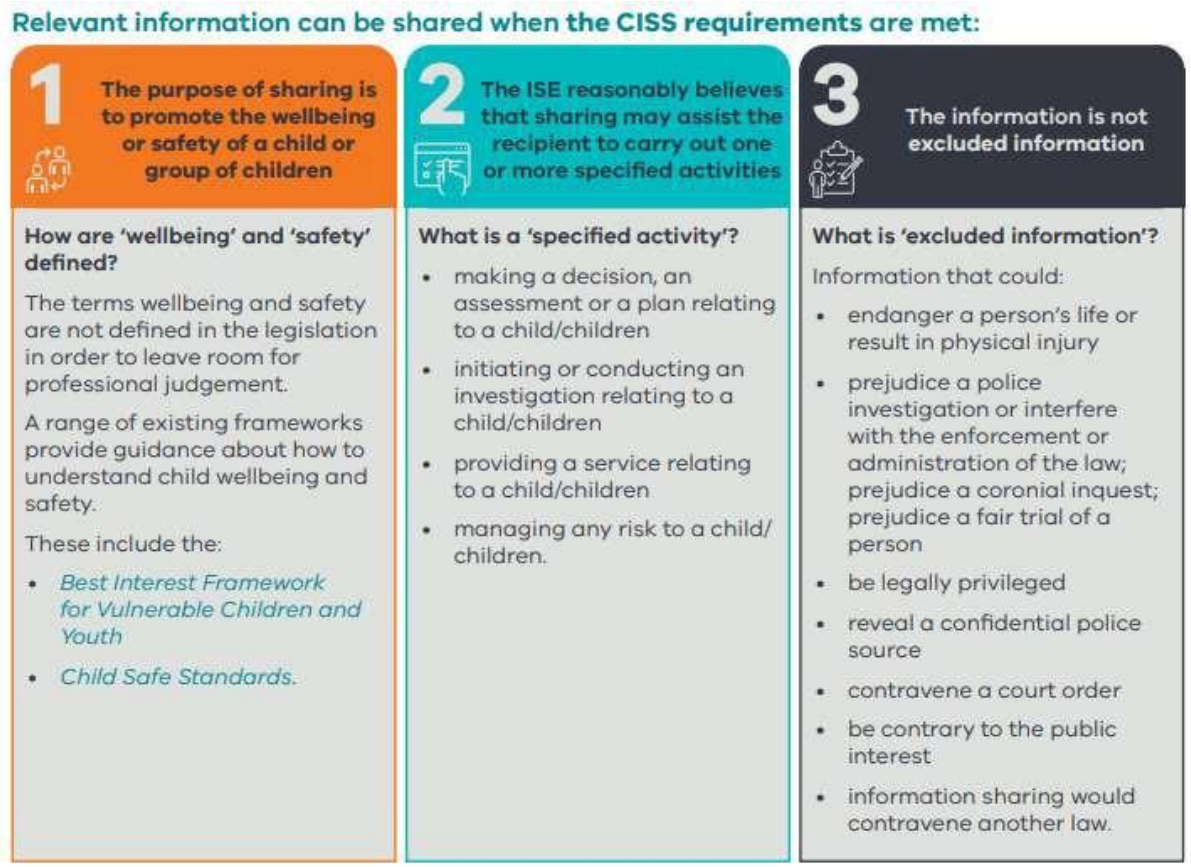


Figure 1: Diagram showing the three-part threshold test for CISS

Source: 'Figure 1: Diagram showing the three-part threshold test for CISS' (Information Sharing and Family Violence Reforms Toolkit: For centre-based education and care services; government, Catholic and independent schools; system and statutory bodies; and education health, wellbeing and inclusion workforces p.12).

Excluded information

Information must not be shared if it falls within the defined category of 'excluded information' or contravenes another law. A full list (including examples) is available in both the Family Violence Information Sharing Guidelines (p.31) and the Child Information Sharing Ministerial Guidelines (p.16). Advice should be sought from the organisation's legal counsel if there is uncertainty.

Workers should not collect, use, or share information as outlined in the source below.

Threshold part 3: Excluded information

'Excluded information' is information that cannot be collected, used or disclosed under the Child Information Sharing Scheme, as set out in Section 41Q of the *Child Wellbeing and Safety Act*.

Excluded information is any information that, if shared, could be reasonably expected to do the following:

a. Endanger a person's life or result in physical injury – this includes the child, their family or any other person. For example, if sharing the location of a child could be reasonably expected to pose a threat to the life or physical safety of the child or another person, this information should not be shared.

b. Prejudice the investigation of a breach or possible breach of the law or prejudice the enforcement or proper administration of the law – including police investigations. For example, any information that could unfairly influence or reveal details of a police investigation or Commission for Children and Young People investigation.

c. Prejudice a coronial inquest or inquiry. For example, information that could unduly influence a witness expected to give evidence before a coronial inquest.

d. Prejudice the fair trial of a person or the impartial adjudication of a particular case. For example, if the information would unfairly influence the outcome of a proceeding.

e. Disclose the contents of a document, or a communication, that is of such a nature that the contents of the document, or the communication, would be privileged from production in legal proceedings on the ground of legal professional privilege or client legal privilege. For example, if the information is legally privileged.

f. Disclose or enable a person to ascertain the identity of a confidential source of information in relation to the enforcement or administration of the law. For example, if that information could reveal or be used to reveal the name of a person who has confidentially provided information to police.

g. Contravene a court order or a provision made by or under the *Child Wellbeing and Safety Act* or any other Act that:

- prohibits or restricts, or authorises a court or tribunal to prohibit or restrict, the publication or other disclosure of information for or in connection with any proceeding

  or

- requires or authorises a court or tribunal to close any proceeding to the public. For example, if information is part of a closed court proceeding.

h. Be contrary to the public interest. For example, revealing information about covert investigative techniques.

Information sharing entities are not required to conduct investigations to determine that information is not 'excluded information' before sharing it. Rather, if they are aware that information falls within an excluded category then they are not permitted to share that information. For example, a disclosing entity does not have to investigate whether there are any open or planned legal proceedings that might be prejudiced by disclosing requested information that meets parts one and two of the threshold for sharing, but if the entity is aware of open proceedings that they reasonably expect could be prejudiced by the disclosure of the information, then they must not disclose that particular information.

Information sharing entities cannot share information known to be restricted under another law (see Chapter 4).

Source: 'Threshold part 3: Excluded information (Child Information Sharing Ministerial Guidelines p.16*).*

Determining the identity of the requester

When receiving a request, the authenticity of the person making the request can be determined via the requester's email address (e.g. j.smith@vicpol.gov.au). If the organisation's email address is not recognised by staff, a telephone call to the switchboard of the organisation should be made – the telephone number listed on the request form should *not* be used to confirm the requester's identity as this may not be associated with the organisation. The process for identifying a requester's identity during a verbal request can be completed by requesting an email from the requester verifying their connection to an authorised ISE organisation.

Verifying ISE/RAE status

The ISE or RAE status of an organisation needs to be determined before there is further consideration of the request. To aid this, an online list has been developed: Information Sharing Entity list search. This searchable database contains organisations and services that are prescribed; however, it should not be solely relied on to verify ISE status as the list is updated at regular intervals

and as such is not live. Ultimately hospitals and integrated health services are responsible for verifying whether an individual is from an ISE *before* they share information.

Confirming the client is linked to an ISE program

It will need to be determined that the person who is the subject of the request is linked to a prescribed ISE program or service. However, note that sharing organisations may be able to share under other permissions, such as with the consent of the client under privacy laws.

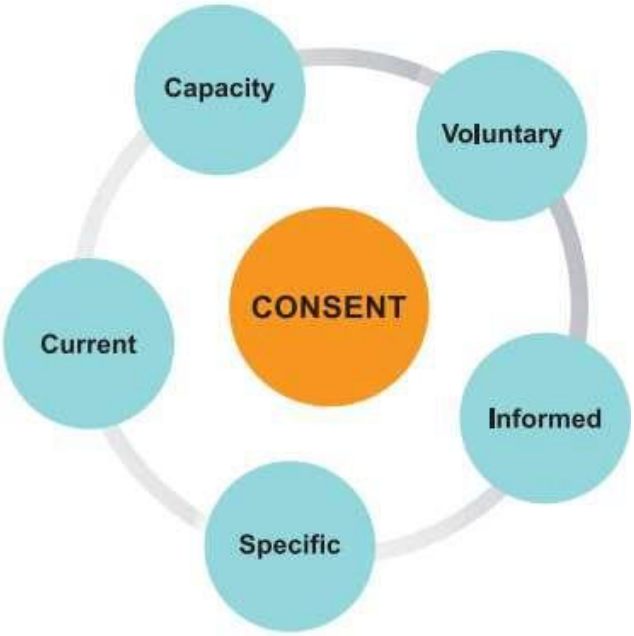
There may also be some instances where the subject of the request is not known to the integrated health service at all and consequently the request cannot proceed under FVISS or CISS legislation.

Understand when consent is required

Health professionals are encouraged to seek the views of patients to share information from the individual (adult or child victim survivor or third party) where it is appropriate, safe and reasonable to do so even when consent is not required. C*onsent requirements* only feature in the FVISS not the CISS (detailed below).

The exception is that *consent should not be sought from a perpetrator or alleged perpetrator* as it is not required under the Schemes and may compromise the wellbeing and safety of victim survivors and/or children. Hospitals and integrated health services are advised to cover this within policies and/or practice guidelines.

Figure 5:
Five elements of consent



Source: 'Figure 5: Five elements of consent' (Family Violence Information Sharing Guidelines: Guidance for Information Sharing Entities p. 104).

Seeking consent promotes victim survivor agency in decision-making and may assist a victim survivor to feel more comfortable to access other integrated health services. This promotes an open and

transparent relationship between service providers, a child victim survivor and a parent who is not a perpetrator.

Consent may be express or implied.

Principles for obtaining consent

Principles for obtaining consent when consent is required, or seeking consent when it is not a requirement under legislation but is best practice where it is appropriate, safe and reasonable to do so, are outlined below.

When sharing information with another ISE, including voluntarily sharing information, the responsibility is on the sharer to seek consent from a victim survivor to specifically share their information at that point in time, when required. When making a request for information from another ISE, the requester should confirm that the sharing ISE has obtained consent from a victim survivor to specifically request their information at that point in time, when required.

There may be occasions where the requesting ISE determines there is a serious threat requiring urgent sharing of information *before* the views of the victim survivor can be sought (note that consent is not required where there is a serious threat as discussed below). Here ISEs have a responsibility to ensure the adult victim survivor or child and their protective (non-perpetrator) parent or guardian is told as soon as possible after their information is shared, where safe, reasonable and appropriate to do so.

Consent under FVISS

It is a requirement under the FVPA (section 144E) to obtain the consent of the 'primary person' unless the ISE reasonably believes that sharing without it is necessary to lessen or prevent serious threat to life, health, safety or welfare of an individual.

Under FVISS, there are different consent thresholds for different groups of individuals. FVISS prioritises a child's safety over any individual's privacy, and victim survivor safety over perpetrator privacy. The Family Violence Information Sharing Guidelines (p.23) states (quote):

a) Consent is **not required** from an **alleged perpetrator** (for an assessment purpose) or a **perpetrator** (for an assessment or protection purpose) to share relevant information to assess or manage risk of family violence to a child or adult victim survivor.
b) Consent is **not required** to share relevant information **about any person** when assessing or managing a family violence **where children are involved** (including assessing risk to an adult where children are involved).
c) Consent is **required** when sharing relevant information about an **adult victim survivor** *and* **there are no children involved**.
d) Consent is **required** when sharing information about a **third party** *and* **there are no children involved**, however, **if children are involved consent is not required** from the third party.

Exemptions

Exceptions to instances where consent is required under FVISS are when the ISE reasonably believes that sharing information is necessary to lessen or prevent a serious threat to an individual's life, health, safety or welfare.

In instances where information is shared without consent, it is best practice to involve victim survivors in the process, wherever possible, so that they have a clear understanding of, and confidence in, the process. This aims to remove barriers to service engagement, and any risk management actions

taken as a result of information sharing promotes the agency of victim survivors and enhances their own safety planning. This will also help to reassure adult victim survivors about why and how their information will be used and disclosed. (Note that this sharing already occurs (outside the CISS and FVISS) under the *Privacy and Data Protection Act 2014* and the *Health Records Act 2001*.)

Example of seeking the views of a victim survivor under FVISS

Sarah is a Community Health Social Worker who is working with a client, Rebecca, who has been newly diagnosed with Type 1 Diabetes. During an appointment, Sarah had noticed indicators that may signify the presence of family violence. Following sensitive enquiry, Rebecca disclosed significant family violence by her current partner, Peter, which included physical assaults, threats to kill and controlling behavior.

There is a limited Family Violence Intervention Order (FVIO) in place, stipulating that they can remain in contact on the provision that Peter does not use family violence against Rebecca. However, despite this Peter has continued to direct violence at Rebecca.

Through undertaking the MARAM Intermediate Risk Assessment with her client, Sarah determined that Rebecca was at serious risk due the number of high-risk factors present. Rebecca herself reported that she feels more fearful than ever, and that her life is in danger.

However, Rebecca does not want to report the FVIO breaches and assaults to the police, citing that Peter would be “furious” if he knew she was talking to the police, and this would significantly increase the risk of further serious assaults.

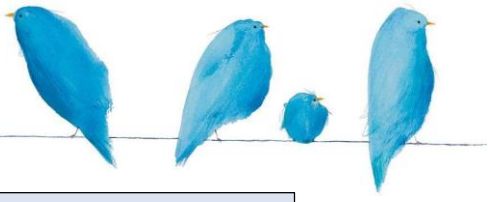
In discussions with her Team Leader, Sarah has made the professional judgement that the threshold of ‘serious threat’ to an individual’s life, health, safety or welfare has been met in this situation. This allows the sharing of relevant information with other ISEs for a family violence protection purpose, without requiring the victim survivor’s consent, as there is a reasonable belief that it is necessary to share information to lessen or prevent the serious threat.

In addition, Sarah shared with Rebecca her concerns for her safety, and opened up a conversation about Rebecca’s reluctance to involve the police. Rebecca spoke about her fears of the police turning up unannounced at their doorstep and repercussions for her safety if Peter remained in the home.

In exploring her safety options, Rebecca said she was open to contacting the Victoria Police’s Family Violence Investigation Unit during her appointment time with Sarah. Sarah then explored avenues for her providing a statement to police, allowing them to investigate the FVIOs breaches and assaults, whilst also prioritising Rebecca’s safety. Sarah then made referrals for Rebecca with her consent to a local Family Violence Specialist Service for immediate safety planning and ongoing case management.

Consent under CISS

Under CISS, consent is **not required** from any parties provided the thresholds for sharing have been met (shared information concerns the wellbeing or safety of a child or group of children). However, ISEs should seek the views of the child and/or parent (provided the parent is not a perpetrator or alleged perpetrator), take these into account and notify the child and non-perpetrating parent if their information is shared where it is appropriate, safe and reasonable to do so.



Example of information sharing without consent under CISS

Ella, who is 11 years old, attends a Victorian government primary school. An urgent case conference is being convened by Ella's school to discuss concerns for her wellbeing. Ella's parents cannot be contacted.

Sue, a Social Worker from a Victorian public hospital that has provided care and support to Ella and her family, has been asked to attend. However, Sue is concerned about providing information about the hospital's involvement with the family at this forum without parental consent.

Sue confirms that the person making the request is from Ella's school, and that the school, hospital program and any other organisations participating in the conference are ISEs. Given this is the case, Sue recognises that under the CISS she is able to share information to promote the wellbeing or safety of Ella and that this information shared under the information sharing schemes can be related to any person, including other family members, and not just Ella. So, Sue participates in the conference.

People requiring specific considerations

Specific considerations need to be made when the subject/s of information sharing identifying as Aboriginal, from culturally and linguistically diverse backgrounds, have intellectual or physical disabilities, identify as LGBTIQ, are older or are from rural, regional and remote areas. Please also refer to the sections 'Considerations when sharing information about Aboriginal people' and 'Considerations when working with diverse communities' below.

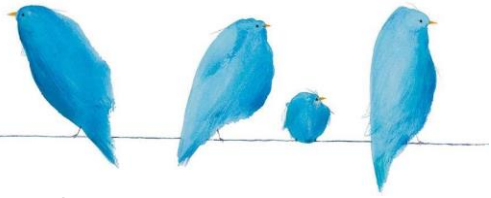
Verbal requests

There will be instances where verbal communication around information sharing will occur, for example in a situation when relying solely on a written process may pose risk issues in time-critical situations. The decision-making process outlined above remains the same, yet communication can occur verbally between ISEs – importantly, verifying the identity of the requester *remains essential*. It is also vital that hospitals/integrated health service staff record the details of what was shared and with whom. Further information is outlined in the 'Documentation' section below.

What information to share?

Once it has been clarified that the requirement of the Information Sharing Schemes has been met, the content/substance of the shared information needs to be decided. (Note that delegates may wish to consult with Senior Social Work or Legal Counsel if uncertain about this given medical records within a hospital or integrated health service may contain a great breadth of medical information about an individual that may span many years.)

Under FVISS, *only information that is relevant to a family violence assessment purpose (sharing with RAEs only) and/or a family violence protection purpose (ISE or RAEs) is permitted to be shared*.



When assessing and managing family violence risk, practitioners should also use the MARAM Framework to:

- guide information sharing under FVISS to identify, assess and manage family violence risk to children and adults
- guide information sharing under the CISS to promote the wellbeing or safety of children more broadly, supported by relevant best interests and developmental frameworks
- ensure that information is shared ethically, appropriately, safely, and lawfully, without further escalating family violence risk
- ensure the agency, dignity and intrinsic empowerment of victim survivors is promoted by partnering with them as active decision-making participants in risk assessment, risk management and information sharing
- ensure information shared is non-discriminatory, culturally sensitive and does not victim blame (holds perpetrators accountable for their behaviour).

Under CISS, *any information that can help promote a child's wellbeing or safety can be determined to be relevant.* This information can be related to any person, not just the child themselves. Professional judgement needs to be exercised when determining if the information meets this threshold.

When sharing information and determining what information is risk-relevant it is important to be aware that personal and systemic biases, prejudice, implicit victim blaming beliefs and discriminatory attitudes often factor into professional judgements. (Section 6.7 of the MARAM Practice Guides covers Risk-relevant Information.)

It is the responsibility of staff delegates to work to ensure:

- all decisions about what information is relevant to share, and how information is shared, does not blame the victim (collude with perpetrators)
- is culturally sensitive
- is non-discriminatory.

To address some of the personal and systemic biases, all staff delegates should participate in ongoing cultural awareness and family violence training.

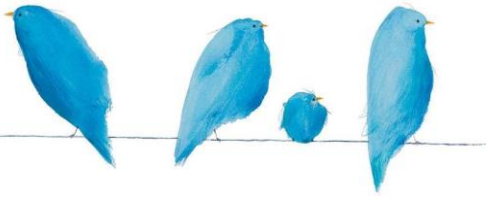
Interface between FVISS and CISS sharing of information

There is some overlap where information may be shared under both Schemes, and also situations where the Schemes are to be applied distinctly.

A request may be received under FVISS for relevant information to assist in managing family violence risk. However, if a child is involved, sharing information about co-occurring wellbeing and safety risks may also be permitted under CISS in order to promote the wellbeing or safety of that child. For example, this may include school attendance or concerns about any developmental delays.

The reverse may also apply. Requests may be received under CISS to assist in promoting the wellbeing or safety of a child or group of children and there may be information that can be shared under the FVISS to assess or manage family violence risk to that child or another person.

These intersections are further explored within the Family Safety Victoria Factsheet – also see section titled 'What is the relationship between FVISS and CISS?' above. Chapter 3 of the Child Information Sharing Ministerial Guidelines: Guidance for Information Sharing Entities also covers 'Sharing information in the context of family violence'.



Considerations when sharing information about Aboriginal people

The principles and specific requirements when sharing information about Aboriginal people needs to reflect self-determination and an understanding of the history of trauma and dispossession that continue to impact on Aboriginal people. This includes the ongoing legacies of discriminatory welfare legislation, policy and practice in relation to the high rates of removal of children and incarceration of Aboriginal people, and the associated implications for consent, privacy and engagement with services for Aboriginal people. Further considerations and guidelines are provided on page 91 and 94 of the Family Violence Information Sharing Guidelines.

In addition to the FVISS and CISS requirements outlined below, it is also advisable to refer to hospital policy on engaging with Aboriginal communities.

Under FVISS

It is a requirement of FVISS that prescribed organisations are committed to ensuring the collection, use or disclosure of confidential information of a person who identifies as Aboriginal is done in a manner that:

- promotes the right to self-determination
- is culturally sensitive
- considers the individual's family and community connections.

For more information refer to Chapter 7 of the Family Violence Information Sharing Guidelines.

Under CISS

CISS also requires prescribed organisations to ensure the collection, use or disclosure of confidential information of a person who identifies as Aboriginal is done in a manner that is culturally sensitive and considers the individual's family and community connections. For more information refer to Chapter 2 of the Child Information Sharing Scheme Ministerial Guidelines.

Considerations when working with diverse communities

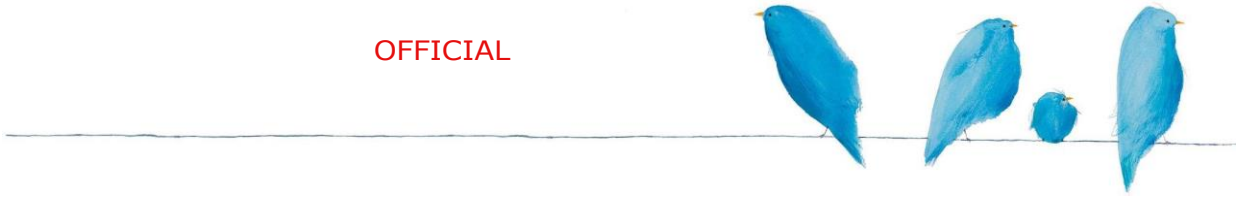
Many factors can affect a patient's response to information sharing such as:

- experiences of discrimination, oppression and trauma that may make some victim survivors fearful or unwilling to give consent to share their information
- understanding of privacy that, within some communities, may be influenced by cultural traditions and beliefs
- language and other communication difficulties which can be a significant challenge to engagement when explaining the complex issues of consent and privacy legislation to victim survivors.

In recognition of this, ISEs are required to take measures to ensure that information sharing practices are reflective when working with people whose circumstances may require additional considerations when accessing services and providing informed consent. This includes:

- people with disabilities
- people from culturally and linguistically diverse backgrounds
- older people
- LGBTIQ communities
- people from regional, rural and remote communities.

For more information refer to Chapter 8 of the Family Violence Information Sharing Guidelines and Chapter 2 of the Child Information Sharing Scheme Ministerial Guidelines.



Format of responses

Responses to requests for information can be either written or verbal, provided there is documentation as to what was shared and with whom. If providing a written response, clearly indicate that it contains sensitive information affecting personal privacy and is a Freedom of Information exempt document. (Also refer to Documentation section of this Guide – Record keeping and information management are detailed in Chapter 10 of the Family Violence Information Sharing Guidelines and Chapter 5 of the Child Information Sharing Scheme Ministerial Guidelines.)

To assist in reducing time spent on providing written responses, and ensuring that all factors are covered, ISEs may wish to develop precedent letter templates.

All requests need to be responded to. If the request is denied because it is believed that the threshold for sharing has not been met, it *must* be documented what request was made and the basis on which the request was denied.

Timeframes for responses

The FVISS and CISS guidelines and legislation require responses under the scheme to be made in a timely manner. However, in the interest of promoting the safety of victim survivors and their children, and for the well-being or safety of children under CISS, an organisation may wish to specify their own timeframes within their policy – this will assist with process management and accountability. For instance, it would be reasonable to expect that a response would be made within two business days, with escalation triggers in place if this is not achieved. However, this should follow an initial triage process to assess risk to ensure an urgent sharing of information can occur where there is a serious threat – these arrangements must be covered in the relevant policies, procedures and guidelines.

Process for voluntary sharing

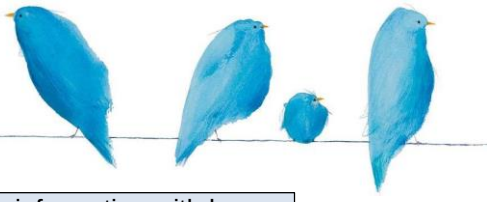
An important part of these legislative reforms is the voluntary sharing of information with other prescribed organisations using the Information Sharing Schemes. Any system that is established by a hospital or integrated health service cannot focus solely upon receiving and responding to requests for information by other ISEs, it *must* also support and articulate voluntary sharing of information.

Example of voluntary information sharing

Sue, a nurse caring for Matt who is a patient in a Victorian public hospital, is aware that Matt has a Family Violence Intervention Order (FVIO) issued against him for threats made to harm his ex-partner. Sue learns through conversations with Matt that he gained knowledge of his ex-partner's new address and plans to "go there" post-discharge "to settle the score".

This information is escalated to a staff delegate who has been assigned information sharing responsibility by the hospital (an ISE). The information relating to Matt's (the perpetrator) knowledge of the victim survivor's new address and his intention to seek this out on leaving hospital could be voluntarily shared with ISEs that are working with either Matt (e.g., perpetrator services) or his ex-partner (specialist family violence services) – or if the risk assessment indicates immediate risk to his ex-partner, the option to ring Police on 000 may also be used.

However, some information may not be relevant to family violence risk assessment or protection (such as some medical or health details pertaining to the perpetrator's hospital admission) so staff from ISEs should refer to MARAM for what is risk relevant information.



The family violence specialist service engaged with the ex-partner can share information with her, regarding the threat from Matt to the extent it is necessary to manage her safety. The threat by Matt in relation to his ex-partner could also be in breach of the FVIO, so sharing this information voluntarily with Police may also be done by the hospital or possibly by the specialist family violence service.

Sharing information as outlined by the FVISS and CISS with the relevant ISEs may be essential for the development and revision of the ex-partner's safety plan and to the assessment and management of her experiencing family violence from Matt. It is important when sharing information to clarify the roles between the ISEs (including the hospital, even if no further engagement is required/planned) in terms of ongoing follow up and action items.

When voluntarily sharing information with RAE and/or ISEs, the same system established to receive requests should be followed. If a delegate group within each program area has been authorised through internal policies, then any voluntary sharing should first be reviewed by someone in this group to ensure that the requirements of the Scheme(s) have been met – including purpose for sharing information, consent requirements (if sharing under FVISS), and whether it is excluded information or prevented from being shared under another law. Some organisations may have implemented the practice where all staff are trained and authorised to share information independently.

All instances of voluntary sharing of information must be documented, detailing the same information as when responding to a request for information –refer to ‘Documentation’ section below.

Receiving voluntary information

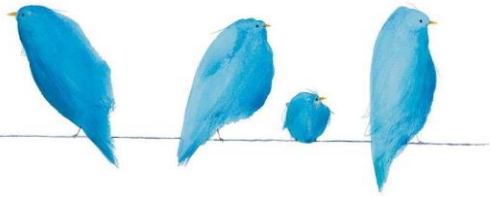
integrated It will need to be confirmed that the other organisation is an ISE and confirm the identity of the sharer. However, it is important to note that information could be being shared under other legal obligations and permissions.

Obtaining consent is the *responsibility* of the *sharing organisation.* However, it is best practice for the receiving organisation to confirm that consent has been gained by the sharing ISE if this is required under the FVISS (remember consent is not required under CISS) or whether (if appropriate, safe and reasonable) the views of the individual were sought before sharing if consent is not required.

It is also important to ascertain what the purpose of sharing is, and how this informs risk assessment or protection purposes for FVISS, or wellbeing or safety of a child or group of children for CISS.

Further, it should be clarified with the sharing ISE what the expected actions for the integrated health service are relating to a family violence protection purpose, or the wellbeing or safety of a child.

The information voluntarily provided should be documented in the medical record, including who provided the information, for what purpose, consent details and whether the views of a child or their non-offending parent have been sought (see next section).



Documentation

Under both Schemes, there is specified documentation that must be recorded in the medical records of the individual whose information is being shared.

Under FVISS

The requirements under FVISS are outlined in detail within the Family Violence Information Sharing Guidelines (Chapter 10).

> When sharing information about **any individual** under the Scheme [FVISS], either voluntarily or in response to a request, an ISE must record:
>
> - who requested the information, what information was requested and the date the request was made
> - what information was shared, who the information was shared with and the date the information was shared
> - a relevant family violence risk assessment and safety plan in respect of a victim survivor about whom the information relates (including if they are a child), and any other family members who are at risk of being subjected to family violence.
>
> Family Violence Information Sharing Guidelines (p.110)

Any consent requirements must also be documented, along with the form the consent was provided (written, verbal or implied). If applicable, the reason for which consent was not obtained must also be documented, whether the views of the individual were sought (including a child victim survivor), and whether the person was informed that their information was shared. Note that consent or obtaining the views of perpetrators or alleged perpetrators is not a requirement under FVISS.

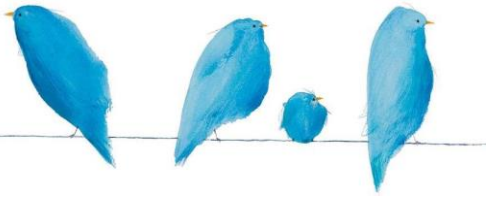
Under CISS

There are documentation requirements when sharing and requesting information under the Child Wellbeing and Safety (Information Sharing) Regulations, which are outlined in the Child Information Sharing Ministerial Guidelines (Chapter 5).

> When a **request has been received**, the following must be recorded:
>
> - the name of the information sharing entity that requested the information
> - the information that was requested
> - the date on which the information sharing entity made the request.
>
> When **disclosing information voluntarily or in response to a request**, the following must be recorded:
>
> - the name of the information sharing entity that received the information
> - the date the information was disclosed
> - a record of the information that was disclosed.
>
> (Child Information Sharing Ministerial Guidelines p.34)

It is also a requirement to document whether the health professional sought the views of the child or relevant family member in relation to the information that they plan to share, and whether the child or relevant family member were informed that their information is to be or has been shared.

The Victorian government website contains examples for record keeping under FVISS and CISS:



Information sharing guides, templates and tools | vic.gov.au.

Refusal to Share under FVISS or CISS

If the hospital or integrated health service does not believe that the request for information meets the threshold for sharing under FVISS or CISS, or is excluded information or contravenes another law, a *refusal to share information* can be given to the requesting ISE. This refusal must be made in writing and outline the reason/s that it does not satisfy the requirements for sharing under either Scheme. Details of the request and the reason why it was refused must also be documented in the relevant individual's medical record.

Confidentiality and privacy

It is vital that sound practices are in place to ensure the safeguarding of an individual's personal information. Sensitive information is often contained within documents exchanged with, and verbal conversations between, ISEs. Therefore, measures are required to prevent the unlawful sharing of information beyond what is allowed within the Schemes and other laws, or with a party beyond the individual or organisation for whom the information was intended.

Control measures would include:

- secure record management
- verification of the identity of the person making the request
- use of encryption software when sending emails to an address outside of the organisation.

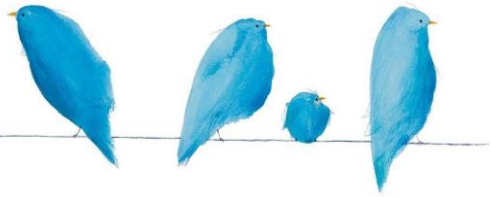
When sharing under FVISS, a portion of information shared will often relate to a perpetrator. As the required documentation will be entered into the perpetrators' medical records, care is required to ensure this information is not accessed by the perpetrator.

Staff education, including for medical staff, may be necessary in order to prevent sensitive information being copied into a discharge summary or other documents which a perpetrator may have access to. Staff are to consider whether to preface any sensitive documentation with the disclaimer of 'not for FOI' or 'information given in confidence'. This will act as a prompt to the FOI team to redact any information that may pose a risk to another person if a perpetrator requests access to their files under Freedom of Information laws.

It is important that information about the Information Sharing Schemes and how they interact with Freedom of Information requirements is included and clearly articulated in relevant Health Information policies and procedures (refer to section Managing access to information and Freedom of Information requests above).

In relation to the security of any documents, the Schemes do not override existing laws and standards relating to data security and record management.

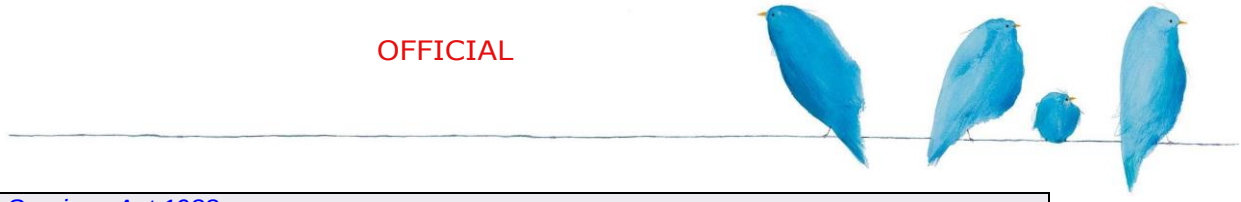
The handling of information under both Schemes is also guided by privacy laws – this is discussed in Chapter 11 of the Family Violence Information Sharing Guidelines while Chapter 4 of the Child Information Sharing Scheme Ministerial Guidelines considers the relationship of the CISS with other laws.



Appendix 1: Relevant Legislation and Overview

Acts relevant to the Information Sharing Schemes and their implementation

Victorian Legislation	*Charter of Human Rights and Responsibilities Act 2006* **Summary:** The Charter of Human Rights and Responsibilities Act 2006 (the Charter) is a Victorian law that sets out the protected rights of all people in Victoria as well as the corresponding obligations on the Victorian Government. **Source:** Charter of Human Rights and Responsibilities Act 2006 | legislation.vic.gov.au
	Child Wellbeing and Safety Act 2005 **Summary:** The Child Wellbeing and Safety Act 2005 (CWSA) provides an overarching framework for promoting positive outcomes for all children and identifies a set of principles as the basis for development and provision of services. It places clear responsibilities with the providers of child and family services to respond according to need and in culturally appropriate and inclusive ways. It recognises the importance of the right mix of places, professionals and high quality programs in order to meet the changing needs of children and families, provide opportunities, promote positive outcomes, intervene early and prevent harm. **Source:** Child Wellbeing and Safety Act 2005 | legislation.vic.gov.au
	Children, Youth and Families Act 2005 **Summary:** The Children, Youth and Families Act 2005 builds on the foundations of the CWSA to provide guidance on additional considerations in promoting positive outcomes for children who are vulnerable as a result of their family circumstances. This Act will commence in April 2007 and guide the actions of family services, child protection and placement services across the state. **Source:** Children, Youth and Families Act 2005 | legislation.vic.gov.au
	Family Violence Protection Act 2008 **Summary:** The purpose of the Family Violence Protection Act 2008 (Vic) is to: • maximise safety for children and adults who have experienced family violence • prevent and reduce family violence to the greatest extent possible • promote the accountability of perpetrators of family violence for their actions. The Act aims to achieve its purpose by providing an effective and accessible system of family violence intervention orders and family violence safety notices. Specialist family violence services are not legal or law enforcement services. However, they should be familiar with the Act and its functions to support victim survivor safety and risk management planning. **Source:** https://safeandequal.org.au/working-in-family-violence/legislative-policy-%20frameworks/#
	Health Records Act 2001 **Summary:** The Health Records Act 2001 (the Act) created a framework to protect the privacy of individuals' health information. It regulates the collection and handling of health information. **Source:** https://www.health.vic.gov.au/legislation/health-records-act

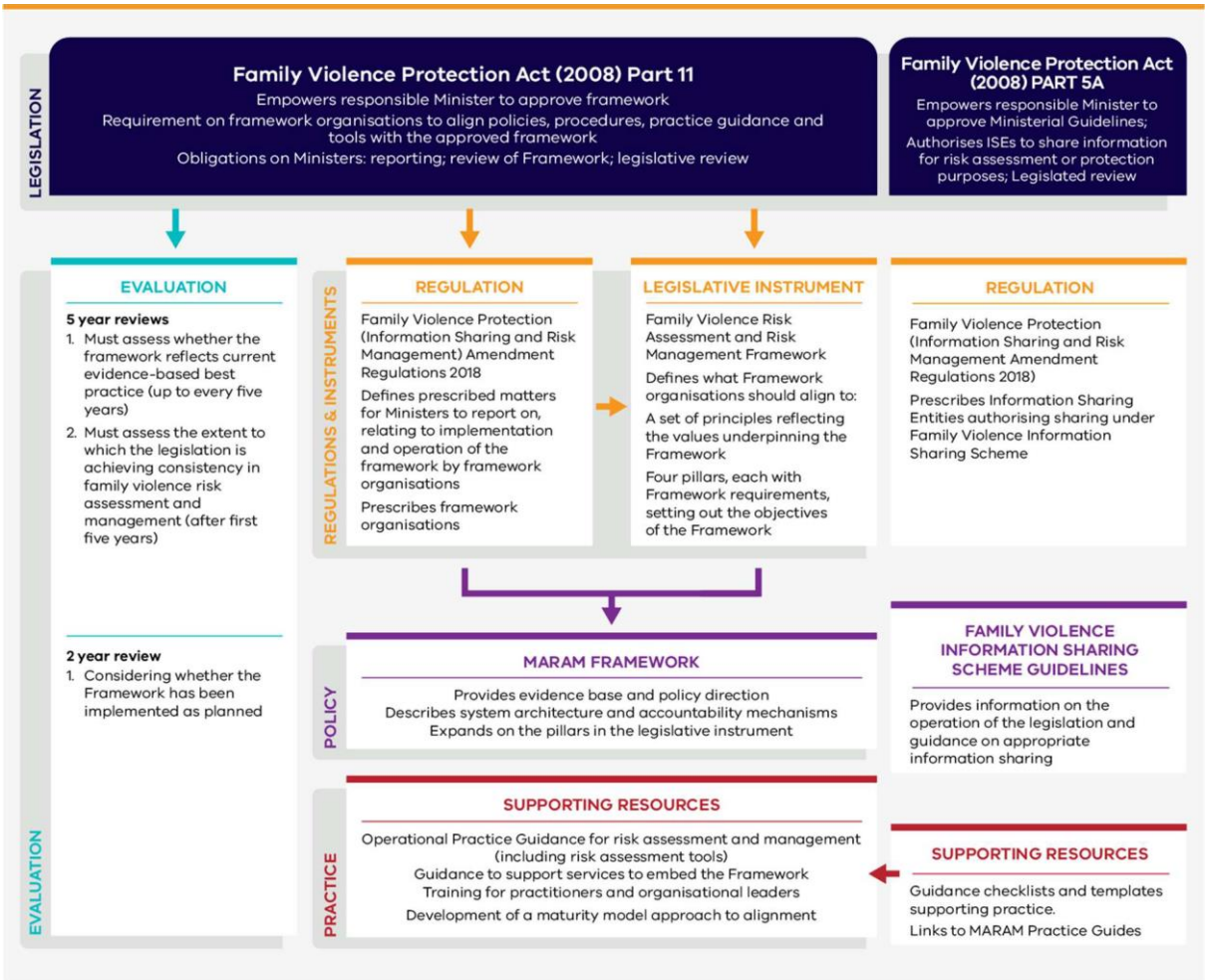


	Health Services Act 1988 **Summary:** Health Services Act 1988 sets out the development of health services in Victoria and ongoing operations of hospitals and other health care agencies. **Source:** https://www.legislation.vic.gov.au/in-force/acts/health-services-act-1988/167
	Privacy and Data Protection Act 2014 **Summary:** It places obligations on Victorian public sector organisations (and certain contracted service providers) to handle personal information in accordance with 10 Information Privacy Principles (IPPs). An interesting aspect of the PDP Act is that it does not apply to health information. **Source:** https://ovic.vic.gov.au/privacy/resources-for-organisations/privacy-officer-%20toolkit/privacy-law-an-overview/
	Crimes Act 1958 Please refer to the link above for more information.
	Public Health and Wellbeing Act 2008 **Summary:** The Public Health and Wellbeing Act aims to achieve the highest attainable standard of public health and wellbeing by: protecting public health and preventing disease, illness, injury, disability or premature death. **Source:** https://www.legislation.vic.gov.au/in-force/acts/public-health-and-wellbeing-act-2008/040
	Freedom of Information Act 1982 **Summary:** The Freedom of Information Act 1982 (FOI Act) gives you the right to request access to government-held information. This includes information they hold about you or about government policies and decisions. **Source:** https://www.legislation.vic.gov.au/in-force/acts/freedom-information-act-1982/112
Federal Legislation	*Privacy Act 1988* **Summary:** The Privacy Act 1988 was introduced to promote and protect the privacy of individuals and to regulate how Australian Government agencies and organisations with an annual turnover of more than $3 million, and some other organisations, handle personal information. **Source:** https://www.oaic.gov.au/privacy/privacy-legislation/the-privacy-act

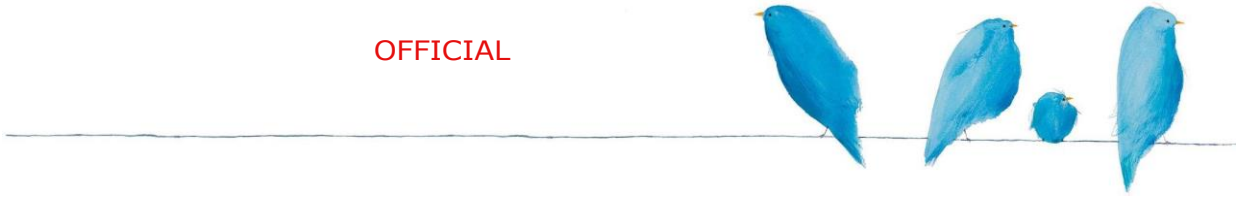
Note: The Schemes don't interfere with existing information sharing legislation, like privacy or child protection legislation.

Changes have also been made to Victorian privacy legislation so information can be shared to reduce or prevent a serious threat to someone's life, health, safety or welfare.

Overview of legislation, policy and frameworks that support Victoria's response to family violence



Source: 'Figure 2: Overview of legislation, policy and frameworks that support Victoria's response to family violence', Chapter 3: Legislation and regulations, Report on the implementation of the Family Violence Risk Assessment and Management Framework 2021-22

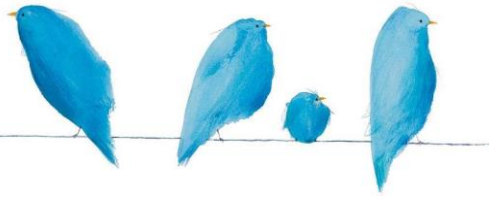


Appendix 2: Resources

Overview of Resources

Six resource documents follow as outlined below.

Resources providing example	
Resource One:	'Family Violence and Child Information Sharing Request' *(request form)*
Resource Two:	'Process for Requesting Information'
Resources Three:	'Information Sharing Scheme Workflow- Responding to a Request'
Resource Four:	'Information Sharing Scheme Workflow - Making a Request'
Resource Five:	Information Sharing Scheme Workflow - Voluntarily Sharing Information
Resource Six:	'Information Sharing Reforms: Implementation Plan (example)' *(can be used to identify gaps, and determine actions and timeframes)*



Resource 1: Family Violence and Child Information Sharing Request

Sensitive Information – may be Freedom of Information Exempt

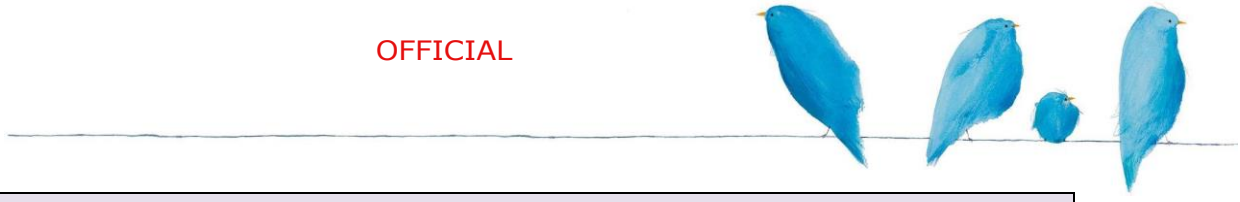
(Information provided in confidence and may include matters that affect personal privacy)

Requesting ISEs are to email completed form to <ISS@yourhospital.vic.gov.au>. Tick one or both.

- Family Violence Information Sharing Scheme (FVISS) request
- Child Information Sharing Scheme request (CISS) request

Requesting Information Sharing Entity details:			
ISE agency name:		ISE contact person *(name and job title)*	Name: Job title:
Request date:		Region *(if applicable):*	
Phone:		Email:	
Is agency also a Risk Assessment Entity (RAE) under FVISS? ☐ Yes ☐ No			

Information request relates to:	☐ A family violence risk assessment purpose ☐ A family violence protection purpose ☐ Promoting the wellbeing or safety of a child or group of children		
The subject of the request:	☐ Alleged perpetrator ☐ Victim survivor- adult ☐ Victim-survivor-child	☐ Perpetrator ☐ Third party ☐ Child or group of children	
Full name:		DOB:	Gender:
FVISS request only:			
Is consent required to share the information in the circumstances?	☐ Yes ☐ No		
How was consent obtained *(if applicable)*	☐ Written ☐ Verbal ☐ Implied		
If consent was over-ridden, reason for this	☐ Child involvement ☐ Serious threat to life or safety		
If consent is not required from a victim survivor, were their views and wishes obtained?	☐ Yes *(outline within request – P.T.O.)* ☐ No		
CISS request only:			
Why is the information about the child required? *(Tick appropriate box and provide any additional supporting information in space below.)*	☐ To make a decision, assessment or plan ☐ To initiate or conduct an investigation ☐ To provide a service ☐ To manage a risk		
Were the views obtained from the child or their parent (non-perpetrator)?	☐ Yes *(outline within request – P.T.O.)* ☐ No (outline below)		



Information requested: (Please attach additional page if required)
1.
2.
3.

Internal use only		
Response letter sent:	☐ Yes ☐ No	Date:
Method of correspondence:	☐ Secure email ☐ Secure post ☐ Fax ☐ Verbal	

Part 5A Family Violence Protection Act 2008
Part 6A Child Wellbeing and Safety Act 2005

Resource 2: Process for Requesting Information

[Insert hospital or integrated health service] have developed a process for Information Sharing Entities (ISEs) to request relevant information under the Family Violence Information Sharing Scheme (FVISS) and the Child Information Sharing Scheme (CISS).

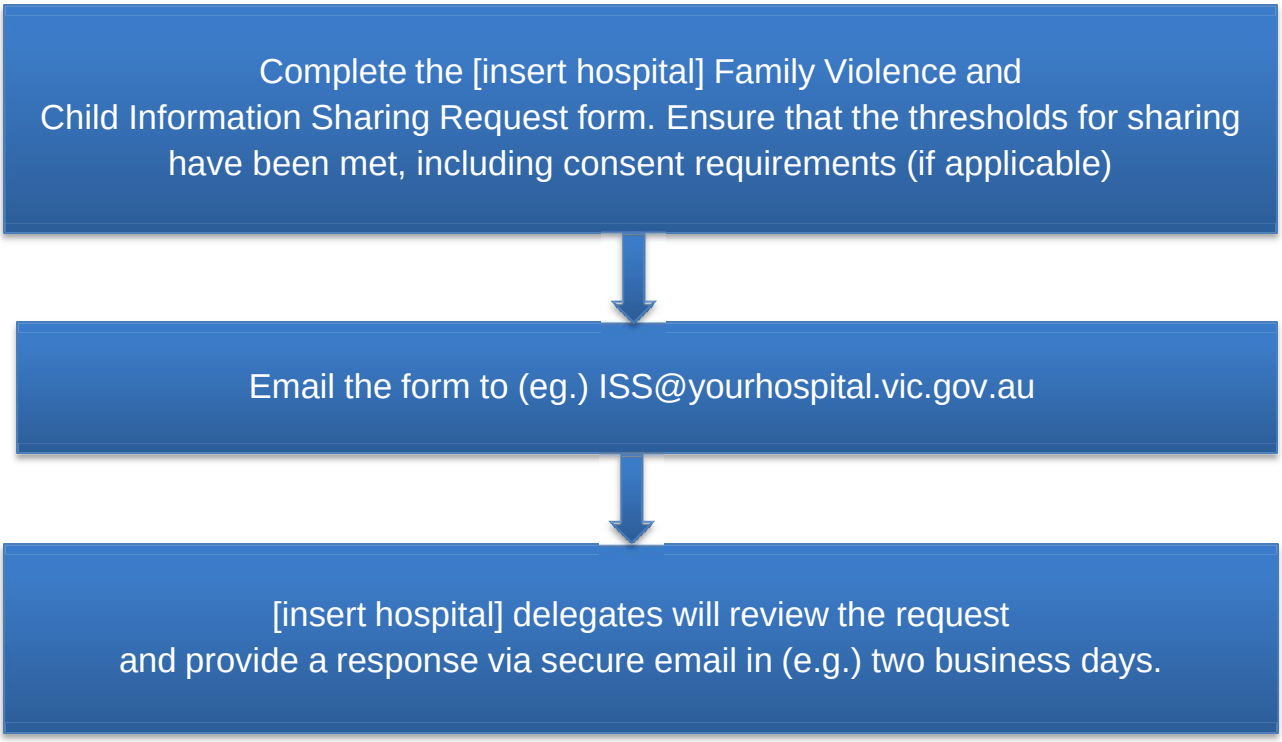
From [date] this applies to [specify areas/ programs] who have been prescribed as Information Sharing Entities by the State Government.

To request information from [insert hospital name] under either scheme, complete the Family Violence and Child Information Sharing Request form and email it to (eg. ISS@yourhospital.vic.gov.au).

Copies of this form can be found on the [insert hospital] website: [Link]

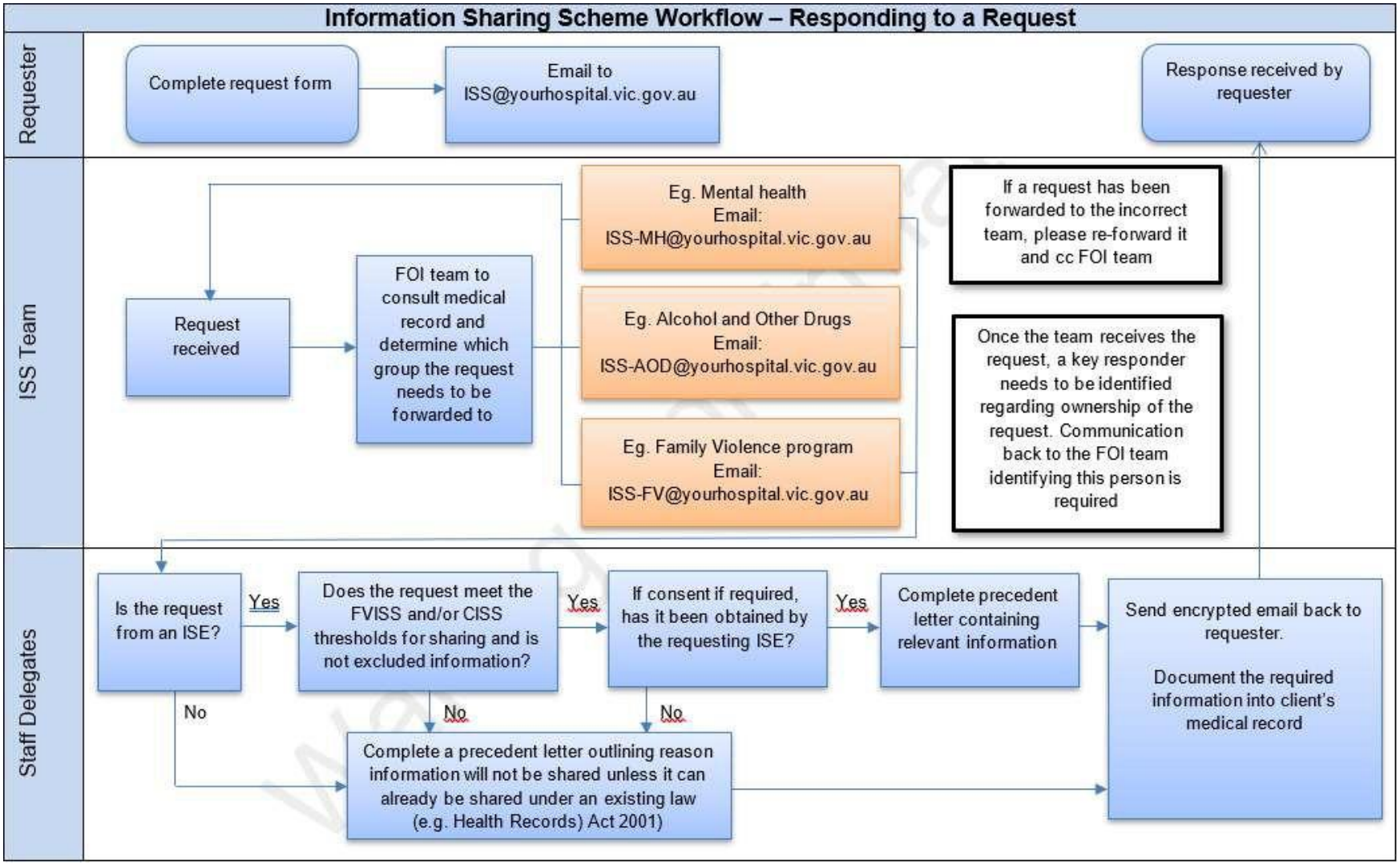
Please note: The onus is on the requesting ISE to seek and gain consent where required under Legislation. Specific detail must be provided as to why information is being sought under FVISS or CISS.

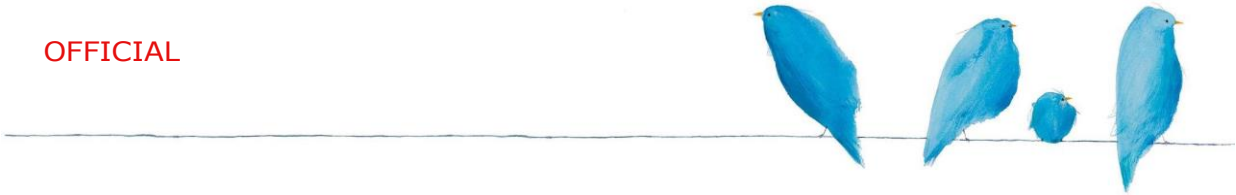
PROCESS FOR FVISS AND CISS REQUESTS



Any confidential information provided under FVISS or CISS should be collected, used and disclosed in accordance with the Family Violence Protection Act 2008, the Child Safety and Wellbeing Act 2005, the Privacy and Data Protection Act 2004 and /or any other relevant state or Commonwealth law.

Resource 3: Information Sharing Scheme Workflow - Responding to a Request

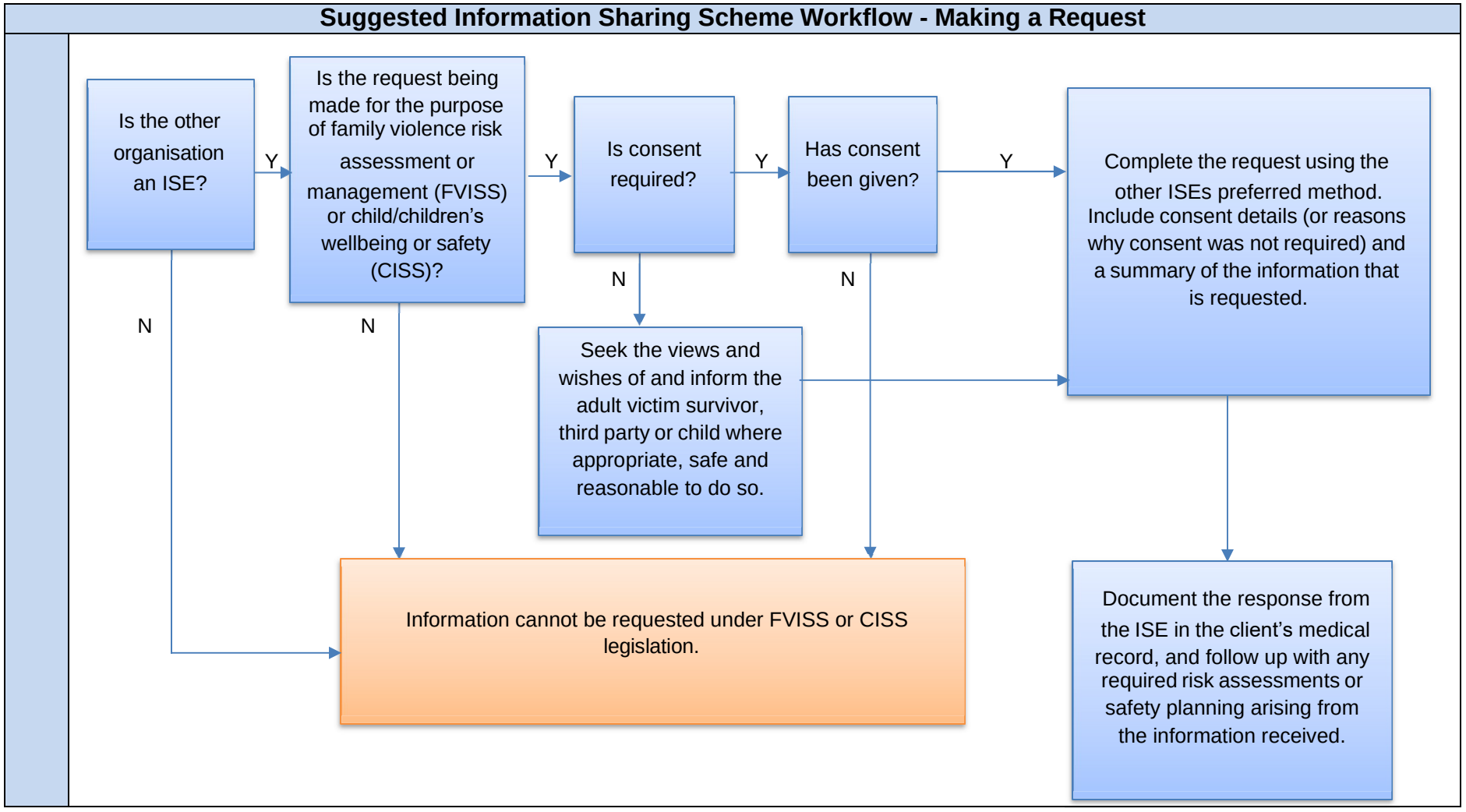




Note: Staff delegates should seek consultation from specialist services as required. Additional measures need to be taken to ensure information sharing practices have been done in a manner that is non-discriminatory and culturally sensitive.

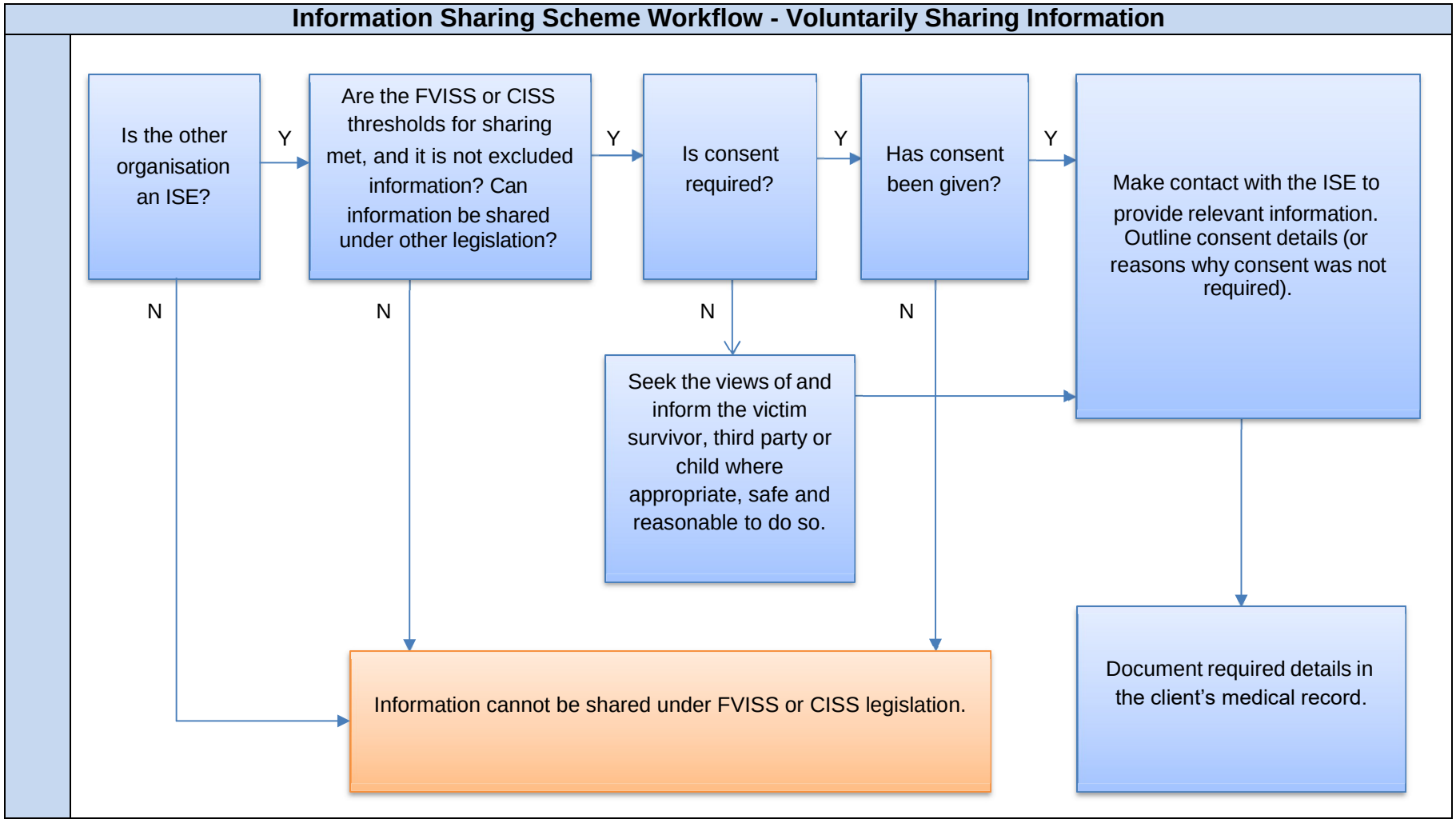
As part of best practice (but not essential to sharing) and when safe and reasonable to do so, have the views and wishes been sought by the Victim Survivor or child if consent is not required?

Resource 4: Suggested Information Sharing Scheme Workflow - Making a Request

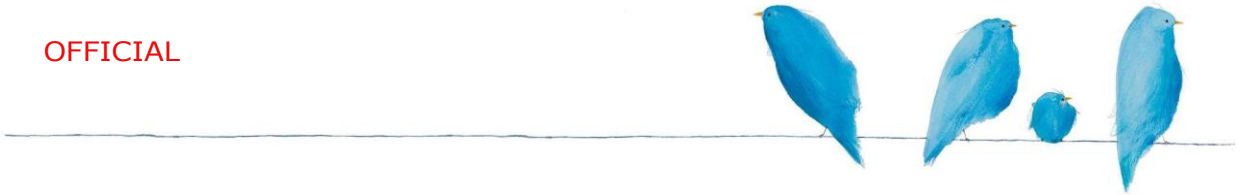


Note: Staff delegates should seek consultation from specialist services as required. Additional measures need to be taken to ensure information sharing practices have been done in a manner that is non-discriminatory and culturally sensitive.

Resource 5: Information Sharing Scheme Workflow - Voluntarily Sharing Information

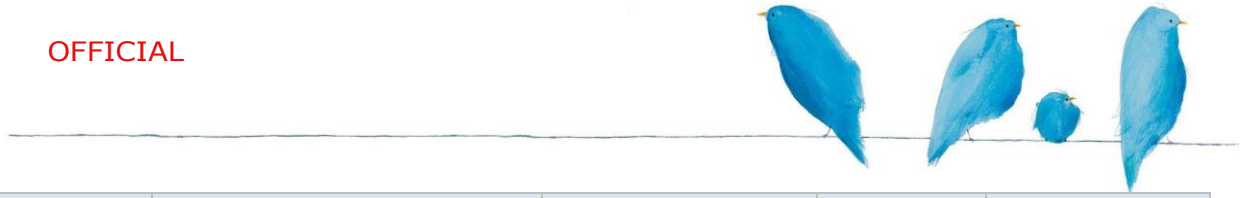


Note: Staff delegates should seek consultation from specialist services as required. Additional measures need to be taken to ensure information sharing practices have been done in a manner that is non-discriminatory and culturally sensitive.

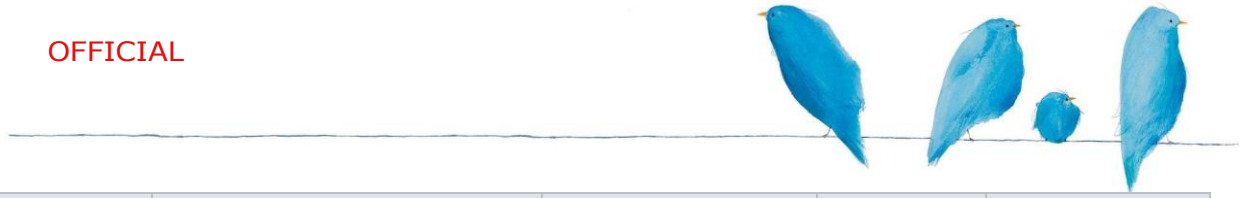


Resource 6: Information Sharing Reforms: Implementation Plan (example)

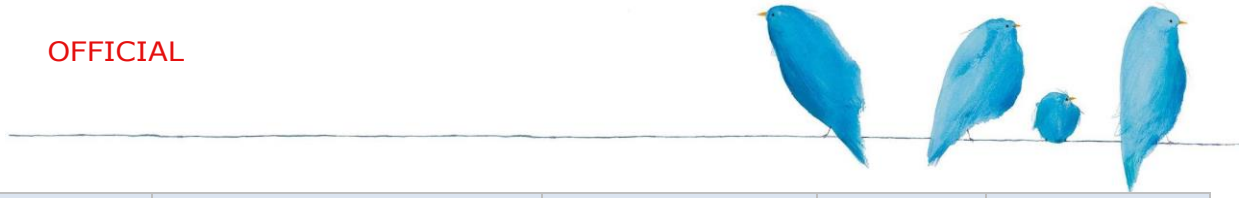
No.	Change Area	Future State	Current Gap	Recommended Actions	Recommended Roles / Groups	Allocated Timeline	Requirements Checklist (Product outcomes only)
1.	Policies and procedures	Network-wide policy to inform and guide practice.	Not currently available.	Draft policy to be developed by ISS Lead with review and input by key stakeholders (Legal, SHRFV, Specialist Family Violence Advisor, Social Work, Health Information Management, Freedom of Information team, Information Technology department).	ISS Lead, Delegated Working Group,		☐ Information Sharing Policy (CISS and FVISS) ☐ Information Sharing Procedure (CISS and FVISS)
		All requests for information and voluntary sharing of information are standardised on a comprehensive form, and systems set up when requesting information from another ISE – allow options for urgent/emergency/crisis sharing.	Generic templates are available, but not specific to the integrated health service.	Form to be drafted and endorsed by implementation working group and Executive governance committee. Electronic copy built into EMR [specify location]. The form is to be available on the intranet and external hospital website, along with an explanation of the process to be followed.	ISS Lead, Health Information Services (HIS) and IT		☐ Information Sharing Request Form ☐ After-hours Implementation Plan ☐ Sample Precedent Letter Templates



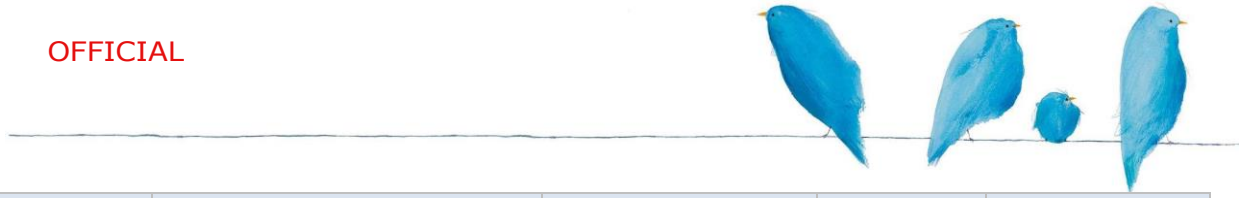
No.	Change Area	Future State	Current Gap	Recommended Actions	Recommended Roles / Groups	Allocated Timeline	Requirements Checklist (Product outcomes only)
		After hours process in place to respond to urgent requests. Development of precedent letter templates, outlining reason for sharing/ not sharing information that has been requested by another ISE.	No formal system currently in place. Potentially time-consuming process for delegates to construct individual responses to requests.	Procedures to be put into place to ensure urgent out of hours responses can be managed by Senior Site Nurses and Exec-on-call as required. Four precedent letter templates will be drafted (two for each scheme either allowing or denying the sharing of information. These will include drop-down options of the reasons why the request was/ was not granted.	Implementation Working Group and Manager of Senior Site Nurses. ISS Lead with review by Legal		
2.	Roles and responsibilities	• Clear allocation of delegated staff who will have internal decision-making authority to share relevant information under the Schemes. • These staff will have been assigned or mapped against MARAM responsibility 6 under MARAM.	Not in place	List of delegates from key departments to be developed and authorised by management as having independent decision-making authority. An overview of Roles and Responsibilities document to be developed to guide expectations around this function.	• Management of prescribed departments to nominate delegates. • Roles and Responsibilities guide to be developed by ISS Lead with input from Implementation Working Group.		☐ Roles and Responsibilities Mapping Document / Plan ☐ Updated Position Description



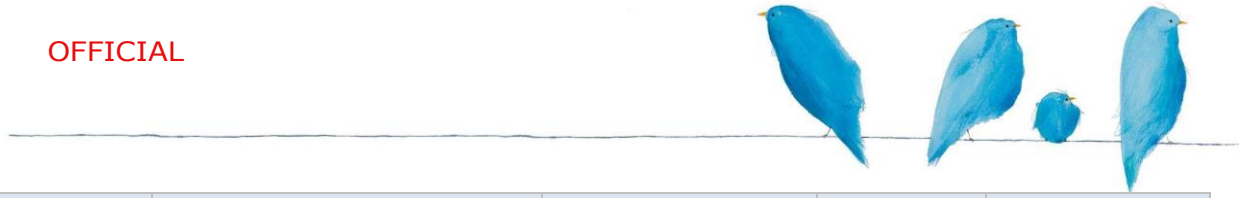
No.	Change Area	Future State	Current Gap	Recommended Actions	Recommended Roles / Groups	Allocated Timeline	Requirements Checklist (Product outcomes only)
3.	Systems and technology	• To create central email point for all requests for information under the Schemes. • Use of secure electronic systems to ensure privacy and security compliance.	No formal process in place. There is a danger of utilising unnecessary resources if requests go through reception or clinical central intake lines.	• To establish a central email address. This will be managed by the Freedom of Information (FOI) team and forwarded onto relevant delegate group via new email distribution lists. • Each delegate group will be responsible for determining if the requesting agency is an ISE and whether the request meets the legislative thresholds for sharing. • Any permissible and relevant information will be collated by the delegate and sent back to the requesting agency using encrypted software (eg. Liquid Files).	HIS, FOI team, IT with guidance by the Implementation Working Group.		☐ Information Sharing Email address ☐ IT Data Security Plan / Physical Records Security Plan
4.	Change management	All staff working within prescribed ISE program areas are to be knowledgeable and confident regarding the	• Executive and Leadership need a clear understanding of the hospital's obligations under the	• Executive briefings to occur outlining obligations from the legislation changes and the workflow processes to be	ISS Lead with support from Executive Governance		☐ Governance Structure



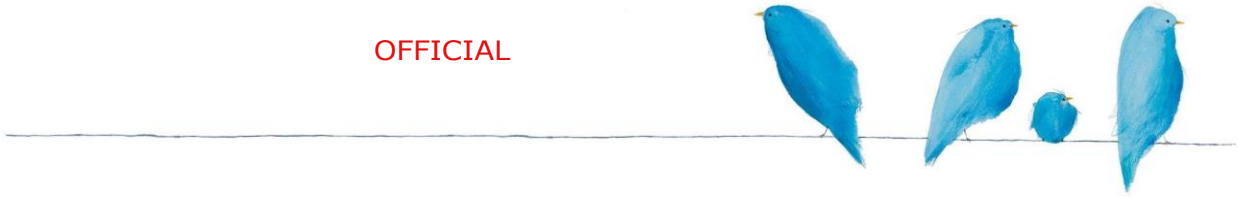
No.	Change Area	Future State	Current Gap	Recommended Actions	Recommended Roles / Groups	Allocated Timeline	Requirements Checklist (Product outcomes only)
		legislation and changes to practice.	Schemes, and provide a positive cultural shift within the organisation. • There is a current lack of understanding with many clinicians about the purpose and function of the Schemes. There is a potential that some clinicians may be concerned that this legislation may have a negative impact on client engagement.	undertaken within the integrated health service. • Presentation to be delivered at Heads of Department meeting. • Face-to-face information sessions will be conducted and are to clearly outline the purpose of the Schemes, and allow space for clinicians to share any apprehensions, and brainstorm strategies to ensure effective communication and engagement with clients.	Committee and Executive Sponsor.		
5.	Staff capability building	All impacted workforces are to be trained to the level relevant to their role.	A portion of the workforce would have participated in the SHRFV Foundational Practice and Sensitive practice training. This now covers practice expectations to contribute to information sharing, yet is not required to go into detail. The majority of staff would not have completed in-depth	Staff to complete required ISS online training developed by DFFH Modules 1-3 Information Sharing and MARAM Online Learning System	SHRFV, Specialist Family Violence Advisor with coordination by ISS Lead.		☐ Induction and Training Plan for All Staff ☐ Tailored Training as Required



No.	Change Area	Future State	Current Gap	Recommended Actions	Recommended Roles / Groups	Allocated Timeline	Requirements Checklist (Product outcomes only)
			training pertaining to the Information Sharing Schemes.				
6.	Communications	• Staff at all levels are to have a good understanding of both Schemes, and feel confident with internal processes relevant to their position. • Information is to be available to clients (both written and verbal) outlining the provision that some of their personal information may be shared with other authorised entities as required by law. • External organisations authorised as ISEs have a sound understanding of how they can request and share information with our hospital under the Schemes,	• Beyond existing ISE programs of Mental Health, AOD and Family Violence Services, large staffing cohorts are yet to acquire knowledge about the Schemes and how they can be operationalised within their area of practice. • Written material in currently in place (eg, Privacy Statement), yet this may need to be updated to reflect new legislation changes. • External ISEs would not have an awareness of how to request or voluntarily share information with our service.	• Email communications to be sent to all departments in scope to provide an overview of the Schemes and links to resources. • Managers are to ensure that online training is completed by their staffing groups in line with the function they perform in relation to Information Sharing. • Expanding upon existing information material for clients regarding their Privacy and Confidentiality, and any legal exceptions for this. This should be provided to clients when first entering a program of the integrated health service, and serve as a prompt for a discussion with the client around instances where their information may need to be shared.	• ISS Lead, in partnership with management of prescribed departments. • ISS Lead and management of prescribed departments. • Implementation Working Group with support from People and Culture-Communications department.		☐ Communication Plan



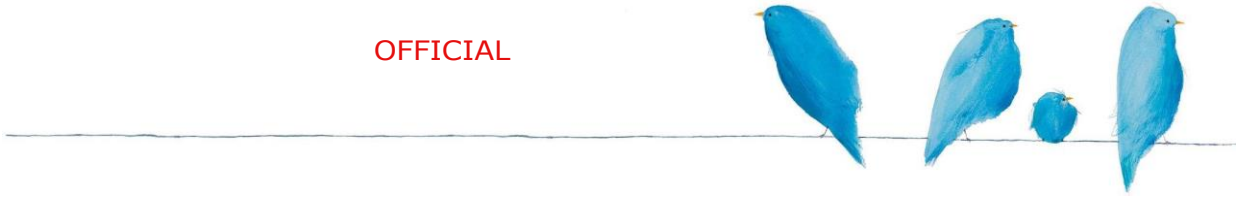
No.	Change Area	Future State	Current Gap	Recommended Actions	Recommended Roles / Groups	Allocated Timeline	Requirements Checklist (Product outcomes only)
		promoting collaboration for improved client outcomes.		• A Communication plan is to be developed. This includes details of the central email address for requests, where to access this in the future and a document outlining the process to be followed.			



Appendix 3: Example case studies for staff training

Overview of Case Studies

Case Study	Keywords
One	Antenatal, Emergency Department (ED)
Two	Elder abuse, Community Rehabilitation Program (CRP)
Three	Children, Emergency Department of a Paediatric Hospital



Case Study One

Ashleigh is a 32-year-old woman who is triaged in the Emergency Department (ED), reporting that she slipped down a set of stairs and injured her left shoulder. X-rays are taken, and significant bruising is noted by medical staff, including older bruises around both upper forearms. Ashleigh reports she slipped down last few steps of the staircase at her partner's home and impacted into the wall. She reported that she had to drive herself to ED, as she "wasn't safe" and "had to get out of there". Sensitive enquiry about family violence are made by the ED nurse. Ashleigh did not disclose any family violence. Nursing staff noted that she appeared agitated and under the influence of alcohol. Along with other testing a Blood Alcohol Content (BAC) was taken showing 0.09 %.

Q: The ED nurse speaks to the NUM (ISS delegate) as to whether they could contact The Orange Door to see if Ashleigh has had recent involvement and whether family violence is occurring.
Can the nurse share Ashleigh's information with The Orange Door to make a referral without her consent?
A: No. The integrated health service is not a Risk Assessment Entity, and family violence has not yet been identified or disclosed.

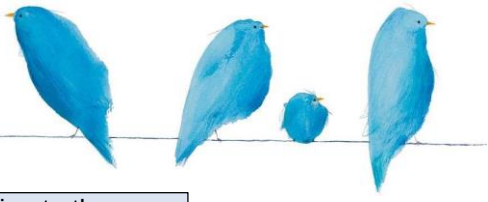
After shift change, Ashleigh reports to the nursing staff that she has received a number of increasingly threatening text messages on her mobile phone from her partner, Scott. She shows these to the ED nurse and then discloses that she is experiencing physical assaults from her partner, which are becoming more frequent. Ashleigh states that the recent incident occurred when Scott was pressuring her for sex. When she declined, he grabbed her by both arms, shook her violently and threw her against the wall, injuring her shoulder.

Ashleigh reports that she had consumed too much alcohol to drive, but states she felt terrified as how he may further hurt her, so drove herself to the Emergency Department.

Q. A referral is made to the ED Social Worker who undertakes a MARAM Intermediate Risk Assessment. During this assessment, the person using violence, Scott, is identified as a current client of the Mental Health service. If the social worker wanted to gather information from the mental health service, what ISS could be used to request information?
1. CISS
2. FVISS
3. CISS or FVISS
4. S. 192 of the Children Youth & Families Act, 2005

A: The correct answer is 2. FVISS

Recent medical record entries from Scott's Mental Health case manager outline episodes of suicidal ideation and threats, particularly in the context of arguments with Ashleigh, paranoid and persecutory thoughts centring around Ashleigh, with Scott fixated on the unsubstantiated belief that she has been unfaithful to him. It is also noted that Scott has been using alcohol and marijuana on a daily basis, and frequent methamphetamine use. He has declined referrals to an AOD service.



Q: Can the ED Social Worker proactively share relevant information to the Mental Health case manager about their client (Scott) and the family violence risks towards his partner?
A: Yes, consent is not needed from the person using family violence when sharing information with another ISE relevant to managing a family violence risk. However, practitioners need to assess if sharing information will impact on the safety of the Victim/ Survivor.

Ashleigh confides that she has been drinking excess alcohol in recent months to manage the stress and anxiety from the relationship. She has recently linked in with an Alcohol and Other Drug (AOD) service to try to reduce this intake. Her medical records also show recent mental health service involvement after Ashleigh's friends contacted mental health triage with concerns about increased signs of anxiety and depression. After short-term community mental health involvement, Ashleigh was discharged from the service to a safe accommodation as Scott remains living at the shared property, with follow-up care to be provided by Ashleigh's General Practitioner (GP).

Q: Under FVISS can proactive sharing be made from the hospital to the AOD service? And is Ashleigh's consent required?
A: Only relevant information that is necessary to lessen or prevent a serious threat to an individual's life, health, safety or welfare can be shared. In this case, provided the AOD service is confirmed as an Information Sharing Entity, information can be shared from the mental health service.
As sharing information is permissible to lessen or prevent a serious threat to an individual's life, health, safety or welfare, consent is not required.
However, ISEs should involve victim survivors in the process to gain their views and to ensure that they understand that only information that is necessary to prevent or lessen the serious threat will be shared.

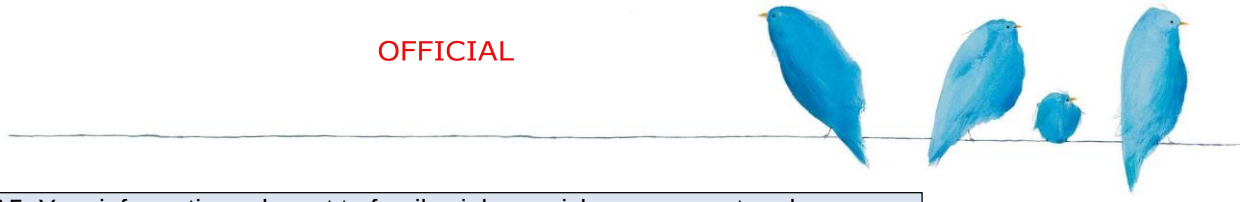
Ashleigh states that Scott had not sexually assaulted her previously, however she reports increasing jealous and obsessive behaviour towards her, with Scott often stating that she should engage in sexual activity with him to prove that she isn't being sexually intimate with anybody else.

When provided with an option for a referral, Ashleigh declines a referral to the Centre Against Sexual Assault, however with support from the ED Social Worker, Ashleigh decides to report the physical assault to Police and engage with the Orange Door. A warm referral to Orange Door intake is made within ED, and Ashleigh consents to ED Social Worker sharing the MARAM Intermediate tool with the Intake worker.

Plans are made with the local Police unit for Ashleigh to present to the station upon discharge from ED and make a formal statement regarding the assault.

The X-ray report does not show any fractures, and Ashleigh is cleared from the ED and Orthopaedic team to be discharged home with GP follow up and proactive sharing with the GP with Ashleigh's consent. Safety planning has occurred with both the ED Social Worker and Orange Door Practitioner, with Ashleigh reporting feeling safe to return to her own home with Orange Door and Police engagement.

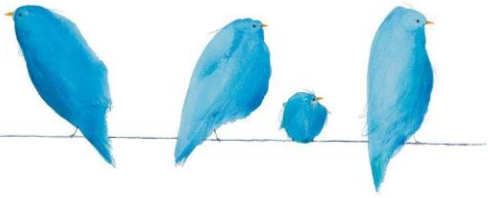
Q: Two days following this incident, a written ISS request is received from the Men's Team within The Orange Door. They are requesting information about Scott, in particular information about any AOD use and current mental health assessments including identified risks. Can this be shared with the Men's Team and how much detail should be shared?



A5. Yes, information relevant to family violence risk assessment and management can be shared with the Men's Team (Risk Assessment Entity) without the consent of the Person Using Violence.

A week after Ashleigh has made a statement to the Police regarding the assault, a written ISS request from the Police is received. They are requesting medical assessments and findings from her recent ED presentation, and also her Blood Alcohol Content reading that was taken at this time.

Q: Under FVISS can the hospital provide information regarding Ashleigh's medical assessments and Blood Alcohol Content reading to the police?
A: No, If the information requested is not relevant to assessing or managing a family violence risk, it cannot be shared under ISS. Police requests for medical record information can be directed to the MedicoLegal department for consideration if sharing is permissible under other legislation.



Case Study Two

Tom is a 75-year-old male with a degenerative vision impairment who lives by himself on acreage in a regional area of Victoria. Tom has previously relied on his wife Ellie to assist with activities of daily living, but Ellie died suddenly two years ago after a cardiac arrest. Tom does not have any children and Tom's only relative is a sister who lives in far North Queensland.

Two months ago, Tom was hospitalised due to injuries sustained after a fall at home and he has recently completed an inpatient rehabilitation stay and has now been discharged home. He has been referred to the Community Rehabilitation Program (CRP) for further support and ongoing outpatient rehabilitation.

Although Tom has an aged care package provider and a case manager, Tom now prefers to rely on his closest neighbour Steven, whom he has known for several years, for assistance with transport and to complete tasks such as grocery shopping, attending medical appointments and paying bills.

During initial engagement and assessment with the CRP social worker, it is identified that after the death of Tom's wife, Steven became more involved in assisting Tom with some of his daily activities and Steven transports and attends all of Tom's CRP appointments with Tom.

The CRP social worker observes controlling behaviours and responses from Steve when he attends appointments with Tom including not allowing Tom to speak for himself and putting him down.

During a private moment without Steve, the CRP social worker seeks Tom's consent to share information about Tom's rehabilitation goals and progress with the aged care provider case manager and Tom's GP but Tom declines as he is a very private person and doesn't want his "business" being discussed with others.

Q: Can proactive information sharing be made to a service regarding Tom at this point? If yes, to what services?

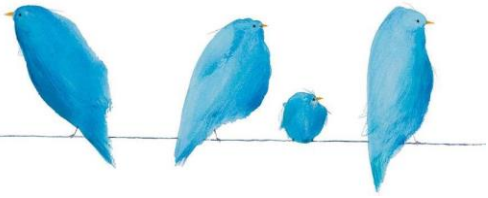
A: After Tom's disclosure of his financial situation and the possibility of isolation from services and supports, the social worker submits an information share without consent to the case manager and GP due to the risk of financial abuse.

Q: Is consent required? Why or why not?

A: When sharing information about a victim survivor who is an adult, an ISE should seek the consent of the adult before sharing information. However, consent is *not* required if the ISE reasonably believes that the collection, use or disclosure of the confidential information is necessary to lessen or prevent a serious threat to life, health, safety or welfare.

After several weeks, the social worker sees Tom on his own after Steven drops him off for his appointment and leaves due to other commitments, arranging to pick Tom up again later.

With further discussion about his current situation, Tom discloses that Steven has Tom's ATM card and pin number, and Tom no longer knows what his bank account balance is and does not receive paper statements anymore and he relies on Steven to do grocery shopping, bill paying and for transport to Tom's regular GP appointments. Tom is happy with this arrangement and does not express any concerns about Steven's management of his finances or appointments.



Q: Based on what Tom has disclosed so far, what are the signs that may indicate elder abuse?

A: Identified indicators of elder abuse includes:

Financial abuse/difficulties, controlling behaviours, and isolation.

- Tom has few family and social supports and is isolated.
- Tom is not in control of his own finances or ATM card and has delegated this responsibility to his neighbour without any oversight of a third party.

It is important to explore Tom's wishes and views and support him with overcoming barriers including:

- Tom does not want to share any information about his situation and is reluctant for others to know any details of his financial and/or health issues.
- Tom states that one of his reasons for not wanting to share information about himself with support services is that he doesn't want to get anyone into trouble.

The social worker again seeks consent to share information with Tom's case manager and GP but Tom again declines stating he doesn't want to get anyone into trouble.

Tom states he has a trusted relationship with his GP who he has been seeing for many years and Tom says that he would seek support and advice from his GP as a first point of call with any concerns that Tom may have.

Tom also states that he is thinking about declining the supports provided by his aged care package as he no longer needs them as Steven "does all that stuff now".

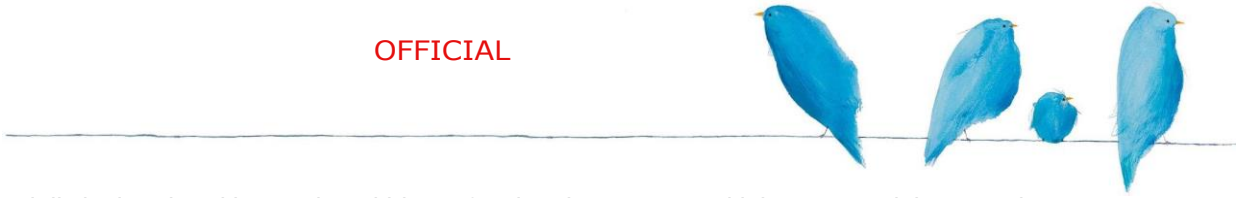
Q: What information should be gathered and recorded for Tom

A: Information gathered during assessment and ongoing service provision should be recorded for Tom as per usual case note recording and documentation. Information regarding any concerns for Tom's health, safety or welfare should be documented with thought given to the sensitivity of the information and how this information will be stored and accessed and by whom.

It is a requirement of the Information Sharing Scheme that a record of disclosures of confidential information, including a record of whether or not consent was gained from an adult victim survivor.

As a patient of the integrated health service, the CRP social worker does have a duty of care to take appropriate steps to ensure Tom's health, safety and welfare.

Given Tom has declined consent to share information, the social worker carefully considers what information to share with both the GP and the home care package provider in order to assist with their further assessment and management of Tom's situation.



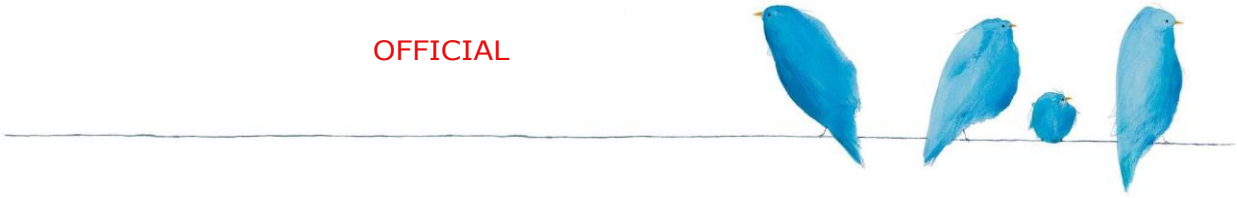
Yes, Tom is socially isolated and has reduced his professional supports and it is assessed that Tom is vulnerable to elder abuse, particularly financial abuse. The social worker ensures that the GP and package provider are aware that Tom has not consented to his information being shared in order to prevent any further isolation and withdrawal of Tom from his trusted supports.

Q: Should Tom be informed that his information has been shared without his consent?

A: Careful consideration should be given to informing Tom of the information being shared without his consent.

Informing him may contribute to Tom's further disengagement from essential health and social supports which would place him at further risk of threat to his welfare.

However not informing Tom could significantly impact on his feeling safe to contact other support / health services which could place him at great risk.



Case Study Three

Mary presents to the Emergency Department (ED) of a Paediatric Hospital with James aged 13 months and Sally aged 6 years. Sally fractured her arm after falling off the backyard trampoline. Eric, the children's father, is at work and not aware of the accident. Mary explains that he works long hours, expects her to solely care for the children and may blame her for Sally's injury. An ED nurse sensitively asks Mary some screening questions and she indicates she feels safe to return home. Sally's arm is assessed and put in a cast. They are advised to return to the Fracture Clinic in two weeks for further assessment. With Mary's consent, a referral is made to the Orthopaedic Social Worker for phone follow up with her. The Social Worker (SW) calls multiple times but is not able to contact Mary.

Q. Sally is not brought to multiple fracture clinic appointments and several attempts to phone her mother, Mary are not successful. The hospital social worker is concerned for Sally's wellbeing and decides to contact her school. Is Mary's consent required before the social worker contacts the school? What IIS would be used?

A. CISS is the ISS. Mary's consent is not required. Usually Mary's consent would be obtained prior to contacting the school as is best practice, however she has been uncontactable so this is not possible. Mary's consent is not required to shared information here given there are children involved with wellbeing concerns. CISS is used in this instance to share information.

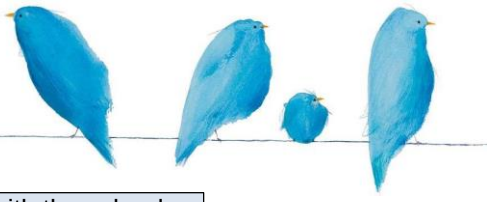
The SW speaks with the Assistant Principal. She proactively shares information using CISS and informs the SW that Sally is usually a good attender however Mary reports that she has been refusing to come to school over the last few weeks. The Assistant Principal comments that a week ago Sally told her teacher that her mummy and daddy are always fighting, and this makes her scared, so she wants to stay with her mum during the day. The Assistant Principal tried to call Mary last week about this and has left several messages without making contact. She has been concerned and is glad the hospital SW has called.

The hospital SW contacts the community Maternal and Child Health Nurse. Using CISS, the Maternal and Child Health nurse proactively shares that James is meeting his developmental milestones and growing appropriately however has been an unsettled infant and this has been challenging for Mary. She does not raise any direct concerns about family violence.

The SW is considering making a request for information to Child Protection (CP) regarding Sally and James to determine if they have a history and/or are currently involved.

Q. If the hospital SW did contact CP to seek information what ISS could be used to request information?
1. CISS
2. FVISS
3. CISS or FVISS
4. S. 192 of the Children Youth & Families Act, 2005

A: Correct answer is 3. CISS or FVISS.
CISS could be used because the threshold for wellbeing concerns has been met here with the failure to attend the fracture clinic.



FVISS could also be used as FV has been identified in the contact with the school and a protection purpose established.

Before the SW can make the request to child protection, she receives a Request for Information (ROI) request under section 192 of the Children, Youth and Families Act 2005 (CYFA 2005) from child protection. The letter detailing the request documents that CP has received a report and need the medical attendance records of the children and any documentation of medical or psychosocial concerns to assist with their assessment of risk. The SW contacts the CP worker directly who proactively shares under FVISS/CISS by advising that a L17 has been received from police who attended the family home in relation to a family violence incident. Mary was physically assaulted by Eric on the previous Sunday evening and sustained bruising to her ribs. Both children were asleep at the time. Police took out a complaint and warrant on behalf of Mary and the children and removed Eric from the home.

Q. Does the SW as an Information Sharing Delegate have a responsibility to record the request from Child Protection in the hospital records and document what is shared?

A. Yes. The hospital should keep a record of the information sharing request and document what is shared.

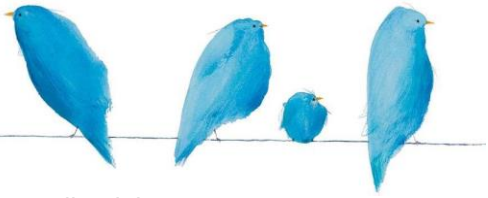
The SW as the delegated information sharer, provides the requested information to Child Protection under s.192 of the CYFA (2005). They determine that the information requested is reasonable and relevant to the purpose outlined in the letter provided.

Child Protection using s.192 of the Children Youth and Families Act, 2005 request that the social worker shares the medical history of Mary's sister Paula Smith. The social worker does not share this information because she believes it does not meet the assessment purpose. How should she manage declining this request?

A. Tell her Team Leader that she has declined the CP request.
B. Tell Mary that Child Protection have made contact and she has declined their information sharing request.
C. Discusses this with the Team Leader if the request is appropriate. If it is determined to not be, write to Child Protection outlining the reason for declining the request and scan the response into the medical record as documentation of the outcome.
D. Document a rationale in the medical record for declining the request.

Answer: C. is the correct answer. The information requested should be relevant to the assessment purpose. The outcome should be documented by the organisation in their records and an outcome sent to CP. It is a good practice to confirm the decision with a supervisor, particularly if you are unsure, however follow your organisation's procedure in relation to this.

Under the FVISS, Child Protection **proactively share** a history of involvement with Sally and James that includes three previous reports in relation to family violence. Two reports were closed at intake in



2021 and one was investigated in January 2022 with a referral to Berry Street Family Violence program. Child Protection inform the SW that Berry Street Family Violence Program remains involved and is continuing to support Mary and the children. They suggest the hospital SW contacts the Berry Street Worker who has an established relationship with Mary and is fully aware of the current situation.

Q. The CP practitioner identifies some information in their file about Eric's criminal background that relates to an upcoming court hearing. They are worried about sharing this as it could be 'Excluded Information.' What should they do?
1. Share the information as Eric is an adult using violence and given this, his consent is not required.
2. Speak with their Team Manager and recommend a legal consult is obtained to determine if the information constitutes 'Excluded Information' and should not be shared.
3. Not share the information.

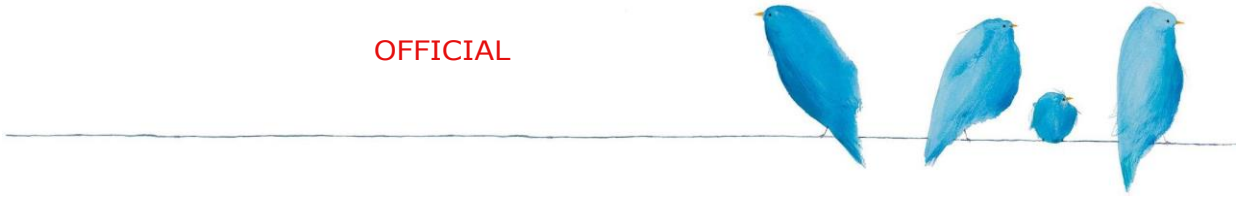
Answer: 2. Speak with their Team Manager and recommend a legal consult is obtained to determine if the information constitutes 'Excluded Information' and should not be shared.
See section in yellow at the bottom of the case scenario titled 'Excluded Information.' This could be provided here to explain what may constitute excluded information.

The hospital SW calls the Berry Street Worker and **proactively** shares (under FVISS/CISS) their contact with CP, confirming the Berry Street Worker's involvement with Mary. The SW informs the Berry Street Worker of their difficulty in contacting Mary to follow up Sally's non-attendance at the Fracture Clinic, and their concern for Sally's safety and wellbeing. **FVISS or CISS could be used in this instance to proactively share as there is now a clear family violence concern (higher threshold) as well as child wellbeing concerns.**

Child Protection using s.192 of the Children Youth and Families Act, 2005 request that the social worker shares the medical history of Mary's sister Paula Smith. The social worker does not share this information because she believes it does not meet the assessment purpose. How should she manage declining this request?
A. Tell her Team Leader that she has declined the Child Protection request.
B. Tell Mary that Child Protection have made contact and she has declined their information sharing request.
C. Discusses this with the Team Leader if the request is appropriate. If determine to not be, write to Child Protection outlining the reason for declining the request and scan the response into the medical record as documentation of the outcome.
D. Document a rationale in the medical record for declining the request.

Answer: C. is the correct answer. The information requested should be relevant to the assessment purpose. The outcome should be documented by the organisation in their records and an outcome sent to Child Protection. It is a good practice to confirm the decision with a supervisor, particularly if you are unsure, however follow your organisation's procedure in relation to this.

Given Mary is assessed to be a victim/survivor, the Berry Street Worker appropriately suggests she contacts her to seek consent to share her information and that of the children, with the hospital SW.



Q. If Mary disagreed with the information being shared could the Berry St worker still share the information?

A. No the information could not be shared without Mary's consent.
B. Given there are children involved, Mary's consent is not required to share information if a protection purpose is established and the information is relevant, not excluded information and if there is a serious threat.
C. As there is FV Mary's consent is not required.

Answer: B. Given there are children involved, Mary's consent is not required to share information if a protection purpose is established and the information is relevant, not excluded information and if there is a serious threat. If Mary disagrees with the information being shared the Berry St Worker should explain to her as there are child safety concerns (protection purpose) she is required to share the information under the FVISS.

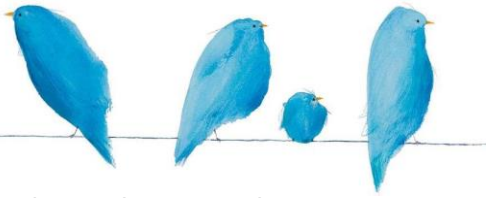
Mary and the children's information can only be shared if it is *relevant*, is *not excluded information* and if there is *a serious threat*. The Berry Street Worker agrees to ask Mary to contact the hospital SW.

Mary calls the SW and makes another appointment for Sally in the Fracture Clinic. She provides consent for SW to share the children's medical information with the Berry Street Worker. She comments that she has also provided consent for Berry Street Worker to share information with the SW under FVISS. With consent, the Berry Street Worker shares their MARAM (Multi Agency Risk Assessment and Management) assessment and risk management plan with the hospital SW. She also shares a copy of the Interim Intervention Order with full exclusions, where both Mary and the children as listed as affected family members. The hospital SW scans this into the children's medical records.

Q. What should the SW do when she receives a MARAM comprehensive assessment and a copy of the Intervention Order from the Berry St worker?
A. She should read the information and shred it.
B. Once received it forms part of the children's medical records, so she should scan in into the EMR and referenced in alerts and case notes.
C. She should make the Multi-Disciplinary Team (MDT) aware of the information and then shred it.

Answer: B. Once received it forms part of the children's medical records, so it is scanned into the EMR and referenced in alerts and case notes. It is important that these documents are recorded and able to be located by appropriate hospital staff to assist with safety planning.

As part of their investigation under the CYFA (2005), the CP worker coordinates a care team meeting between the hospital SW, the Berry Street Worker, school and Maternal and Child Health nurse for further assessment, risk management and planning. Mary is aware of the meeting and has provided consent to all professionals for information sharing under the FVISS so information can be shared that relates to the safety and wellbeing of both Mary and the children. The FVISS and CISS are both applicable in relation to information sharing about the children given there is FV (FVISS) and child safety/wellbeing concerns (CISS). As these organisations are ISEs and Child Protection is a RAE (a



subset of an ISE) under the FVISS information can be shared for FV protection (*protection purpose*) this includes ongoing assessment. The Berry Street Worker has been in contact with the Men's Referral Service who have confirmed that the father, Eric has relocated to Sunbury and has engaged in counselling to address his violent behaviour.

Q. When the Berry St Worker contacts the Men's Referral Service is Eric's consent required for the Men's Referral Service to share information about his engagement with their service?

A. Eric's consent is not required in this instance as he is identified as a adult using family violence. The Men's Referral Service can share this information without Eric's consent because it is being used to assess and manage risk of FV.

Two months later the hospital SW receives a delegated Freedom of Information (FOI) request from the father, Eric for both children's medical records. All case notes detailing the FV concerns, assessment and planning are not shared using the family violence risk exception because the documents: identify Mary as providing information about Eric and contain information that may increase the family violence risk for Mary and the children.

Q: What information can be shared with Eric?

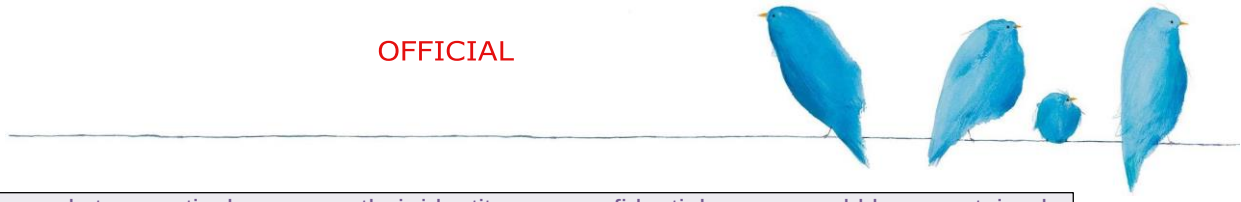
A. A intermediate MARAM assessment.
B. Case notes detailing Mary's disclosures of family violence and fear of Eric.
C. A medical note detailing only Sally's progress medically.
D. Case notes detailing the school's contact with the hospital with concerns about Sally's attendance and her disclosure that her parents' fighting makes her scared.

Answer: C. A medical note detailing only Sally's progress medically. All other options contain sensitive and/or third party information and should not be shared with Eric under FOI.

Excluded information

Information is excluded from the Scheme and should not be shared under Part 5A if, given the facts known to the worker, sharing that information could be reasonably expected to:

1. endanger a person's life or result in physical injury (e.g. if sharing the address of the victim survivor could alert a person known to pose a threat to their whereabouts then this information should not be shared)
2. prejudice the investigation of a breach or possible breach of the law or the enforcement or proper administration of the law in a particular instance (e.g. if information reveals the details of a police investigation)
3. prejudice a coronial inquest or inquiry or the fair trial of a person or the impartial adjudication of a particular case (e.g. if the information was cited as evidence in a closed session of the court)
4. disclose the contents of a document or a communication that would be privileged from production in legal proceedings on the ground of legal professional privilege or client legal privilege
5. disclose, or enable a person to ascertain, the identity of a confidential source of information in relation to the enforcement or administration of the law (e.g. where certain information is

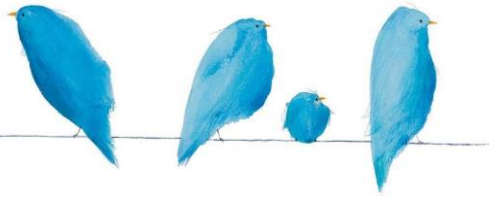


known only to a particular person, their identity as a confidential source could be ascertained if that information was shared)

6. contravene a court order or law that prohibits or restricts, or authorises a court or tribunal to prohibit or restrict, the publication or other disclosure of information for or in connection with any proceeding
7. contravene a court order or law that requires or authorises a court or tribunal to close any proceeding to the public (e.g. if the Court closes proceedings under Section 30 of the *Open Courts Act 2013* or Section 68 of
8. the Family Violence Protection Act on the basis that an affected family member, protected person or witness may be caused distress or embarrassment, then an ISE would not be able to share information about the proceedings that took place in closed court)

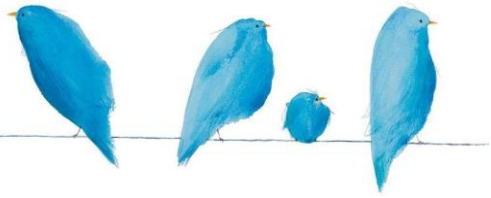
9. be contrary to the public interest (e.g. information that could reveal covert investigative techniques).

It may be necessary for an ISE to obtain legal advice to determine if any of these exemptions apply. ISEs may also have their own specific guidelines (consistent with these Guidelines) to further assist staff to understand these exceptions.



Glossary of Terms

Child:	A person who is under 18 years of age
CISS:	**C**hild **I**nformation **S**haring **S**cheme enables information sharing between authorised organisations to promote a child's wellbeing or safety
FOI:	**F**reedom **O**f **I**nformation
FVISS:	**F**amily **V**iolence **I**nformation **S**haring **S**cheme enables the sharing of information between authorised organisations to assess and manage family violence risk.
Hospitals and integrated health services:	Refers to public hospitals and integrated health services that are prescribed as an Information Sharing Entity under the Information Sharing Schemes
ISE:	**I**nformation **S**haring **E**ntity as prescribed under CISS and or FVISS
MARAM:	**M**ulti-**A**gency **R**isk **A**ssessment and **M**anagement Framework
RAE:	**R**isk **A**ssessment **E**ntity – a subset of ISEs and may request information for a family violence assessment purpose under FVISS
Schemes:	Term used to reference both the Family Violence Information Sharing Scheme (FVISS) and the Child Information Sharing Scheme (CISS)
Staff delegates:	Staff who have been nominated and authorised internally by the organisation to make decisions relating to the disclosures of information under FVISS and CISS.
Alleged perpetrator:	A person who is alleged to pose a risk of committing family violence. Information about alleged perpetrators can only be shared with risk assessment entities for a family violence assessment purpose.
Third Party:	Any person whose confidential information is relevant to assessing or managing family violence risk but is not perpetrator or alleged perpetrator.
Diverse communities	In line with MARAM framework, diverse communities refer to the following groups: diverse cultural, linguistic and faith communities; people living with a disability; people experiencing mental health issues; lesbian, gay, bisexual, trans and gender diverse, intersex and queer/questioning (LGBTIQ) people; women in or exiting prison or forensic institutions; people who work in the sex industry; people living in regional, remote and rural communities; male victims; older people and young people (12–25 years of age).



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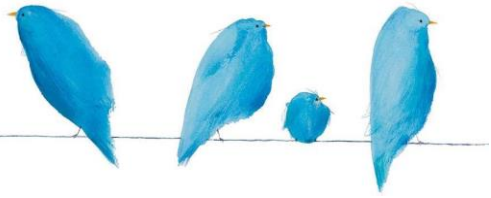

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Acknowledgements

Sharan Ermel Strengthening Hospital Responses to Family Violence Regional Sector Coordinator, Bendigo Health.

Rebecca Mills Program Manager, Vulnerable Children & Family Violence, The Royal Children's Hospital.

Christie Tran (Health) Senior Policy Advisor | Priority Projects, Department of Health.

Joan Kennedy (Health) Manager | Workforce Wellbeing and Priority Projects, Department of Health.

Dianne Rokvic Social Worker, Women's Alcohol and Drug Service (WADS), The Royal Women's Hospital.

Renee Blight Safeguarding, Strategy and Reform Practice Lead, Peninsula Health.

Amanda Morris Senior Program Manager Family Violence | Strengthening Hospital Responses to Family Violence (SHRFV), Statewide Lead (Metropolitan Sector), The Royal Women's Hospital.

Christina Coldebella Social Work Team Leader, The Royal Women's Hospital.

Jacinta Bourke Acting Manager Social Work, Barwon Health.

Cherann Edwards (Health) A/Manager | Workforce Wellbeing and Priority Projects, Department of Health.

Karen Todd Manager of Social Work, Strengthening Health-Hospital Response to Family Violence Lead, Barwon Health

Solmaz Yavari Project Officer Family Violence, The Royal Women's Hospital.

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