INQUIRY INTO SERVICE COORDINATION IN COMMUNITIES WITH HIGH SOCIAL NEEDS

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Opportunities for information sharing: Case studies

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Abbreviations

APP	Australian Privacy Principle
ASP	Accommodation Service Provider
CS	Community Services (NSW Family and Community Services – Community Services)
CYPCP Act	*Children and Young Persons (Care and Protection) Act 1998* (NSW)
DPC	NSW Department of Premier and Cabinet
FACS	NSW Department of Family and Community Services
GIPA Act	Government Information (Public Access) Act 2009 (NSW)
HASI	Housing and Accommodation Support Initiative
HPP	Health Privacy Principle
HREC	Human Research Ethics Committee
HRIP Act	*Health Records and Information Privacy Act 2002* (NSW)
IPP	Information Protection Principle
KiDS	Community Services information system
NCYLC	National Children's and Youth Law Centre
NGO	Non-government organisation
NSW	New South Wales
OOHC	Out Of Home Care
PPIP Act	*Privacy and Personal Information Protection Act 1998* (NSW)
SPRC	Social Policy Research Centre
WellNet	Information system used by Child Wellbeing Units

Executive Summary

This is the report of a project to research the exchange of personal information between government agencies, and between government and other sectors. The project was commissioned by the NSW Government Department of Premier and Cabinet (DPC) and conducted by the Social Policy Research Centre (SPRC) at UNSW Australia in partnership with the National Children's and Youth Law Centre (NCYLC).

The purpose of the project was to examine:

● the policy and legal context of information exchange

● how the policies are interpreted by different stakeholders

● gaps, enablers and opportunities for improving the sharing of personal information within and between government and non-government organisations to support more effective service delivery.

The methodology involved a short literature review and case studies of three areas of human service delivery:

● child welfare

● children moving between schools

● the Housing and Accommodation Support Initiative (HASI).

Each case study involved interviews with key stakeholders, including front line workers and managers, in relevant agencies and the development of case scenarios to examine the gaps and policy interpretations of different stakeholder groups. A small number of stakeholders were interviewed who have a generic engagement with information exchange across different policy domains. In all, 35 people were interviewed.

Research suggests that sharing information is often perceived to be complex by front line workers and agency managers. Many practitioners are reluctant to share information even when they have the legal authority to do so, and many agencies have a risk-averse attitude to information sharing even when this may be in the interests of clients. There is often a disparity between the actual legal and policy context and the perceptions of those involved.

Factors influencing information sharing can be viewed from three key perspectives:

● political/policy

● organisational

● technological.

Organisational factors are the most significant barriers (and enablers) of information sharing. Organisations with risk-averse cultures or those which value client confidentiality over other objectives are less likely to share information appropriately with other agencies.

Legislation and policy can also create significant barriers to information sharing. However, the research shows that the interpretation of these policies is more significant than policies themselves.

Technological barriers to information sharing include different data storage and client record formats and privacy protection in storage of information. However, the research indicates that technological barriers can generally be overcome where necessary.

Legislative Framework

The legislative framework has been developed to manage the tension between personal information sharing and information protection (privacy). Information sharing incorporates the duty or discretion to proactively share personal information and to respond to requests to share such information.

The legal provisions refer primarily to situations where it is not possible to gain consent from the information subject to exchange information. Best practice is to obtain informed consent from the information subject wherever possible.

Findings

Case study 1: Child welfare

Information is exchanged between statutory agencies such as Health, Family and Community Services (FACS), Education and Police, between statutory and non-government organisations (NGOs), and between NGOs when services are provided to children and families.

The legal and policy context for information sharing in child welfare is *Chapter 16A* of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)* (*CYPCP Act*).

Chapter 16A creates a mechanism for information sharing for child protection purposes between *prescribed bodies* and requires them to take reasonable steps to co-ordinate the provision of services.

Technological barriers, enablers and opportunities to sharing personal information

A number of technological issues were identified in this case study. These included:

- the incompatibility between different health databases

- difficulties with the way information is stored on the database used by the Child Wellbeing Units of Education, Health and Police ("WellNet") and technical issues regarding access to information on this database by Police

- lack of a monitoring system which would track who is sharing information under Chapter 16A and with whom it is being shared

- lack of a system to help workers know of agencies that may have information about their clients.

However, none of these were seen as significant barriers. Confident and experienced workers could navigate the technical challenges and share information appropriately. Nevertheless, addressing some of the technical issues would facilitate appropriate information sharing. Technology is improving constantly, and this is likely to facilitate improvements in the ability of agency records to be shared.

Organisational barriers, enablers and opportunities to sharing personal information

Many organisational barriers around information sharing in child welfare have been addressed in recent years. The level of awareness amongst the workforce of Chapter 16A was high. However, there was room for improvement in a number of areas. For example:

- There is a risk-averse culture in many human service agencies.

- There are gaps between perceptions and actual legislative and policy constraints, in particular regarding agencies proactively sharing information.

- There is a reluctance to discuss with families the need to share information; workers were likely either to report to the child protection Helpline or not share the information.

- Many workers reported not knowing who to ask for advice about when information should be shared and the process for exchanging information.

Political/policy barriers, enablers and opportunities to sharing personal information

The research did not identify any significant legal or policy barriers to exchanging information. Most barriers occurred in the interpretation of the legal and policy constraints rather than in the actual legal or policy provisions.

The legislative support provided through the provisions of Chapter 16A was seen as a significant enabler for information exchange, especially as this was accompanied by a high-profile roll-out and significant investment in training.

Conclusion: Child Welfare

Overall the research findings confirm that information sharing in child welfare has improved as a result of the change of legislation and the accompanying training and organisational support. There is still reluctance by some agencies and professionals to share information.

The mix of a clear, statutory framework and guidelines issued under that framework, in particular Chapter 16A, appears to be adaptive for the purposes of promoting information sharing.

More needs to be done to monitor how information is shared, the circumstances in which Chapter 16A is used, and the circumstances where requests are turned down. Improvements in the actual process of sharing information and of the technology will also further facilitate appropriate information sharing.

Case study 2: Schools

Information is exchanged between schools when students move from one school to another, and between schools and other agencies that are providing services to students.

The legislative context for information sharing between schools and between schools and other agencies is in part established by Part 5A of the *Education Act 1990 (NSW)* and Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (NSW).*

When a child moves between school sectors, the parent is responsible for completing the information required by the new school. Most parents provide comprehensive information to the new school, but some parents withhold important information about their child from the new school.

Interpretation of the legislation and policy by schools

Generally information is shared appropriately. However, there are gaps between legislative and policy obligations as well as different constraints and perceptions arising from inadequate understanding or poor practice. The existing legislation supports information sharing, including between schools from different sectors, where the sharing of information concerns the welfare of the child or due to risk of violence.

Technological barriers, enablers and opportunities to sharing personal information

Few technical barriers to information sharing between schools within or across school sectors were found. This is, however, technologically easier for state schools because some of the relevant information is held centrally.

Organisational barriers, enablers and opportunities to sharing personal information

The legislative and policy guidelines appear to be reasonably well known and facilitate information exchange. Occupational health and safety legislation had also reportedly assisted. Poor understanding of the information sharing provisions under Part 5A and Chapter 16A emerged as the main barriers to good practice in the education case study:

- There was some confusion about how to share information in practice. Some participants had only a partial awareness of the relevant legislation and were uncertain about what it meant in practice.

- Cultural resistance to exchanging information occurred, for example, where a student had a poor record and schools wanted to give the child a 'fresh start'.

Where there was trust and/or familiarity between schools and with other agencies, sharing information became much more efficient.

Political/policy barriers, enablers and opportunities to sharing personal information

No significant legal, policy or political barriers to information sharing between schools were identified.

Although the reliance on parents to provide relevant information to the new school is generally appropriate, this can cause difficulties for the child in question and for other children in the new school to whom the school has a duty of care. However, there were differing views about whether formalising exchange would address this problem. Where the information exchange could occur using Chapter 16A, parental consent is not required.

Conclusion: Schools

Overall, information exchange in this context was found to be appropriate with a few notable exceptions. There did not appear to be a strong case for any changes in legislation in this case study.

Case study 3: Housing support (HASI)

The Housing and Accommodation Support Initiative (HASI) for people with mental illness is a partnership program between Housing NSW, NSW Health, NGO accommodation support providers (ASPs), and community housing providers. HASI aims to provide access to stable housing, clinical mental health services, and accommodation support to adults with a mental health diagnosis. Previous research had identified information exchange as a challenge for the initiative.

HASI partners are subject to the legislative and policy framework that applies to all information in New South Wales Health. A *HASI Manual* was produced early in the program and is currently being reviewed.

The HASI program does not have a specific legislative framework governing its information sharing activities because HASI is a program for adult clients who are assumed to maintain full control over information sharing apart from the General and Health Privacy Code. Seeking and obtaining consent to the sharing of personal information is the basis for the HASI program's collaboration, and is largely based on consent forms signed by the consumer upon entry to the program. Staff are nevertheless expected to discuss with clients when information is shared.

When exchanging information without consent, HASI program staff must establish that an exemption is operative and must act in compliance with the exemption.

Barriers and facilitators of information sharing

Practice was variable around information sharing across agencies and locations:

- In some cases there was a lack of clarity with information sharing both where consent had been provided and where consent had been withdrawn. Few of the interviewees referred to the relevant legislation and codes of practice.
- Practice around information exchange was poorer where interagency meetings were not being held regularly.

Conclusion: HASI

HASI differed from the other two case studies in that information exchange is a fundamental part of the program, and all HASI clients sign a consent form to information exchange as a condition of receiving the service. However, the legal and policy provisions around information exchange are less clear for vulnerable adults than they are for children.

Repeating the training on gaining consent and sharing information would support common understandings of practice around information exchange. Training would increase confidence across all levels of partner organisations. Re-establishing regular interagency discussions could improve information exchange in HASI.

There appeared to be little need for a change of legislation although legal protection of HASI workers is less clear than in the other two case scenarios.

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Conclusions

Overall, professionals in NSW tend to exchange information appropriately, with some indications of over-cautious practice where information is not shared appropriately. There were very few occasions reported where information was shared inappropriately. Information exchange worked well when the information was not sensitive. In more difficult cases, information exchange was variable across the state and across different agencies and sectors.

The findings of this research were consistent with the international literature.

In NSW, the two main reasons for the lack of information sharing were:

● risk-averse organisations

● organisational or professional cultures which did not value holistic interventions.

The key gap in all three case studies was the lack of discussion about information sharing with the information subjects or their carers.

The need for more exchange of information

Information exchange is not an end in itself; it is part of the broader quality of service delivery. Effective and appropriate information sharing can only take place in a context where:

● There is a clear legal and policy framework.

● Policies and procedures specify the appropriate processes, but are flexible enough to allow for these processes to be tailored to individual situations.

● Organisational cultures facilitate appropriate information sharing and collaborative practice while taking into account peoples' rights to privacy and confidentiality.

● The human services workforce has knowledge of the legal and policy framework and is trained and supported in delivering good practice.

● Workers and agencies trust each other to use the information appropriately.

Technical issues

Developments in technology have facilitated information exchange, and it is increasingly possible for agencies to share information across technological platforms. On the other hand, improvements in technology can contribute to risks of breaches of privacy legislation when information is inappropriately accessed. The study found that in no case

did technology create a fundamental barrier to information sharing (or conversely provide a solution to problems around information sharing).

Legal framework

There did not appear to be significant legal impediments to information sharing in NSW.

Legal reform has made a major difference to information sharing activity, particularly around children. The passing of Chapter 16A and Part 5A have facilitated substantial changes to practice across agencies and sectors.

The introduction of specific legislative authority has clearly been helpful in the ongoing development of a culture of appropriate information sharing in NSW.

The mix of a clear, statutory framework and guidelines issued under that framework appears to be an adaptive one for the purposes of promoting information sharing.

Policy framework

At present, there is little overarching guidance for NSW agencies around appropriate decisions regarding privacy and information exchange. There should be greater clarity and consistency across agencies and sectors around the application of laws relating to sharing information and for agencies to understand how information exchange operates in practice, including how another agency will use the information that has been provided. Education, training and promotion should be undertaken across all human service sectors.

Organisational culture and structure

A number of factors were key to developing appropriate organisational cultures including:

- *Leadership and effective management*: Strong leadership within organisations was the main factor underpinning the overall organisational culture around information sharing.

- *Trust:* Building trust requires organisations to work together over a period of time and for workers to become familiar with their counterparts in other agencies. This requires consultation, training and structures where difficult issues can be resolved*.*

- *Guidance:* All human service organisations should have access to guidance that clarifies the conditions and processes for information exchange and helps navigate the balance between information sharing and privacy*.*

- *Consent:* Good practice always involves seeking to obtain consent from the information subject. Many workers did not feel well trained or supported around discussing with clients when sensitive information needed to be shared. Even if clients have signed a consent form, it is still important to inform clients when information is shared and what information has been exchanged, and to explain how the information will be used. This may not only be a legal requirement but also facilitates consent.

- *Proactive sharing of information:* Information sharing still tends to be passive rather than active; agencies tend to respond to information requests rather than proactively deciding that another agency should be provided with particular information about a client/student*.*

It is important that agencies in the government and NGO sector develop organisational cultures in which appropriate information sharing takes place proactively, without the need for a request to be made.

1   Introduction

This is the report of a project to research the exchange of personal information between government agencies, and between government and other sectors. The project was commissioned by the NSW Government Department of Premier and Cabinet (DPC) and conducted by the Social Policy Research Centre (SPRC) at UNSW Australia in partnership with the National Children's and Youth Law Centre (NCYLC).

In order to provide effective, safe, and efficient services, service providers must share information with each other about individual service users. Yet, clients and service users, as well as third parties involved in service provision, have a right to privacy and confidentiality. Indeed a fundamental element of trust in public services relates to the expectation that information given to service providers will not be disclosed without consent unless there is a very good reason to do so. This applies whether the service provider is a state government department, commonwealth government department, non-government organisation (NGO), or a private sector agency.

Previous research (McClelland, 2013) suggests that many practitioners are reluctant to share information even when they have the legal authority to do so, the protocols for sharing information can be considered complex, and many agencies have a risk-averse attitude to information sharing even when this may be in the interests of clients. It is thus important to explore the current understanding of policies, legislation and other frameworks which offer protection around personal information, and how they are being applied in practice.

This report presents case studies that document:

- the policy and legal context of information exchange

- how the policies are interpreted by different stakeholders

- gaps, enablers and opportunities for improving the sharing of personal information within and between government and non-government organisations to support more effective service delivery.

This report presents three case studies that document information sharing in practice:

> **Child welfare:** This case study relates to information exchange under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)*. The Act provides a framework for information sharing between agencies to

facilitate the provision of services to children and young persons by agencies that have responsibilities relating to safety, welfare, or the wellbeing of children.

Schools: This case study relates to information exchange between schools, including between state and non-state schools, for example when a student transfers from one school to another, in particular where there are concerns about the student's behaviour and welfare.

Housing support (HASI): This case study relates to information sharing within the Housing and Accommodation Support Initiative (HASI). This is a partnership program between Housing NSW, NSW Health, NGO Accommodation Support Providers, and community housing providers for people with mental illness. The prompt exchange of information ensures safe and effective service delivery, both for staff and people using the program.

Each case study includes the policy and legislative context for information sharing; how the policies are interpreted by agency employees; and identifies any gaps between policy and practice, what enables or prevents the sharing of information; and identifies options for sharing personal information in each context.

The remainder of the report is structured as follows:

- Chapter 2 provides a description of the methodologies and limitations of the research.
- Chapter 3 presents the findings of the literature review.
- Chapter 4 provides the legislative context, both in terms of Commonwealth law and NSW law.
- Chapters 5–7 present the case studies relating to child welfare, schools, and housing support (HASI) respectively.
- Chapter 8 presents the key findings and conclusions.

2   Methodology

A multi-method approach was used to provide a comprehensive picture of the way information is shared within and between NSW Government agencies, as well as with external parties, in order to deliver services in three specific areas (schools, child welfare and housing support). The research incorporates:

● a literature review of enablers and barriers to information exchange

● an analysis of the legislative and policy context for each case study

● interviews with stakeholders including people who were identified as having roles in developing policy, providing legal advice, and in applying the policy framework in the three case studies identified

● interviews with stakeholders who had a more strategic role in information sharing

● an analysis of qualitative material from interviews within the policy context of each case study.

2.1   Literature review

A brief review of the international and Australian literature was conducted on the effectiveness of mechanisms for information exchange. This included identifying where approaches have been successful in overcoming some of the barriers to effective information sharing. The literature review is presented in Section 3.

2.2   Analysis of legislative and policy context

Research into the dominant legislative frameworks applying to each case study was conducted. The research is presented in Sections 5.1 (child welfare), 6.1 (schools) and 7.1 (housing support) and in Appendix B: Overview of privacy legislation.

A brief review of policy was also undertaken to identify any inconsistency with legislation. A broader discussion deriving from the legal research is presented in Section 4.

2.3   Interviews with stakeholders

Thirty-five people from 12 organisations were interviewed (by telephone) in July/August 2014 to gain insights into information sharing between different parties in the context of the three case studies identified (see Table 1 below). Participants were identified to represent each of the three case study areas and include senior staff, legal/policy

advisors, as well as practitioners. In addition, three participants were interviewed to discuss information sharing at an overarching policy level. All participants were recruited at arm's length by invitation from the DPC. The topic guide for the interviews is attached in Appendix A.

Table 1: Summary of interview participants by case study

	Policy/legal staff	Operational staff
Child Welfare	9	7
Schools	3	6
Housing Support (HASI)	5	7
General	3	-

Note: Four interviewees were able to contribute to more than one case study; two participants agreed to be interviewed a second time to discuss preliminary findings of the research.

2.4 Analysis of qualitative material

Thematic analysis was used to analyse the qualitative interviews. Interviews were recorded, transcribed and coded in line with the themes outlined in the Scope of Work set out by the NSW Department of Premier and Cabinet.

2.5 Ethics approval

Ethics approval was obtained from the UNSW Human Research Ethics Advisory Panel I (Social/Health Research) on 21 July 2014 (Ref 9_14_030). All research participants were recruited at arm's length and provided written consent to participate in the interviews. All data in this report is de-identified to maintain confidentiality of research participants.

2.6 Limitations of this research

This research was conducted with the following limitations:

- The findings are limited to the three case studies selected and therefore cannot be generalised to all contexts where information is shared between agencies and across sectors in the human services.

- Every effort was made to draw on a broad range of stakeholders – this research was in part limited by the availability of stakeholders. There may therefore be perspectives which are not fully represented in this report.

● The research was conducted in Sydney and metropolitan NSW. There may well be significant differences in the way information is shared in rural and remote communities, especially in Aboriginal communities. This should be borne in mind when reading this report.

3 Previous research

In recent years, governments, both in Australia and internationally, have adopted policies to increase inter-agency collaboration with the aim of improving the integration of service delivery in areas such as health and social care (Bellamy, Raab, Warren, & Heeney, 2008; Lips, O'Neill, & Eppel, 2011; Richardson & Asthana, 2006; Van Eyk & Baum, 2002). These changes and other pressures to share information, such as managing risk and improving efficiency, have resulted in public organisations moving from information protection towards a culture of information sharing (Yang & Maxwell, 2011). Another key driver for information sharing arises out of the increasing complexity of issues which human service interventions are addressing. This has led to a growing recognition that no single agency has adequate information to address the issues alone (Conklin, 2001) and therefore interventions must involve collaboration between different organisations and different disciplines. There are therefore a number of reasons why personal information should be shared in the delivery of human services:

- providing a range of services tailored to the needs of the individual or family
- improving the efficiency and quality of service – in particular so that service providers can make the best assessment of the needs of their clients in order to provide high quality service
- reducing client burden – clients often do not wish to provide the same information to multiple service providers
- improving safety – when a client is believed to be a risk to themselves or others, the assessment of risk must take into account as much relevant information as possible.

3.1 Tensions in sharing information

While there is pressure to share personal information across organisations, there is also pressure to protect privacy and the confidentiality of personal information (Appari & Johnson, 2010; Bellamy & Raab, 2005; Lips et al., 2011; Richardson & Asthana, 2006). Privacy of information has become increasingly important as the technology for producing and making information available has developed, and therefore the opportunities to breach privacy have increased exponentially. Four possible information sharing models are identified in the literature:

- an ideal model where information is shared and withheld appropriately
- an overly-open model where information is withheld appropriately but shared inappropriately

● an over-cautious model where information is shared appropriately but withheld inappropriately, and

● a chaotic model where information is both shared inappropriately and also withheld inappropriately (Richardson and Asthana 2006).

Information sharing is a key component of collaboration amongst agencies, with other components including co-location, joint training, common assessments, multi-agency teams, and one-stop shops. Despite the evidence of poor outcomes where agencies do not collaborate, improving outcomes through collaboration has proved difficult to achieve (Atkinson, Jones, & Lamont, 2007; Darlington, Feeney, & Rixon, 2005; Glisson & Himmelgarn, 1998; Richardson & Asthana, 2006; kylie valentine & Hilferty, 2012; Van Eyk & Baum, 2002). Joint working is a means for addressing human service delivery problems (Phillips et al., 2011) rather than an end or principle in itself.

Research has explored a range of barriers and enablers to collaboration, but less attention has been paid to inter-organisational information exchange as a specific issue (Richardson & Asthana, 2006). Existing research indicates that there are differences between countries and locations. For example, UK research found that information is not always shared when it should be and is sometimes shared when it should not be (Bellamy et al., 2008). On the other hand, New Zealand research found a lack of legal provision for sharing information and that 'need to know' criteria continue to apply, with client consent used to provide specific personal information to other agencies and professional reliance on 'off the record' information (Lips et al., 2011).

A Western Australian study of partnerships in providing mental health care found barriers in communication, including information sharing between mental health services and community services, that were caused by differing expectations (Sweeney & Kisely, 2003). A study of factors influencing service coordination in rural communities in South Australia found that the preferred option and perceived best practice for sharing information about service users was informal contact, but at the same time, concerns about confidentiality and gossip were nominated as inhibitors (Munn, 2003). Another relevant study examined a model of service delivery in Queensland state schools that aimed to promote collaboration and information sharing between supports for children and youth in education settings, and the formal state protection agency (Knight, Knight, & Teghe, 2007). This study found that the model was successful, and its key component included well-trained and experienced human services professionals who could identify needs, build capacity, and link support systems.

3.2   Barriers to information sharing

There are a number of interrelated factors that affect information sharing between organisations, including: individual and agency interpretations of policy documents and legislation; governance structures; technical factors such as compatibility of computer systems; training and support; organisational structure and culture; trust, rewards, incentives and other social factors; and individuals' beliefs about information sharing (Richardson & Asthana, 2006; Yang & Maxwell, 2011). Some barriers are systemic or entrenched and can only be resolved by policy responses rather than changed working arrangements by services (valentine and Hilferty, 2012). Factors influencing information sharing can be viewed from three key perspectives:

● technological

● organisational, and

● political/policy. (Dawes, 1996; Yang & Maxwell, 2011).

Research suggests that while improving the capability of information technology can benefit information sharing between organisations, overcoming technical issues is less difficult than addressing organisational and political factors (Yang and Maxwell 2011).

Literature on how professional cultures might shape information sharing practices identifies profound differences in professional cultures. For example, health professionals (whose view is shaped by a medical model which usually focuses on the individual patient) are generally less likely to share information than social care professionals (who work from a social model where the individual client is seen as part of a family and community) (Drake, Steckler, & Koch, 2004; Hunt & Arend, 2002; Richardson & Asthana, 2006; Sweeney & Kisely, 2003).

The research consistently identifies shared understandings and trust, or at least management of mistrust, as among the most important determinants of whether staff from different organisations are prepared to share information (Dawes, Cresswell, & Pardo, 2009; Gil-Garcia, Chengalur-Smith, & Duchessi, 2007; Lips et al., 2011; Van Eyk & Baum, 2002; Willem & Buelens, 2007).

3.2.1   Technological barriers to information sharing

Within the literature a number of technological barriers to information sharing were identified. It should be noted that information technology is rapidly evolving and recent developments such as 'cloud computing' have greatly improved the ability to transfer information across systems and to ensure the safety of information. Nevertheless, the

literature indicates that factors such as incompatibility of databases and mismatched data structures can create practical barriers, which make information sharing cumbersome and challenging in some circumstances (Dawes, 1996; Lips et al., 2011).

3.2.2 Organisational barriers to information sharing

While a wide variety of barriers and enablers to information sharing are identified in the literature, it is clear that collaboration, including information sharing, is a developing process that is challenging and time-consuming, and that successful collaboration is based on a need to work together to improve services, so that the benefits outweigh the difficulties (Munn, 2003; Stewart et al., 2002; Van Eyk & Baum, 2002). Further, those networks that are more extensive and varied and share a greater depth and breadth of information present greater barriers, costs and risks. However they also offer greater potential benefits than those that are more limited (Dawes et al. 2009).

Specific organisational factors which can create barriers to information sharing include:

Mistrust between groups and agencies

A number of studies in different fields of service provision have found that where professional groups or organisations mistrust each other, sharing personal information about clients is likely to be minimised. Mistrust can arise out of a number of factors including professional cultures which question the professionalism of others, competition between agencies, a history of problematic collaboration, and personal or professional animosity between individual managers in different organisations. (Akbulut, Kelle, Pawlowski, & Schneider, 2009; Gil-Garcia et al., 2007; Van Eyk & Baum, 2002). Mistrust can also arise out of concerns of loss of autonomy or misuse of information by other organisations (Bellamy & Raab, 2005; Yang & Maxwell, 2011).

Organisational structures and cultures

Differences between the aims, values, agendas and goals of organisations may have profound effects on their willingness to work collaboratively and share information with others. Some organisations may prioritise confidentiality over all other considerations (Bellamy et al., 2008; Gil-Garcia et al., 2007) or organisational cultures can be driven by risk-averse or self-protective management styles which discourage or even prevent sharing information about clients with other agencies. Organisational structures can also hinder information sharing, particularly where it is not clear who has responsibility within an organisation for decision making around information sharing, or where there are no

clear policies or protocols for sharing information with others (6, Bellamy, Raab, Warren, & Heeney, 2007; Drake et al., 2004; Yang & Maxwell, 2011). Organisational self-interest can also result in an aversion to sharing information with other agencies, even when this may be in the interests of clients (Dawes, 1996).

Lack of knowledge of other organisations

In contexts where there are multiple services, there may be a lack of knowledge about which organisations are providing relevant interventions and therefore which organisations are most appropriate for sharing personal information about individual clients (Munn, 2003).

Professional cultures and perspectives

As discussed above, in general, professions that identify with the 'medical model' view that individuals, especially adults, as the patient or client, tend to view sharing of information about the individual as a breach of professional responsibility. Often, medical professionals do not believe that asking about the social circumstances of their patients is part of their task (Bunting, Lazenbatt, & Wallace, 2010; Dawes, 1996; Dawes et al., 2009; Munn, 2003; Richardson & Asthana, 2006). In some professions, such as psychoanalysts, breaching confidentiality is discouraged even if the client requests for information to be shared (Bollas & Sundelson, 1996). Reluctance to share information is not confined to the medical and paramedical professions and is, in fact, part of many professional cultures.

Perception that collaboration and information sharing is challenging

Many professionals find the process of sharing information challenging and time consuming. Practitioners may be unfamiliar with the legislation and the protocols for exchanging information, and may not have the time to discuss issues with colleagues from other organisations. Resource issues may also affect the capacity of organisations and individuals to exchange information, including access to legal advice and also practical resources to identify, extract and share the relevant information (Bigdeli, Kamal, & de Cesare, 2013; Dawes et al., 2009; Munn, 2003; Van Eyk & Baum, 2002).

Another challenge for practitioners is the concern that sharing information will compromise their relationship with clients or have other negative repercussions (e.g. for a child at risk) (Bigdeli et al., 2013; Bunting et al., 2010; Hawkins & McCallum, 2001; Lips et al., 2011). These challenges can create considerable reluctance to share information

(Bunting et al., 2010; Dawes, 1996). This may also be part of a more general resistance to organisational change (Gil-Garcia et al., 2007).

Differences between information needs of different agencies

Different organisations may have different needs for information depending on the type of work they are doing with clients; this could affect their willingness to share information with others. For example, some agencies may record minimal information about clients whereas others will keep comprehensive files on each client (Lips et al., 2011).

3.2.3 Political/policy barriers to information sharing

Laws and regulations

A key barrier to information sharing can arise out of the laws and regulations governing the exchange of information between agencies (Dawes, 1996; Yang & Maxwell, 2011), including lack of legislative support for sharing of information (6 et al., 2007; Darlington & Feeney, 2008; Yang & Maxwell, 2011). In some cases, the law explicitly prevents sharing of information, but in many cases the barrier can arise out of confusion about how the relevant laws and regulations apply, including fear of being wrong (for example in reporting children at risk), being disciplined, or being subject to adverse publicity as a result of inappropriate exchange of information.

The primacy of programs

Government programs aimed at addressing specific problems can cause difficulties for agencies when information is deemed to belong to the program rather than the department or agency as a whole (Dawes, 1996).

Institutional and professional politics

Political considerations can play an important role in facilitating or creating barriers to sharing information (Van Eyk & Baum, 2002). These include partisan dynamics in organisations (Dawes, 1996; Yang & Maxwell, 2011) as well as political influences such as those from politicians and interest groups (Dawes, 1996).

Privatisation and competitive tendering

In an overall context where agencies are competing with each other for work, information exchange may be inhibited due to reluctance to disclose commercially sensitive material (Munn, 2003).

3.3   Enablers to information sharing

Within the literature, a number of enablers or key factors were identified from successful approaches to information sharing.

3.3.1   Technological enablers to information sharing

Improvements in technology, for example in records management systems and databases, can enable more efficient exchange of information, as can improvements in the workforce's ability to use technology appropriately (Akbulut et al., 2009; Bigdeli et al., 2013; Gil-Garcia, 2012; Yang & Maxwell, 2011).

3.3.2   Organisational enablers to information sharing

Building trust and social networks

Where inter-organisational trust is low, efforts to develop trust and knowledge of other organisations can facilitate information exchange (Akbulut et al., 2009; Bigdeli et al., 2013; Darlington & Feeney, 2008; Dawes et al., 2009; Lips et al., 2011; Willem & Buelens, 2007). This was found in the evaluation of Keep Them Safe in NSW, where in some parts of the state, Community Services Centres had invited NGOs to allocation meetings to demonstrate how cases were prioritised. This had reportedly resulted in much higher levels of mutual trust locally, and also appropriate information sharing (Shang & Katz, 2014).

Where there are adequate protections for personal data, agencies are likely to trust each other and be more willing to share information with each other (Lips et al., 2011).

Organisational structures that facilitate coordination

Information exchange is facilitated by organisational structures in which responsibilities for information retention and exchange are clear, and where links with other agencies are structured into the organisation (Dawes et al., 2009; Willem & Buelens, 2007). This is further enhanced if organisational staff have a clear understanding of the benefits of information sharing (Van Eyk & Baum, 2002). Fundamental to developing an organisational culture of collaboration is that the senior leadership actively promote coordination and information sharing, including promotion of a culture of information stewardship rather than ownership (Akbulut et al., 2009; Bigdeli et al., 2013; Van Eyk & Baum, 2002; Willem & Buelens, 2007; Yang & Maxwell, 2011). Workforce development should include training to increase awareness of when to share information and address

barriers and concerns, actively developing shared understandings of key assumptions, expectations, terms and concepts (Bunting et al., 2010; Dawes et al., 2009; Hawkins & McCallum, 2001; Van Eyk & Baum, 2002). Adequate funding and resources are also key (Akbulut et al., 2009; Dawes et al., 2009; Van Eyk & Baum, 2002). Aligning objectives between agencies can be challenging as it involves building trust and developing common objectives while still recognising the unique contribution of each agency. Meetings, training and other collaborative activities, as well as improved technology, are all resource intensive and, in themselves, are not guaranteed to create more efficient and higher quality services. System change therefore has to be carefully planned and implemented.

3.3.3 Political/policy enablers to information sharing

Collaboration between agencies around information sharing involves more than each organisation having appropriate structures and functions. Agreement on aims and agendas between organisations is equally important (Van Eyk & Baum, 2002). Networks of collaboration and joint case management by staff from different agencies can provide the context in which information can be shared appropriately and efficiently (Darlington & Feeney, 2008; Dawes et al., 2009; Munn, 2003).

Laws, regulations, guidelines and protocols that mandate sharing should underpin the efforts of organisations to work together and provide a more holistic service (6 et al., 2007; Darlington & Feeney, 2008; Lips et al., 2011; Yang & Maxwell, 2011).

3.4 Summary

This short examination indicates that the empirical literature around information sharing is still rather limited. Much of the literature focuses on collaboration and coordination more broadly rather than information sharing as such. Nevertheless, the issues are relatively well-understood and the solutions are, in principle, reasonably clear. However, the implementation of some of these principles can be extremely complex, and some of these solutions require significant resources and high levels of commitment from the agencies involved. Exchange of information always involves a judgement which balances the rights of citizens to privacy with the need to better protect vulnerable members of society and the imperative to provide high quality and holistic services. In most cases, the decision is reasonably straightforward but there are many situations in which these judgements can be very difficult.

4   Legislative frameworks

This section discusses three of the most important themes emerging from the legal research and analysis: the relationship between personal information sharing and personal information privacy; seeking consent as both legal requirement and best practice; and information sharing as a positive, proactive duty. A more detailed outline of privacy legislation applying to the case studies appears in Appendix B. The specific legal frameworks applying to each case study are identified in Sections 5.1, 6.1 and 7.1 below.

4.1   Personal information management: to protect, to share or both?

Personal information sharing and personal information protection (privacy) are distinct but closely related practices and legal concepts. Personal information sharing incorporates notions of a duty or discretion to respond to requests to share others' personal information and a duty or discretion to proactively share such information.

Personal information protection, on the other hand, incorporates notions of a duty or discretion to maintain the privacy of personal information that has been collected from others, and specifically <u>not</u> to share it with others unless the informed consent of the person to whom the information relates has been obtained.

The aims of personal information sharing and personal information protection also differ. Taking one example of an information sharing regime operating in New South Wales, an objective of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (referred to as Chapter 16A from this point on) is to facilitate services for children and young people by agencies that have responsibility for the safety, welfare or wellbeing of children and young persons, by authorising or requiring those agencies to provide or receive personal information relating to the provision of the services. Agencies themselves, therefore, may be required to determine when, how, and what personal information of their clients' is shared with others (s 245A).

Conversely, personal information privacy has been defined as:

> The claim of individuals, groups, or institutions to determine for themselves when, how, and to what extent information about them is communicated to others. (Westin, A cited in Arditi, 2008)

It can be seen, therefore, that the twin concepts of personal information sharing and personal information protection appear to embody a fundamental tension about the

control of data that identifies and defines individuals, and in particular *who* has a say about *who* has access to personal information and *why*, as well as *how* the information is gathered, stored and used.

Whilst the aims of personal information sharing and personal information protection may seem to be in tension, the two also have much in common. In both, law or best practice requires that consent should be sought wherever possible before any sharing of personal information. Both, therefore, attempt to place the person to whom the information relates at the centre of decision-making. And both may therefore be regarded as important indicators of high quality, client centred service delivery (see Section 4.2 below).

Other similarities and overlaps across the concepts are common. Stand-alone legislative information sharing regimes such as Chapter 16A, referred to above, will generally exempt acts undertaken in compliance with the regime from liability, including under privacy legislation. Privacy legislation, on the other hand, contains express exemptions that permit information sharing for certain specified purposes, some of which clearly overlap with stand-alone information sharing regimes, and provide express exemptions for acts done in compliance with law, including such regimes. Privacy legislation in New South Wales also authorises the creation of subordinate codes of practice and public interest directions that themselves can further modify obligations under the legislation and effectively regulate information sharing by specific agencies and for specific purposes. The *Health Records and Information Privacy Code of Practice 2005* and the *Privacy Code of Practice (General) 2003* discussed in Section 7.1 below are examples of such instruments.

It is in light of these similarities, differences and overlaps that personal information sharing and personal information protection can both be conceptualised as part of a broader category of personal information management. Any person or agency that collects personal information should, therefore, strive to be equally aware of their legal and policy obligations pertaining to both personal information protection (privacy) and personal information sharing. It is clear from this research that organisations and staff are not always as aware of their information sharing obligations as they are of their obligations under privacy legislation (see Chapters 5–7).

A more nuanced understanding of obligations under both privacy legislation and information sharing mechanisms is required. In particular, organisations need to better understand the benefits of good information sharing practice and the protections that it affords them. However, organisations also need to understand that compliance with information sharing mechanisms does not obviate the need for compliance with privacy

laws and certain other laws, where relevant, such as the *State Records Act 1998* (NSW) and the *Government Information (Public Access) Act 2009* (NSW) (*GIPA Act*). Effective information sharing mechanisms will generally only exempt an organisation from compliance with privacy and other relevant laws to the specific and limited extent permitted by the information sharing regime. All other activities relating to personal and health information remain subject to the requirements of privacy and other laws. Information could and should legitimately be exchanged in the interest of the public in order to facilitate human service delivery, subject to the privacy provisions of the Acts. Privacy can be overridden where the public interest overrides the person's consent to information exchange.

There are a number of obligations arising under privacy legislation (and the GIPA Act for public sector agencies) organisations should always consider:

● Personal and health information collected should be protected from misuse, interference and loss, unauthorised access or modification or disclosure.

● Reasonable steps should be taken to ensure that the information collected is relevant, accurate, up-to-date, complete and not misleading.

● Wherever possible the organisation should take reasonable steps to ensure that the individual is aware that the information has been collected, consents to the collection and is made aware of any laws that may authorise the disclosure of the information, and

● Information subjects can obtain access to the information and can request correction of inaccurate, out of date, incomplete or not misleading information.

Maintaining these privacy obligations within the information sharing context would operate as an important safeguard against inappropriately sharing information.

Identifying privacy and other legal obligations as necessary safeguards within authorised information sharing contexts represents an appropriate compromise between the pressures to share personal information and the pressures to protect privacy identified in Sections 3.2.1 and 3.3 above.

Importantly, where NSW public sector agencies are provided a legislative mechanism to share individuals' personal information, agencies are still required to manage the information in accordance with the NSW privacy regime (e.g. with regard to storage and retention of information).

4.2   Consent and best practice

Seeking consent to the sharing of information is best practice in most circumstances. When there are circumstances in which seeking to obtain consent would be impracticable or poses a risk to the information subject, the practitioner or a third party, recourse to statutory frameworks may become necessary. It may also be necessary to consider the statutory framework if consent is unreasonably withheld to exchange information, but it is still necessary to share that information.

In the case studies that follow, relevant guidelines and policy documents strongly support a client's participation in decision-making and the obtaining of a client's consent to the sharing of personal information wherever practicable. Key instruments examined in the research support the obtaining of consent as best practice. These include the *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (the *Guidelines*)*,* the *Guidelines Issued under Part 5A of the Education Act 1990 for the Management of Health and Safety Risks Posed to Schools by a Student's Violent Behaviour* (the *Risk Guidelines*), and the example of the HASI referral form in Appendix C.

It is clear from the *Guidelines* referred to above, that clients' participation in matters affecting them, in decision-making, and specifically in decisions to transfer their personal or health information to another organisation is an ongoing, episodic process and not something that can be undertaken at one point in time and thereafter ignored.

In recognising the ongoing nature of a client's participation in service delivery and decision-making, the right of a client to withhold consent to the sharing of personal or health information must be recognised. Where a client is reluctant to consent or withdraws consent, and a service provider nevertheless has good reason to believe that information should be shared, the service provider should look to the legal authority that would permit such sharing. In the case studies that follow, such authority is found primarily in Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), Part 5A of the *Education Act 1990* (NSW), the above-mentioned *Guidelines*, the *Health Records and Information Privacy Code of Practice 2005,* and the *Privacy Code of Practice (General) 2003.* In each case study, the relevant legal framework and policy environment acknowledges that even when information is shared without consent, the person who is the subject of that information should be told that the information has been shared, with whom it has been shared, and the purpose for which it has been shared, including by what legal authority.

Information sharing for the purposes provided by a statute is, therefore, a lawful, targeted departure from privacy obligations. However, privacy compliance and compliance with other relevant laws such as the *State Records Act 1998 (NSW)* and the *Government Information (Public Access) Act 2009 (NSW)*, at both an organisational and client relationship level, remain fundamental to good practice in the human services. This is especially the case when building the trust with clients, which lays the foundation for seeking and obtaining their consent wherever possible. Best practice in information sharing should therefore involve seeking consent of the information subject rather than relying in the first instance on statutory powers which may override the need for consent. The latter is of course easier but is most often an indicator of poor quality practice, while privacy compliance has been recognised as an effective enabler of information sharing (Lips et al., 2011).

Only where it is impractical to seek consent, or where seeking consent itself may further increase the risk to the person or another person, should these statutory powers be invoked. Even in these situations, the information subject should be informed that information has been shared and the reasons for sharing the information. Similarly, if the subject does not give consent, but in the view of the professional the information should nevertheless be shared, the information subject should be informed about this (again unless providing this information will create risk to the individual or a third party). As indicated by the SA Ombudsman:

> A client's informed consent to share information must be sought in all situations where it is considered reasonable and practicable to do so. The decision to share without consent must be based on sound risk assessment and approved by the appropriate officer in your agency or organisation.(Ombudsman SA, 2013, p. 6)

4.3   The duty to tell

Depending on the circumstances of particular cases, an organisation may owe a duty to share relevant information about a client with another organisation where to do so would assist in minimising or eliminating a risk of foreseeable harm. On such occasions, the organisation should look to the legal authority that would permit such sharing without the organisation being in breach of its obligations under privacy or other relevant legislation. In the case studies that follow, such authority is found primarily in Chapter 16A, Part 5A, the Guidelines and the Codes of Practice discussed above in Section 4.2.

It is noteworthy that none of these instruments comment upon the occasions on which there may be a duty to disclose information without the need for a request to be made by

another organisation. Indeed, none of the legislative or policy frameworks examined could be said to actively encourage a culture of *proactive sharing of information prior to a request being made,* whether that be to fulfil a duty of care owed to third parties or, to fulfil more effectively the specific policy objectives of the information sharing framework or program.

In *Director General, Department of Education and Training v MT (GD)* [2005] NSWADTAP 77, the New South Wales Appeal Panel of the Administrative Decisions Tribunal noted:

> In certain circumstances, a legal duty to disclose confidentially-acquired information is well-established in English law.[1]

Laws, regulations or policies that mandate information sharing have been identified as efficient enablers of information sharing (Darlington & Feeney, 2008; Lips et al., 2011; Young & Maxwell, 2011). Any such exchange would, however, still need to acknowledge the importance of relevant privacy and other legal safeguards being implemented when sharing information. The NSW Administrative Decisions Tribunal has commented on this specifically, indicating that agencies have an obligation to check the accuracy of information and consider their legal obligations under privacy legislation when sharing sensitive information.[2]

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[1] See for example, *W v Edgell* [1989] EWCA Civ 13; [1990] 1 All ER 835 (CA) – psychiatrist disclosure of patient's violent tendencies to relevant authorities, *R v Devon CC, ex p L* [1991] FLR 541 – social worker's knowledge that a man who lived with three different women who had children in their care was a child abuser, *R v Harrison* (unrtd, CA, Rougier J, 10 July 2000) – statement to prison chaplain by prisoner as to future murderous intent (paragraph 84).

[2] *NK v Northern Sydney Central Coast Area Health Service (No.2)* [2011] NSWADT 81

5 Case study 1: Child welfare

Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) was enacted in 2009. The Chapter provides a legal framework for information sharing between agencies to facilitate the provision of services to children and young persons by agencies that have responsibilities relating to the safety, welfare or wellbeing of children.

Previous SPRC research (k valentine et al., 2014) indicated that although the passing of Chapter 16A has improved information sharing, there were still considerable difficulties for many agencies around information sharing, and that practice was variable across agencies, sectors and geographical locations. Additionally, the process for sharing information was perceived as being cumbersome and bureaucratic. There was also evidence that agencies in other jurisdictions in Australia, some of which have far more prescriptive requirements than in NSW, nevertheless manage to share relevant information efficiently and safely. This case study examines, in more depth than has previously been possible, the specific cultural and organisational barriers around information sharing in NSW.

The case study involved interviews with 16 participants (9 policy staff and 7 operational staff – see Table 1 above). Participants included representatives from the NSW Department of Family and Community Services (Community Services), the NSW Department of Health, the NSW Department of Education and Communities, the NSW Police, other government agencies in NSW, and the non-government sector. Interviews were conducted by telephone using the topic guide presented in Appendix A. In addition to discussing the legal and policy framework for information sharing, interviewees were presented with a number of scenarios to see whether and how they would share information in those circumstances.

5.1 Legal and policy context

The legal and policy context for information sharing in child health and welfare is established under *Chapter 16A* of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)* (*CYPCP Act*).

Chapter 16A creates a mechanism for information sharing between *prescribed bodies* and requires them to take reasonable steps to co-ordinate the provision of services to children and young people (s 245A(1)).

1) The object of this Chapter is to facilitate the provision of services to children and young persons by agencies that have responsibilities relating to the safety, welfare or well-being of children and young persons:

   (a) by authorising or requiring those agencies to provide, and by authorising those agencies to receive, information that is relevant to the provision of those services, while protecting the confidentiality of the information, and

   (b) by requiring those agencies to take reasonable steps to co-ordinate the provision of those services with other such agencies.

2) The principles underlying this Chapter are as follows:

   (a) agencies that have responsibilities relating to the safety, welfare or well-being of children or young persons should be able to provide and receive information that promotes the safety, welfare or well-being of children or young persons,

   (b) those agencies should work collaboratively in a way that respects each other's functions and expertise,

   (c) each such agency should be able to communicate with each other agency so as to facilitate the provision of services to children and young persons and their families,

   (d) because the safety, welfare and well-being of children and young persons are paramount:

      i. the need to provide services relating to the care and protection of children and young persons, and

      ii. the needs and interests of children and young persons, and of their families, in receiving those services, take precedence over the protection of confidentiality or of an individual's privacy.

Prescribed bodies include any organisation that has direct responsibility for, or supervision of health care, welfare, education, children's services, adoption services, residential services or law enforcement services to children and includes a wide range of specific government departments, investigative agencies and courts (s 248(6) *CYPCP Act;* cl 8, *Children and Young Persons (Care and Protection) Regulation 2012*).

5.1.1 Best practice: Obtaining consent

In most circumstances, seeking and obtaining the consent of relevant individuals to share their (or their child's) personal information will be best practice and is the desirable mechanism through which information sharing should take place. The *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (the *Guidelines)* state: "while

consent is not necessary, it should be sought where possible. Organisations should at a minimum advise children, young people and their families that information may be shared with other organisations" (see also Section 4.2 above and s 9(2)(a), *CYPCP Act*). However, when a child's safety, welfare or wellbeing is at issue and consent is not able to be obtained or is withheld, Chapter 16A of the *CYPCP Act* provides specific legislative authority for the sharing of relevant information.

5.1.2 Duty of care

Organisations that assume responsibility for aspects of a child's welfare, safety and wellbeing owe a duty of care to the child. The duty of care may arise from a contractual agreement, tortious duty, obligations under workplace health and safety laws, or may stem from the exercise of a statutory power. In any event, it will generally be the case that the organisation assumes a level of responsibility for the safety of the child.

Depending on the circumstances of a particular case, an organisation may on some occasions owe a duty to share relevant information about a child with another organisation (or to another part of its own agency) where to do so would assist in minimising or eliminating a risk of foreseeable harm (see Section 4.3 above). On such occasions, Chapter 16A of the *CYPCP Act* provides a mechanism by which such information can be shared proactively by the organisation without the need to receive a request (s 245C(2)). Notwithstanding that such proactivity is permitted by Chapter 16A, the research team was unable to identify any statement of policy within the policy documents examined that actively encourages workers to proactively share wherever appropriate.

5.1.3 Responding to requests

Chapter 16A enables information to be requested by one prescribed body from another prescribed body (s 245D). Chapter 16A also permits the sharing of information without the need for a request from another organisation (s 245C(2)). The information may be requested and/or disclosed either in writing or verbally.

Where the prescribed body requests information and provides sufficient justification that receiving the information would assist them to take action relating to the safety, welfare or wellbeing of the child or young person (or a class of children or young persons), the providing agency must comply with the request (s 245D(1)-(3)).

Section 245D (4) and (5) permit the agency with the information to refuse to provide information in reply to a request on certain limited bases and only upon providing reasons in writing for refusing the request. For example, an agency is not required to provide information if it reasonably believes that to do so would endanger a person's life or physical safety or would not be in the public interest.

For example, if organisation 'A' were to receive a request for information from organisation 'B', it must comply with the request if none of the limited justifications for refusing to provide information apply and 'A' reasonably believes that the information requested may assist 'B' to:

(a)   make a decision, assessment or plan relating to a child's safety, welfare or wellbeing

(b)   initiate or conduct an investigation relating to the safety, welfare or wellbeing of a child

(c)   provide any service relating to the safety, welfare or wellbeing of a child

(d)   manage any risk to the child or other children (s 245D(2)).

The Guidelines contain a series of helpful template letters and checklists to guide decision-making and communications under Chapter 16A.

5.1.4   Relationship of Chapter 16A to privacy and other laws

Chapter 16A explicitly provides for protection from liability for compliant information sharing, stating that a person acting in good faith will not be liable for any civil, criminal or disciplinary action for *providing* relevant information (s 245G). The Act also states that any other Act or law that prohibits or restricts the disclosure of information (including state and commonwealth privacy legislation and the law relating to confidentiality and defamation) does not operate to prevent the *provision* of information under Chapter 16A (s 245H).

It would seem, therefore, that the provider of information is well protected by these provisions. However, the receiving agency must use the information for the safety, welfare or wellbeing of the child or young person (or class of children or young persons) to whom the information relates (s 245F).

Further, all personal and health information held in relation to a particular child must be maintained pursuant to an organisation's obligations under relevant privacy legislation, except to the specific extent permitted by Chapter 16A. The Guidelines helpfully advise:

Information must be handled and stored in a secure way. A written record of exchanges of information under Chapter 16A should be made and stored in a way that is consistent with the existing legislation (including the *State Records Act 1998*, *Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Protection Act 2002*).

Reporter identity still needs to be protected under s29. This means that those requesting information may still receive redacted versions of reports.

5.1.5 Child Wellbeing Units

From 2010, Child Wellbeing Units were established in the NSW government agencies responsible for the largest number of child protection reports: NSW Health, NSW Police Force, and the Department of Education and Communities.[3] The aims of Child Wellbeing Units are to:

● act as change agents, reshaping agency responses to child protection by:

  o advising, supporting and educating Mandatory Reporters as to whether there is a risk of significant harm, and escalating high risk matters to the Department of Family and Community Services Child Protection Helpline

  o identifying potential responses by the agency or other services to assist the child or family for cases that did not meet the risk of significant harm threshold

● drive better alignment and coordination of agency service systems, and speedy appropriate responses to children in need of assistance or at risk of significant harm

● develop an information system to enable agencies to work together and share basic information, by allowing Child Wellbeing Units to know if a child is already known to the Department of Family and Community Services or another agency

● provide a valued, sustainable, high quality service, which is relevant to the role of the Mandatory Reporters and the service delivery models in their respective agencies.

Where concerns about children do not meet the risk of significant harm threshold, information about the child or young person is entered into WellNet – the Child Wellbeing Unit database. This information is only visible to staff in Child Wellbeing Units Child Wellbeing Units help Mandatory Reporters to identify services available to support the family within their own agency or in other organisations.

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[3] Initially a CWU was established in the Department of Family and Community Services (FACS) but this was decommissioned in 2013.

Child Wellbeing Units therefore have a key role within their organisations for promoting collaborative practice and therefore for ensuring that exchange of information about vulnerable children is carried out appropriately and efficiently.

5.2 Interpretation of the legislation and policy by agency employees

There was widespread agreement among interviewees that the enactment of Chapter 16A had greatly increased information sharing for children's safety, welfare or wellbeing, but that there remain areas where practice could be improved. Interviewees also pointed out that good information exchange practice under Chapter 16A was not simply about information exchange 'in itself' [C6], but needed to be assessed in terms of its overall purpose and outcomes:

> … in an ideal world we would all have a really strong appreciation of why it is that we're exchanging information and what the overall goal of us working together is. It's actually about getting better outcomes for kids and families. [C6]

For example, information exchange in a school might often focus on teaching and learning outcomes, while the focus for a childcare worker might be different. Further, good practice concerned relationships between the worker and the family, and the worker and other services, rather than simply information:

> 16A needs to be much more than just agencies exchanging forms. There needs to be verbal communication and establishment of trust between officers where the details and the essence of what we're trying to achieve, that is the protection of the child and the family, can be discussed and explored. [C2]

Some interviewees indicated that prior relationships and trust were also important in the process of sharing information. Where a worker knew and trusted the person they were sharing information with, the exchange of information tended to be much easier than with agencies or individual workers who were not familiar.

Interviewees also stressed that obtaining consent to share information remains best practice, but Chapter 16A means consent is not mandatory and information can still be shared to support the safety, welfare or wellbeing of children where consent is not given:

> In a domestic violence situation, I might not want to tip someone off to the fact that we were making enquiries and the government was involved. Whereas in another situation, you're working with a family, you've built up good trust and a bond, and you're just going through a process of checking and supporting them, in those cases most people are quite fine to provide consent. [C2]

Many participants asserted that regardless of whether consent is given, families can be involved in the information sharing process:

> In case conferences around particular families, we always encourage the family to be involved. That's one mechanism that does actually settle everyone down, because then there isn't any question of the family not being party to the information that's being shared about them. [C12]

5.2.1 Implementing Chapter 16A

Organisational Culture

Research participants reported that Chapter 16A and the associated *Keep Them Safe Implementation Plan* 'has made a hell of a change' [C9] and that, overall, there is 'an ongoing culture change process' [C4] resulting from its introduction, involving:

> A much stronger awareness across government and non-government organisations of the need to collaborate in order to maximise the safety, welfare and wellbeing of children and young people in New South Wales. There is a much stronger common conversation about the need to share information. [C4]

> Keep Them Safe is still changing the culture from one where it's so heavily focused on reporting (to a focus on planning for the intervention). [C8]

Interviewees reported that information sharing had increased, and some interviewees noted the 'case by case' nature of information sharing which require nuanced conversations about what was needed and why:

> The system works pretty well but you come across, quite appropriately I think, conversations we need to have to say 'Well what are you really asking for? Why do we need to give this?' and back and forth. This far into 16A I think we've encountered less dilemmas than I thought we would … It's about that case by case nature of it. That's [our] experience and the other thing is that people really want to share information to understand what's going on with cases. [C8]

This confirms that the change in legislation has not resulted in inappropriate exchange of information, and that each case is treated on its own merits, which is an indication of good practice. The introduction of Chapter 16A had generally been well received by staff and had clearly facilitated good information sharing practices. However, this was not the case everywhere.

5.2.2 Variation in information sharing practices

Whilst interviewees commented that the introduction of Chapter 16A had led to good practice, it was also clear that this was not consistent within or across different agencies.

Unclear practice

Clear understanding and good practice were stronger in some areas than in others. First, despite the significant training and development effort that accompanied the introduction of Chapter 16A, there was a general consensus that awareness and practice among workers was still inadequate. A number of interviewees were of the view that there was a need to remind staff who were already trained about best practice [C6, C10], support staff members who were not as well trained [C4], and to train new staff [C7]. There may be particular agencies or departments within agencies who work with children but are not fully aware of their responsibilities under Chapter 16A [C4]. Some prescribed bodies were unclear about their status under the law:

> In some areas there's a very good understanding, and then in other areas there'd be a very poor understanding. If you use 16A regularly and you're comfortable with it, and you know where the resources and tools are, you're going to be fine, but if you come across 16A once every three or six months and it's not quite common and it's not quite standard, and you're not very familiar with it, it's got the potential to scare some people. [C2]

If staff are not using Chapter 16A regularly, despite earlier training, they may not be familiar with how to share or access information [C6, C10].

Some participants were concerned that not all staff were sure about the processes for sharing information, particularly when the concern is with prevention or early intervention. Others noted that they may not know who to talk to in order to find out information about a family:

> How do I pick up the phone and know who else is involved and have a conversation locally about who's going to help this family … … it might be hard to apply 16A if you really don't know who to talk to. [C8]

Local workers in this situation might contact a Child Wellbeing Unit or child protection staff in Family and Community Services. With early intervention, one interviewee suggested that staff may not want to do anything at this stage, but wanted their concerns officially recorded on a database for the future [C8].

Some interviewees were of the view that the collaborative aspects of the legislation in terms of coordinating service delivery were not sufficiently emphasised [C8]:

> The little-referred to part of 16A is the requirement to take reasonable steps to coordinate service delivery where it relates to safety, welfare and wellbeing. That aspect of 16A is so critical to why we share information … when 16A commenced, we were so focused on purely the information exchange aspects of it that some of

the other aspects such as service coordination weren't perhaps highlighted in the same way that providing information was. [C6]

Concerns about information sharing

Some workers were concerned that information sharing for child safety, welfare or wellbeing would be used inappropriately or even illegally, or 'losing control of information once it is shared' [C5]. Departmental views on information security also affected information sharing:

> Health feels very strongly about the security of its records, Education as well, they've been burnt probably with family law issues and things like that. They're very careful about what they exchange.[C9]

Others were concerned about the extent of the information that they could share.

> Procedurally we've gone from requesting people to supply information to making just about every request under Chapter 16A and so we're using the Chapter very extensively and in fact probably even too extensively.[C1]

> Often when there's information sought about adult family members, [it's] sensitive information, HIV status, Methadone treatment, which sometimes seems to be more of a fishing expedition and is not well thought out. We're constantly discussing it, and we're having extra meetings with Police about sharing and the investigation teams. That says to me it's not as straightforward and well understood as it should be. [C3]

One interviewee with a good understanding of the legislation noted that it was important to clarify which part of a person's health information was relevant to the health, welfare and safety of the child, and which should remain confidential medical information. This was not always easy to determine.

Responding to requests rather than volunteering information

Interviewees said staff were more prepared to respond to requests for information than to volunteer information and were conscious that what they 'could potentially improve is the proactive provision of information to others' [C6]. They were also conscious that they were more prepared to share information when the risk of harm was greater than when the sharing was for prevention or early intervention:

> Once we get children to the risk of significant harm level, people are reasonably clear about the need to share information. … I think the further back you get up the early intervention and prevention pathway, the processes are equally clear, but people don't feel they're as clear on the ground. [C12]

Inconsistent approach within and between different organisations

A number of interviewees noted differences between agencies' willingness or capacity to share information. These accounts differed, possibly reflecting that variations in practice occur in specific areas of organisations rather than in those organisations as a whole. Factors suggested to explain these differences included understanding, capacity, and culture. Interviewees reported a number of specific areas where the practice of information sharing is seen to be inconsistent.

Interviewees noted that government agencies were more confident in their use of Chapter 16A to share information than non-government organisations – possibly due to their experience, training [C13], and support [C12], and possibly due to differences in culture. One interviewee thought that non-government organisations were less confident than government organisations in sharing information:

> Non-government organisations tend to be less confident … about how much information they can exchange. They tend to be probably a little bit more an advocate still for the family, which is good, but if you're exchanging information it's at the stage where there's a child with health and safety issues. [C13]

Among government departments, some interviewees pointed out that health workers had come from a cultural background of not sharing information due to the privacy of health records [C9]. Others identified an inconsistent understanding and implementation of Chapter 16A among health and other workers, often within the same agency, sometimes leading to delays in information sharing [C9, C13]. Most of this inconsistency was attributed to a lack of understanding or inexperience with Chapter 16A:

> You might have a fantastic child protection service that knows how to use [Chapter 16A], but the drug and alcohol team only used it three times and never understood it fully or, the other way around. Because they don't have a shared understanding within Health about what they can and can't share and what 16A might mean for the child, as opposed to the mum, as opposed to the boyfriend. [C9]

One interviewee identified a recent cultural shift within Health to greater sharing of information:

> NSW Health staff… share information with much less resistance than previously. There was a previous culture in New South Wales Health… where staff believed that their primary responsibility was to the privacy legislation… When it comes to acting in the best interest for the safety and wellbeing of that child and young person, recognising that that is not a breach of privacy legislation has been quite a culture shift for health staff. [C4]

However, this was not reported consistently within the organisation:

> The youth mental health people, they're out there and they're doing it, but nobody else inside Health thinks they're even allowed to… [C9]

Some of the interviewees believed that Family and Community Services was the most difficult agency with which to share information. One was of the view that some Community Services staff were still adjusting to sharing information as well as receiving it [C13]:

> When we ring CSCs (Community Services Centres) we get varying responses about what they think we should know about cases. [C13]

One participant indicated that whereas in the past Community Services had shared information about children in Out of Home Care (OOHC) with NGOs, this was no longer the case, and (in this person's experience) NGOs are now unable to view case files of children who were now in their care. From the perspective of FACS, its policy had never been to automatically release the entire file to an NGO. The obligation to maintain the anonymity of reporters remains a core element of mandatory reporting. In addition, there will be a substantial amount of information on a child's file concerning the family context at the time of a child's removal, which an NGO need not know to properly case manage the child in out-of-home care.

Differences were expressed by interviewees about the best processes for seeking information. One Health interviewee commented on requiring background information in order to release information to ensure it contributed to the safety, welfare and wellbeing of the child [C8]. Another medical practitioner found the process under Chapter 16A too restrictive and suggested that departments collaborated more to discuss cases:

> It would be much easier if [multi-agency meetings] were routinely set up by Community Services … about kids they were concerned about, that we might be looking after in the clinics, and we can discuss their progress. … We have asked the Child Wellbeing Unit, and they won't come along and just discuss whoever comes up that's of concern to us … they've generally said to us send us specifics about children, why you want this information … It seems very cumbersome. [C11]

This again illustrates the variability of practice across agencies and sectors. It also demonstrates the tensions between the strict interpretation of Chapter 16A by some agencies who require a formal request for specific information, and others who believe that information sharing should be less bureaucratic and more focused around collaborative practice.

Managing the sharing of information

Information sharing is still a bureaucratic and resource intensive activity. Some government agencies had been overwhelmed by the volume of additional work created by Chapter 16A and recognise the need to implement good data systems to help manage this process:

> The [government] agencies possibly didn't realise how much this would be used, and that's created additional work depending on what unit you talk to. Government I think struggle with the volume. So I think FACS struggle with the volume, I think Health at times struggle with the volume… If we're going to exchange information, we've got to have data systems that have got tools that can redact information within the system. We're working with someone now trying to get an app to make that happen. [C13]

Smaller organisations, such as a medical practices, are not equipped to manage requests which may affect their decisions about whether to share information. As one interviewee said:

> Your GP, even if they're working within a clinic, often won't have that same level of admin support behind them to put in place an easy way for that information to go out … that's where they start thinking about, "Well, is this essential to what I should be doing? Do I value add here - what's the benefit for my patient from a health perspective? I can't see it, therefore I won't play ball." [C1]

This illustrates the challenges to sharing information across the board and indicates a significant barrier for information sharing, both in large and small agencies.

5.2.3 Practical and technical issues

Participants raised a number of practical and technical issues that impacted on the sharing of information under Chapter 16A.

Decentralised records

A number of participants reported that patients have multiple localised records connected to different health services they received, including separate records for different hospitals and separate records for emergency, mental health, and community health. These records are not available to practitioners outside of each location, and the information is not available to be shared. This is a major barrier to information sharing under Chapter 16A. One interviewee reported that the Ministry of Health's record system was an obstacle to information sharing:

One of our worst child deaths was where Health itself weren't sharing information [within the organisation] and they didn't know who was seeing what. They had such a disaggregated system that it lends itself to poor sharing of information. The take up of electronic records is still low and you still have quite a fair degree of localised record holding. Wherever you get that and you have medical practitioners who only rarely deal with children, there's a reticence about sharing. [C9]

Determining whether a child is at risk cannot always be assessed by one isolated incident and often relies on considering other information related to the child or their family about other incidents. However, the 'hospital does not have information about presentations to other sites, to other hospitals – so you haven't got a full picture' [C13].This information was not immediately available from the Child Protection Helpline either:

They say, 'Well why do you want to know?' and 'We can tell you there's been something but we can't give you the detail' or limitations in the kind of information they'll give you. …you can eventually get that information. After hours it is difficult, it does take extra effort. [C13]

Health services are decentralised, and each local health district has a number of systems on different sites that store health records. The introduction of the Australian Governments national eHealth records is a national system that will incorporate information from existing healthcare systems into a personal summary of key health information. The scheme is voluntary, individuals must register to participate, and will only incorporate discharge summaries from hospital records. The eHealth system will not address the issue of decentralised records within Health in NSW.

Access by Child Wellbeing Units

A second issue concerned access by Child Wellbeing Units to records held by other Child Wellbeing Units. When Health and Education Child Wellbeing Units are granted access to the detailed records of another CWU, it is for an unlimited time. However, the Police Child Wellbeing Unit is granted access to records held by the other Units for only 14 days. These arrangements limit access to information, but removing them would also cause difficulties, as outlined by an interviewee:

The basis around [limiting access to 14 days] was if things changed later and anything was ever added to that event, we run a risk of leaving it open where someone could go into it and basically make out something that would have, in a new request, declined that request. …We've had the general counsel involved and they've said that we have no option but to remove that 14 day limit …[and] that it's our responsibility to be able to review the database or come up with a system so that … we can go back and check that nothing has changed. That [function] isn't

> currently available in WellNet, you haven't got a system that can do that for us, and to do it individually would be so time consuming. [C13]

This illustrates the complexity of collecting and storing information and the necessity to be vigilant that information shared is relevant and up to date. The interviewee also suggested that changes needed to be made to the database to identify and report on new items being added.

Mechanisms to request information

Some interviewees suggested that there is a lack of clarity about the mechanics of who to make a request for information to and how, with different systems operating in different departments:

> I've had a couple of requests that come into the Ministry of Health for detailed information. Ministry of Health does not hold any patient information whatsoever ... The service provision is all done through separate statutory health corporations. [C3]

> People would prefer to do it in a more formalised way, yes in urgent cases it might be done verbally and backed up with, you know, written exchange.… It's like everyone that you talk to has a slightly different system, some are more stringent than others. [C13]

These quotes also indicate that the issues around information sharing are in some ways different when the family is involved in statutory processes such as the courts or Police proceedings. In those circumstances agencies have to be very careful about how the information can be used and whether the client or other third parties can be affected by the exchange of information. This is quite different from information exchange in early intervention which is primarily driven by a need to provide a holistic service to children.

One interviewee noted that Chapter 16A was used in requests for information sharing even where this chapter did not apply, for example for interstate requests, on the basis that the organisation receiving the request would decide whether it could release the information [C1].

Ownership and release of information

When the Police share information with another agency, for example FACS, the information becomes the property of FACS; however, interviewees indicated that FACS does not advise Police before releasing that information such as when subpoenaed in a family law case. This situation could, according to some participants, increase risks to people named in the release and may 'cause someone to be seriously injured' [C13].

However, no examples were provided of such a situation having actually occurred to date.

5.2.4 Limiting information sharing

Although information sharing was considered to have brought benefits, some interviewees acknowledged the need for limits to information sharing:

> I don't know that we've got in place rigorous enough arrangements to deal with the situation that the power may be one day misused. [C2]

Within prescribed bodies, appropriate information sharing 'does not mean a whole organisation should be able to have access to absolutely everything' [C7] – although there are no formal constraints on how far information is shared within the organisation. There may indeed be risks, particularly (but not only) in smaller communities, that information may be shared for the wrong reasons 'that can lead to a culture of just reporting for reporting's sake, or for vindictive reasons' [C2].[4]

Interviewees stated that there are already safeguards: first, under the Commonwealth *Crimes Act*, it is an offence for a public sector official to disclose information where there is a duty not to disclose it (*Crimes Act 1914* (Cth) s 70); indeed, NSW law has a specific offence against public sector officials disclosing personal information (*Privacy and Personal Information Protection Act 1998* (NSW) s 62). In addition to criminal offences, there are civil penalties under Commonwealth privacy legislation for serious or repeated instances of unauthorised disclosure of personal information (*Privacy Act 1988* (Cth) s 13G). However, one interviewee suggested that:

> There might be a need to remind people about what you can share, also about the context and the purpose for which you're sharing it, and what they're allowed to do with that information. [C7]

Further training and information about the legislation was a reoccurring theme, with many interviewees confirming that training should be repeated from time to time.

5.3 Understanding the legislation using scenarios

Three scenarios were discussed in order to understand how privacy legislation may be applied in practice by interviewees.

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[4] It should be noted that no examples were given in this case study of information being inappropriately shared across organisations. However this is not an indication that this never occurs.

5.3.1 Youth mental health scenario

The following scenario was developed to explore the issues relating to information sharing between health and other sectors around cases where there are serious concerns about the wellbeing of a young person, but these are not child protection matters. This scenario raises questions of consent, confidentiality and interagency collaboration.

Scenario 1: Youth mental health

A girl of 14 is admitted to the emergency department following a suicide attempt. She is discharged from hospital after a couple of hours, and the family are advised to seek help from a service provider or school counsellor. The family are given the numbers of local counselling agencies. The hospital staff are very concerned about the young woman's state of mind.

- Would they/you share information with the school/NGO/GP/other agency about the child?
- What factors would facilitate or prevent this information being shared?
- What would be the process for sharing information?
- What would be best practice in this case?

Seven of the eight interviewees who commented on Scenario 1 thought that the school and/or some other agency should be contacted in this situation. Interviewees commented that the limited capacity of emergency departments meant that, in practice, this might not always happen. Several interviewees commented on the need for information sharing to happen:

> … is there anybody that she trusts, that she's ever talked to about some of these issues, to get some indication from her about whether or not she is safe in her family or not, whether or not suicide attempts relate to things that have happened in her family … the next step would be to talk to the young person about the types of service providers that are available in the local area and check whether any of those are places that she might go. If that's the case then a warm referral together with the young person to that service would be appropriate … it would be information sharing with a person present. I would also be checking with the young person, whether or not she would like her parents to be involved in this process or not because those can be critical issues. [C4]

One interviewee suggested that privacy concerns would mean they might contact the girl's GP but would not inform the school:

> I think we probably wouldn't ring up the school. We might ring up the GP and we'd certainly discuss it with any people here that are seeing the child, but I think we would ask permission. If a child says, 'No, don't tell my school', we wouldn't. That's different to 16A. That's more your doctor-patient confidentiality issue of not breaching the patient's request … I think it depends on the age, to be honest. So if it's a young child, there's not an issue because you don't generally ask a young child whether it's okay to share their information. [C11]

One interviewee commented that emergency departments would probably not share information, but if the child was admitted to a ward, especially if there was a social worker on the team, the information would most likely be shared. This is consistent with the literature cited in Section 3.2 above suggesting that medical professions tend to be less willing to share information than professions grounded in social and community services. One interviewee said it would not be best practice to just give the contact for a service:

> The normal and best practice in Health would be that you would send a discharge summary, a referral letter, back to the treating GP, [and] a referral will be made to the community based health service support … if it's during the day you might be able to make the appointment. [C14]

The interviewee who thought the school and other services should not be contacted commented on this decision:

> [Give] people the benefit of the doubt. You're never 100% sure what's happened. If you're uncertain enough to let them go back home with their parents and back to school and all of that, but you've got a niggling doubt that maybe they're an abused or neglected child, what you would be sharing is just your hunch or your suspicion … maybe you shouldn't prejudice the way other people see that situation. [C11]

However, those who supported sharing information couched their comments in terms of support for the young person.

> The young person didn't want to share. … I think there might be a gap there in terms of people's understanding of 16A and how it can be used, where it can be used and can't be used and whereby, if a young person or a family does not want information to be provided that you've virtually got an obligation to that young person to let the relevant people know and it needs to be done in a professional caring way where people won't make judgements but where support can be put into place where required. [C10]

5.3.2 Childcare scenario

The following scenario was developed to explore the relationship between early childhood education services and other agencies and also to consider the implications of sharing third party information. Long day care centres are generally not involved in child welfare issues, but from time to time they may become involved with families where there are particular concerns which may impact on the wellbeing of children.

> Scenario 2: Childcare
>
> A preschool is concerned about the behaviour of one of the parents of the children in the school. There are no child protection concerns but the mother is looking more and more depressed each day, and she complains that she is finding life very difficult since she has split from her partner. She tells another parent that she is going off her medication and has told her psychiatrist that she does not want any further treatment.
>
> - Would it be good practice for the preschool to contact another agency in this situation? If so, which agency?
> - What challenges are there in assessing whether there is a child welfare issue?
> - Would the response be different depending on whether the information about the parent going off her medication was hearsay as in the description – or if the information came from the parent herself?

Five interviewees commented on Scenario 2. There were no clear answers to this scenario. Suggestions from interviewees included using the Mandatory Reporting Guide or consulting the Child Wellbeing Unit if their centre was affiliated with the Department of Education and Communities. One interviewee thought it was not appropriate to contact the woman's psychiatrist at this point. It was, however, seen as important to engage with the mother:

> Often childcare centres have good relationships with parents, so a first engagement with the mum about how she is, is there any support that the childcare centre can offer, and whether or not they've noticed any issues for the child, so staying child focussed and engaging the parents around that. [C4]

Another interviewee suggested using the Family Referral Services linked to the Keep Them Safe reforms:

> A focus from the childcare worker with the parent on how hard it can be sometimes to be a parent, how most of us need support, how helpful these services can be to get support, and making with that person a warm referral to the family referral service which would provide a bit more of a safety net to assist getting some support services for this woman. [C4]

Another interviewee thought that depression in itself was not the key issue, noted that 'every parent has mild issues' [C12], and thought that the deciding factor would be the potential effect on the child:

> If mum were a bit depressed, but the child is still managing to come to school dressed and well and eager to learn, and there's no impact, then I don't actually necessarily see that my role is actually to be telling anybody … if I was seeing an impact on the child, that the child was starting to miss school, the child was starting to come to school without food or whatever, and we've clearly got a

mother who is too depressed to get up in the morning to look after the child, well then we're in a different circumstance; I'd be absolutely notifying people. [C12]

Two interviewees thought that the key factor in deciding to contact another agency would be whether there were signs that there was any risk to the child, suggesting that the centre could keep a close eye on the mother and engage with her, or they could also consider offering for her to see a service.

One interviewee also indicated that information would probably be shared if the childcare centre was working with another agency regarding the child, or had good working relationships with a local NGO, but that otherwise the centre would probably not share any information.

5.3.3 Early childhood scenario

The following scenario was developed to explore issues around early childhood parenting. In particular, where there is not a clear risk but there are indications that the situation is problematic and could get more difficult for the child and the parent.

Scenario 3:

An early childhood nurse sees J after she has given birth to her first child. J is a single mother aged 21 living on her own. J's mum lives around 20km away but does not have a car and can only visit occasionally. The father of the baby is in prison, and J tells you he will be released soon and she is worried about what will happen if he comes back as he is a drug misuser. J seems to be managing quite well but complains of lack of sleep. The child is slightly underweight, and J complains that she isn't interested in eating or sleeping. You give her information about a local support service and she says she will think about it.

- Should the nurse contact the prison, other service, GP or any other service?
- What would prevent her from doing so?
- Who else would be involved?
- What would be the likely outcome?
- How would this be recorded?

J calls to tell the nurse that her mum didn't come yesterday as planned because she has been admitted to hospital. J says that she is OK and she thinks the baby is beginning to feed better, but she still cries all night. She tells the nurse that she might go to the local mum's group [or whatever service] that she has found on the internet. She thanks the nurse for her help and says she no longer needs the service because she is feeling better. Her tone is depressed and tearful.

Four interviewees commented on Scenario 3. Interviewees were of the view that 'with that scenario there are risk factors but clearly the biggest concern is what support is this woman getting around parenting and concerns about a lack of support' [C8]. Two interviewees suggested using the Mandatory Reporting Guide. One suggested the nurse should at least be contacting the Child Wellbeing Unit. All four interviewees thought that

the most important response was to engage with the young mother, hear the concerns, and secure some ongoing support:

> Ask her about would it help to talk to somebody about this … . Then one of the other things that can help is for us to talk to the service about the things you've told me so you don't have to retell them. It's much more about engaging the client in that process so that they're part of it. Then information sharing in that situation is entirely appropriate. [C4]

> The number one thing to do with this mum is to establish the relationship with Child and Family Health Nursing Service … not here's the name of A, and turn up when you can. This is a classic case for a sustained nurse home visiting program. [C12]

One interviewee also commented that issues had been raised about work underway to advise the caring parent of a child sexual assault victim when the offender was to be released from jail, but the continuing challenge if that parent was not permitted to share this information with anyone else and so was 'entrapped with that information' [C4].

Overall, interviewees who commented on all three scenarios emphasised that in these situations the answer was not simply information sharing, but that the information sharing operated in the context of engagement:

> The worst type of information sharing is done in a way that excludes the client and or is part of a cold referral, it's unlikely to assist. [C4]

These findings confirm that, on its own, information sharing often acts simply to reduce the anxieties of a worker about a child. However, as indicated in the literature review, good practice would require the information to be used by agencies to provide an intervention which would help to support the family or at least to actively monitor the situation to ensure the safety of the family. This point is discussed further in Section 8 below.

5.4 Gaps between perception and actual legislative and policy constraints

The effectiveness and appropriateness of information sharing under Chapter 16A is difficult to evaluate because of the decentralised nature of the activities that occur:

> There is no database which will describe the number of 16A requests being refused or being requested … because the whole intent of 16A was to remove it from a central hub, a clearing house, and allow people to exchange information directly among themselves. When you remove the clearing house or hub-type model, then the ability to collect data clearly dissipates. [C1]

The absence of comprehensive, systematic data about the use and effectiveness of Chapter 16A was highlighted; however, participants recognised that it would be expensive and labour intensive to collect this information. The provisions in Chapter 16A are clearly being used, yet some interviewees indicated a lack of evidence of any problems or formal complaints about its use [C2].

Suggestions for improving information sharing included the development of a more systematic way of knowing who is working with a family so that the relevant workers can be approached to provide information under Chapter 16A.

Some staff whose role involves the safety, welfare or wellbeing of children are not clear about the legislative and policy obligations and constraints in this area. For example, some staff members are unclear about when or whether privacy legislation is relevant in situations relating to the safety, welfare or wellbeing of children.

Some practitioners have received training but need to be reminded of the operation of the legislation, and others have received training but rarely used Chapter 16A and so lacked confidence in making difficult decisions about the safety, welfare or wellbeing of children under the provisions. Due to the turnover of staff in all the relevant agencies, some staff are not sufficiently trained in the provisions of Chapter 16A.

Some staff members appear not to be seeking consent to sharing information first, where it is practicable to do so. There does not appear to be a culture of discussing information sharing with clients or explaining to them the rationale for information exchange, nor is there comprehensive training in this area for workers, either in the statutory or NGO sectors. Some staff, when worried about child welfare, are more comfortable putting information on a database than engaging with other agencies in relation to the information. Staff are overall more confident about sharing when the risk of harm is significant than for early intervention and prevention. This is mainly because there are clear guidelines for action when a child is assessed to be at risk of significant harm (the Mandatory Reporters Guide) whereas there is little guidance for children who fall below this threshold.

Many practitioners are reluctant to share information proactively. Staff are overall more confident about responding to requests for information than proactively providing information to others. Some staff are concerned that sharing does not give people 'the benefit of the doubt'.

Overall, the collaborative and proactive aspects of Chapter 16A are not always sufficiently emphasised, and Chapter 16A is often seen merely as a vehicle for information exchange itself rather than for promoting more holistic interventions.

Interviewees noted differences between agencies' willingness and capacity to share information, but these accounts differed. However, interviewees suggested that:

- non-government organisations were less confident than government agencies

- small bodies such as GP clinics found it difficult to make time to share

- government departments sometimes found the volume of work related to sharing challenging.

- Family and Community Services response to requests to share is not consistent – in particular the Child Protection Helpline was perceived to always be responsive.

The organisational culture in both Health and Education places great importance on privacy of records and patient confidentiality, sometimes creating an impediment to information sharing where legally there is no obstacle.

5.5 Summary and discussion

5.5.1 Technological barriers, enablers and opportunities to sharing personal information

A number of technological issues were identified in the interviews with stakeholders in this case study. These included:

- the disaggregated site-specific nature of Health records

- limited access by Police to the WellNet database and some difficulties with the way information is stored on this database

- lack of a monitoring system which would track who is sharing information under Chapter 16A and with whom it is being shared.

However, these were not seen as significant barriers. Where practitioners were confident and experienced, they could get around the technical challenges and share information appropriately. Nevertheless, addressing some of the technical issues would facilitate appropriate information sharing. Staff often do not know of relevant agencies that may have information about their clients. One solution suggested was the establishment of a database which identifies the key agency working with vulnerable clients so that others can access the key worker where this is appropriate. However, a great deal of further

work will need to be done in order to assess whether this would, even in principle, be a cost effective solution. Another approach would be the Patchwork system from the UK, which enables service providers to form a network to share information about a particular person. This is being trialled on the NSW Central Coast.

5.5.2 Organisational barriers, enablers and opportunities to sharing personal information

A number of organisational barriers and enablers were identified. Perhaps the most significant organisational barriers were the gaps between perceptions and actual legislative and policy constraints (see Section 5.4 above), particularly in regard to agencies proactively sharing information when this is appropriate. This was reported as being part of a risk-averse culture which pervades many of the human services.

Many workers are reluctant to discuss information sharing with families, particularly in sensitive or complex cases; workers are likely to either report to the Child Protection Helpline or not share information with others.

There has been training for most organisations around the introduction of Chapter 16A, and this was viewed as very positive. However, there does not appear to be adequate training or organisational protocols around discussing sensitive issues with families and informing them of what information is retained about them and the circumstances under which this may be shared.

Although the general level of awareness amongst the workforce of Chapter 16A was high, many workers identified difficulty in knowing who to ask for information about the circumstances in which information should be shared and the process for exchanging information. Staff training, workforce development, and cultural change could address the issues outlined above:

- Some interviewees suggested further training was required; another suggested training should be provided in a practice setting (for example, the Practice First Program); others suggested what was needed was workforce development or change management rather than training.

- Online training is helpful in reaching more staff but does not offer the interactive approach needed.

- Training needs to be continual and requires regular follow-up.

Overall, there was a strong belief that good working relationships and building networks, relationship and trust between those who need to share information was the most effective way of avoiding pitfalls and ensuring that information is exchanged appropriately

and in the best interests of the child and family. However, effective information sharing is not only related to personal or organisational relationships. It also requires the resources and infrastructure to effectively exchange information and to record what has been shared. This includes training, availability and clarity of advice as well as clear protocols within the organisation.

5.5.3 Political/policy barriers, enablers and opportunities to sharing personal information

The legislative support provided through the provisions of Chapter 16A was seen as a significant enabler for information exchange, especially as this was accompanied by a high profile roll-out and significant investment in training the workforce. The research did not identify any significant political or policy barriers to exchanging information. The majority of legal and policy barriers occurred in the interpretation of the legal constraints rather than in the actual provisions of Chapter 16A or other privacy or information products.

5.5.4 Conclusion

Overall, the research findings confirm that information sharing in child welfare has improved considerably across the board as a result of the change of legislation and the training and organisational support for these changes. Yet, there is still considerable anxiety around information sharing and reluctance of some agencies and professionals to share information. The response to the scenarios confirms that there are often no 'right' answers in difficult cases, but that good practice requires careful consideration of the principles and how they apply to the specific case.

The mix of a clear, statutory framework and guidelines issued under that framework appears to be an adaptive one for the purposes of promoting information sharing.

There are still some important developments which will be required in order to further improve policy and practice in this area. In particular, closer and more systemic monitoring of how information is shared, the circumstances in which Chapter 16A is used, circumstances where requests under this Act are turned down, for example. Improvements in the actual process of sharing information and of the technology will also further facilitate appropriate information sharing.

6   Case study 2: Schools

A wide range of information is sought and/or shared between schools and with other agencies. Information is sought and/or shared if health or risk concerns arise about a student, or when students move between one school and another. When students move between schools, relevant information may relate to the student's needs, attendance, any strengths that the school could be supporting in the new schooling system, any additional support that the student might need, risk and behaviour management, and progress in specific learning areas. Information on student needs covers significant health issues such as allergies or diabetes, disabilities, and specific learning needs, e.g. autism or dyslexia. Risk and behaviour management issues could include risk to the child or other children, past violent behaviour, family violence, juvenile justice history, or self-harm.

The exchange of information in the school context is less complex than the child health and welfare case study presented above. This is because in general, there are fewer agencies involved and schools have protocols for dealing with student transfers. Nevertheless, a range of complex situations may arise in the sharing of information in schools. Agencies involved in sharing information include government and non-government schools in the same state/territory, interstate and internationally, Police, Juvenile Justice, Community Services, the Department of Immigration, Out of Home Care services, and other community services. In addition, parents and carers are involved in sharing information.

There were nine interviewees for this case study (3 policy/legal staff and 6 operational staff – see Table 1). Participants included representatives from the Department of Education and Communities, government schools, and non-government schools. Interviews were conducted by telephone using the topic guide presented in Appendix A. In addition to discussing the legal framework for information sharing, interviewees were presented with a number of scenarios to see whether and how they would share information in those circumstances.

6.1   Legal and policy context

The legislative context for information sharing between schools and between schools and other agencies is in part established by Part 5A of the *Education Act 1990* (NSW) (Part 5A) and Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)* (Chapter 16A) (discussed in Section 5.1). While Chapter 16A provides legislative authority for schools and other prescribed bodies to exchange information about students

under the age of 18, the NSW Department of Education and Communities' *Legal Issues Bulletin No.50* states that where the information sought is in relation to a school student's history of violence, Part 5A of the *Education Act 1990* (NSW) and associated guidelines should be used instead.

Under Part 5A, the Department of Education and Communities, non-government school authorities or a school can request a *relevant agency* to provide information about a particular student (including those over 18[5]) to assist a school to assess if the enrolment of a student at a school is likely to constitute a risk (because of the student's behaviour) to the health or safety of any person (including the student) and to develop strategies to eliminate or minimise any risk (ss 26B(1), 26C and 26D(1)). Relevant agencies include schools, the Department of Education and Communities, non-government school authorities, TAFE, public health organisations, the Department of Ageing, Disability and Home Care, the Department of Community Services, the Department of Juvenile Justice, the Department of Corrective Services, and Police.

In effect, Part 5A extends the NSW Department of Education and Communities' *Privacy Code of Practice*, which allows for the use and disclosure of information where that would promote a safe and disciplined learning environment.

6.1.1 Best practice: Obtaining consent

As with Case Study 1 (Child health and welfare), in most cases seeking and obtaining consent to the sharing of personal information remains best practice and is the desirable process through which information sharing should take place wherever practicable. The Guidelines issued under Part 5A for the *Management of Health and Safety Risks Posed to Schools by a Student's Violent Behaviour* (the *Risk Guidelines*) state:

> A school or educational authority must notify a parent, and where practicable the student, that information is being sought from a relevant agency. The parent and student should be given an opportunity to consent to the information being obtained, unless the guidelines say otherwise, before a school or educational authority requests the information from a relevant agency. The parent and student must also be advised of what may happen if consent is not given (that is that the request for information can be made without their consent) (paragraph 4.6).

It is the duty of everyone having responsibilities under Part 5A to comply with the *Risk Guidelines* and hence to provide parents and students an opportunity to consent to the information being obtained wherever possible (s 26M).

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[5] See section 26A of the Education Act (1990).

6.1.2 Duty of care

All schools[6] will owe a duty of care to their students, teachers and other staff members. The duty of care may arise from a contractual agreement, tortious duty, obligations under workplace health and safety laws, or may stem from the exercise of a statutory power.

Depending on the circumstances of a particular case, a school or other organisation may on some occasions owe a duty to share information about a student's violent behaviour with another school, where to do so would assist in minimising or eliminating a risk of foreseeable harm (see Section 4.3 above). In *Schools and the Law,* Butler and Mathews suggest that a school authority may owe a duty to third parties in cases where its activities, or those of its staff and students, create a risk of injuries to those third parties (Butler & Matthews, 2007, p. 11)

On such occasions, Part 5A provides a mechanism by which such information can be shared proactively by one school with another school at which the student enrols without the need to receive a request (s 26D(5)). Notwithstanding that such proactivity is permitted by Part 5A, the research team was unable to identify any statement of policy, within the many policy documents examined, that actively encourages school staff to proactively share such information wherever possible. As with the previous case study, proactive sharing of information is therefore permitted but not required.

6.1.3   Responding to requests

Schools often seek information relating to a student's previous violent behaviour and any records relating to disciplinary action, including any suspensions and expulsion. A *relevant agency* has a duty to provide the information sought under Part 5A if the agency has that information in its possession (s 26D(3)).

6.1.4 Relationship of Part 5A to privacy and other laws

Part 5A states that a person acting in good faith and with reasonable care will not be liable for any civil or disciplinary action for *providing* relevant information (s 26F(3)). The Act also states that any other Act or law that prohibits the disclosure of information (including state and commonwealth privacy legislation and the law relating to

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[6] In NSW it is the Department of Education and Communities rather than the individual school that owes students a duty of care. Schools are not separate legal entities. The Department's duty of care obligations are met through the actions of staff.

confidentiality and defamation) does not operate to prevent the *provision* of information under Part 5A (s 26F(1) and (3)).

It would seem, therefore, that the provider of information is reasonably well protected by these provisions. It is noteworthy, however, that despite section 26F bearing the title "No offence or liability for disclosure of information", the provision in fact offers no protection for any breach of the criminal law. This may be a drafting anomaly which in that case should be rectified at the earliest opportunity.

Although they are protected from liability under privacy legislation for the provision of information, providers or receivers of information cannot ignore their privacy obligations. All personal and health information held in relation to a particular child must be maintained in accordance with the agency's obligations under relevant privacy legislation, except to the specific extent permitted by Part 5A. The *Risk Guidelines* advise that the use or disclosure of relevant information is authorised irrespective of any provision in the privacy legislation to the contrary, provided the disclosure is done in accordance with the guidelines (p 39).

Thus, schools need to balance the need for disclosure with the right to privacy, taking into account the guidance relating to Part 5A.

6.1.5 Transfer of information across borders

When students move interstate, information exchange between schools relies on parental consent. This is formalised by a national system – the Interstate Student Data Transfer Note. There is no provision to override parental consent in these situations. There is no protocol for information sharing when students come from overseas.

6.2 Interpretation of the legislation and policy by agency employees

In most situations where schools share information, there are relatively few difficulties because consent is obtained by parents; the information is not sensitive or contested; or there are well-developed protocols or prior experiences between schools. However, there are circumstances when sharing information faces challenges due to legal, policy or procedural constraints, or differing interpretations of these constraints. This may be due to the type of information being shared (from academic record to information about family circumstances to reports from school counsellors), and whether the information is shared

between public schools within the same state, or between a public school and another school or a school in a different state. Information may also be shared between schools and third parties (e.g. medical practitioners, social services, the Police) and vice versa. Further complexities arise when the information to be shared involves third parties.

Students move schools for a variety of reasons, and interviewees from both the government and non-government sectors noted that information sharing could be helpful for student outcomes. They also noted that a proportion of those who moved were vulnerable or came from troubled families, and moved schools after being suspended or because their families were avoiding child protection authorities. In these cases, sharing information was clearly legal and appropriate. However, there are cases where difficult decisions need to be made, for example where there are concerns about a child that do not reach the child protection threshold and where parents are unwilling for information to be disclosed.

The provision and sharing of personal information in this context is being implemented differently within and between the different stakeholders, as described below.

6.2.1 Information sharing between parents and schools

Information is sought from parents when enrolling a child at a school, including information about previous suspensions and expulsions. This is not necessarily provided in full by parents because they seek to 'protect their children' [S3]. Parents may not share information if they perceive sharing may disadvantage their child, for example, information about past problem behaviour, significant health problems, and disabilities. One interviewee noted that this caused difficulties when the school was enrolling a student who may have been expelled or suspended for a number of violent incidents. Government school Principals expressed concern about students arriving in the school without knowledge of the student's past violent behaviour. One also noted that parents were concerned about this, with 'massive haemorrhaging of enrolments' [S7] in schools where there were problems with violent students attacking other, in this case, vulnerable students.

6.2.2 Information sharing between government schools

When students first seek to enrol in government schools, in addition to parents being asked to provide enrolment information, they are also asked to consent to information being obtained from other schools the child has attended. This information is entered into and then sourced from the Department of Education and Communities' information

system. There is a unique student number that follows the student and the information can be accessed by any state school to help a child enrol and settle into the new school [S2].

When the student moves from one school to another, the information, which includes all of the personal information of the child, can be readily accessed by their new school. The parent provides information as part of the enrolment process in that new school, but the school is able to access information from the system to help them prepare for a child as they enrol in the school.

This process means that, where students move between government schools, the legal situation concerning the sharing of personal information is straightforward. Interviewees reported that this information sharing practice is open and appropriate. Communication is usually between Principals from the two schools or sometimes between Deputies. If there are more complex issues, there may also be information shared confidentially between school counsellors, with recommendations for support or intervention passed to the Principal. One interviewee noted that sharing of counsellor files took longer than sharing of other information because it was transferred through District Guidance Officers. Additional information will be shared between Principals where there are issues of violence or risk. Information can also be exchanged in accordance with Chapter 16A, preferably after consent has been sought.

From interviewee comments, it would seem that not enough information is being entered onto the Department's system, or being provided by parents, and the school is therefore inadequately prepared to deal with any problems arising. This could affect the welfare of the child, their family, fellow students, or the teachers.

6.2.3 Information sharing involving non-government schools

Where students are moving between government schools and schools in other sectors, or between schools in the Catholic and Independent sectors, less information is generally shared. One Principal from the government sector commented that whilst there is an obligation for the school to share information with the new school, information is less forthcoming when the student is coming from the Catholic and Independent systems into the public system or vice versa[S8].

Information from non-government schools is only shared on the basis of parental consent, with certain exceptions: if the Principal at either school believes the student presents a threat to themselves or others by reason of violence including self-harm, or

where there is concern about the welfare of the child. One interviewee from the non-government sector was of the view that the situation was unclear, particularly when Principals are balancing the requirements to protect privacy and other sensitivities such as family court orders:

> This is where Principals get pretty confused because they say 'Hang on you sent me a memo last week banging the privacy drum, now you've sent me a memo saying that this information can be compulsorily required, where does that leave me?' Then you introduce a few side issues like family court orders and you can understand Principals getting a bit confused. [S8]

On the other hand, another interviewee from the non-government sector was of the view that although there are legal differences impacting on government and non-government schools, the same information can still be sought under the existing legislation:

> If people understand 16A and 5A they can, using the relevant process and forms, get the relevant information from the right people. [S6]

Interviewees from government schools said that the information shared with them when students moved from non-government schools varied significantly, from insufficient, to sufficient and appropriate information sharing, to information sharing beyond the provisions such as forwarding information without either parental consent or a request from the school (which is permitted under Part 5A). However, all interviewees from government schools stated that in many cases the information shared was minimal and did not cover key issues regarding student needs, health, welfare, and behavioural problems including violence. Anecdotally, where a lack of sharing of information had occurred and where the student had engaged in violent or illegal activities, this included situations where the parent did not consent as well as situations where parental consent was given. One interviewee explained that in many cases parents hoped for a 'new start' [S5] (see also Section 6.2.1 above) and suggested that some parents would be very angry and may even take legal action should the school provide information to the child's new school about poor behaviour or disciplinary action. Another interviewee, who had experienced parents failing to disclose significant health problems, suggested that 'they don't want it going on records and things like that for fear it will carry over into future employment; it stigmatises' [S7]. One interviewee suggested that some of the problems in information sharing from non-government schools occurred in cases where the government school did not follow the process under the legislation and 'just asked for the information – that sort of thing happens regularly where people don't realise you can't just pick up the phone' [S6].

These quotes indicate that although most information sharing is carried out appropriately, some school Principals do not have a very clear understanding of the legal provisions around information sharing and their obligations towards the care and protection of children. In recognition of this, the Department of Education and Communities has moved to address uncertainties by developing a joint resource document addressing information exchange between Principals.

6.2.4 Information sharing interstate

As noted above, transfers of students between Australian jurisdictions are covered by the Interstate Student Data Transfer Note, which does not give authority to schools in any sector to share information interstate without parental consent. Neither Chapter 16A nor any other NSW legislation can be invoked to allow schools to transfer information without consent. An interviewee advised that even where there is risk involved, in the absence of consent or an exception to the privacy legislation, the grounds for sharing information are limited:

> In the absence of consent, because those legislations don't apply across borders, unless it's imminent and an exception applies to the privacy legislation, then there are parameters on what can be shared. [S4]

This issue affects border towns including major population centres along the NSW/Victoria, NSW/Queensland and NSW/ACT borders.

6.2.5 Information sharing with other organisations

Information may also be shared between schools and other government and non-government organisations such as state Housing, Community Services, Police, Juvenile Justice and Health agencies as well as the Commonwealth Department of Immigration, under legislation, related to child protection and welfare. Schools are also asked, or in some cases subpoenaed, to provide information for court proceedings, for example in family law cases. Interviewees were satisfied with many of these interactions, although some interviewees said that understanding the provisions for sharing was still incomplete and described some instances where information sharing was inadequate or did not occur.

There are also instances where information should be provided by other organisations to schools to ensure the safety and wellbeing of the child, but in some cases were not. For example, a hospital emergency department did not inform a school where a student presented as being a risk for privacy reasons [S2]. Similarly, schools may not be made

aware of Apprehended Violence Orders (AVOs) involving children or parents, and one interviewee expressed concern about possible dangers in not having this information. Some other bodies such as Intensive English Language Centres and Out of Home Care (OOHC) provided information to schools, but this information was not necessarily detailed. In the case of OOHC, only recent information was likely to be shared.

One interviewee expressed concern about experiences of lack of information sharing by the Department of Education and Communities itself, 'where they see their role as to just get students into schools regardless of the issues' [S7] without always informing Principals of students' violent history. However, this was not a concern expressed by the majority of interviewees.

In some cases, memorandums of understanding (MoUs) existed between schools and the Police, but they were not always effective in achieving their intended outcomes. One interviewee said:

> A lot of the Police don't know that there is any memorandum of understanding at all. A lot of the junior officers, in particular, have no idea that it exists, whereas senior Police tend to. Or the Police that are involved in safety and security to do with schools, do, but others don't. [S7]

Information sharing with other organisations was successfully facilitated through strong relationships; for example, one interviewee from a government school had 'a wonderful relationship with our Police' [S3].

6.3 Understanding the legislation using scenarios

Two scenarios were discussed with interviewees in order to understand how legislation may be applied in practice.

6.3.1 Trauma scenario

The following scenario was developed to explore situations where there is concern about the wellbeing of a student, but there is no risk to other students, and where transfer between school sectors is not an issue.

Scenario 1: Trauma
Jani is 14 years old and is a recently arrived asylum seeker. Jani enrolled in a school at the beginning of the year. Two weeks into the school year, something is discussed in class that leads Jani to have an uncontrollable reaction in which she appeared to re-experience in her own mind past traumas. During the course of the experience, Jani was not a risk to any other student, only herself. This experience came as a complete shock to Jani's teacher, other students and school staff. Prior to enrolment at the school, Jani had been enrolled in a non-government intensive English Language Centre to prepare her for school education in Australia, was in receipt of out-of-home care services from a large NGO, and had a case worker from the Department of Immigration.

The five interviewees who commented on this scenario had somewhat varied experiences of the extent to which adequate information would be shared in this situation. The variation in the responses suggests inconsistent practice in this area. For example, one interviewee said that the Department of Family and Community Services would contact the school and offer support [S3]; another said the out of home care case manager would coordinate and talk to the school [S6]; and another suggested the English Language Centre would provide information [S7].

In addition, information was not necessarily able to be made available proactively due to difficulties in accessing and transferring information. For example, one interviewee said that as out of home care records were not on a shared database, it was unlikely that the services would know what school a child was at until the school told them. However, once aware, procedures and an MoU were in place to ensure that the Department of Families and Community Services could work with the school and develop a plan [S3].

As one interviewee highlighted, the person most likely to inform the school of any issue would be the carer of the child:

> I'd say the sorts of people that look after refugee kids, they'd have been in the school and given us a whole heap of stuff to do … I think probably [in] a government school that that child would be immediately looked after in an appropriate way. [S8]

6.3.2 Violence scenario

The following scenario was developed to explore interviewees' understanding of information sharing practice relating particularly to school education and students with a history of violence.

Scenario 2: Violence – transfer from a non-government to a government school
David is 15 years old and arrived at the school during the term from the local non-government school. On his first day at school, David physically assaults an older student, Mikey. On investigating the matter, the Principal finds that there is an ongoing dispute between David's

family and Mikey's family and that this dispute was also evident at the previous non-government school where Mikey had also previously been a student. The Principal finds that both Mikey and David had been suspended from that school for related violence. More recently, David was expelled from it for violence directed at another member of Mikey's family. At the time of their enrolments at the school, neither David nor Mikey's families indicated any prior suspensions or expulsions and no information was provided by the non-government school.

Interviewees noted that information about a child's history is requested from parents by the school at the time of enrolment (see Section 6.2.1 above). However, if the parents had not disclosed this information, the school would not have known about the problem. The fact that the parents and the non-government school did not provide any detailed information about the two students could itself be a trigger for further enquiries under 16A, particularly given that at least one transferred mid-term:

> I would have expected in that circumstance that something would have alerted the Principal of the government school when the young person or children were enrolled in the school, to go and access some further information about that young person. [S2]

When the violent behaviour became known, interviewees were clear about the risks and their obligations: 'there's an obligation under work health and safety legislation to assess the risks posed by violent behaviour' [S1]. Part 5A authorises the exchange of information between the government and non-government schools about information relevant to the assessment and management of risk. Sometimes non-government schools negotiate with government schools about the transfer of students. However, Principals commenting on this scenario stated that they did not necessarily know when transferring students had a history of violent behaviour or a history with other students, which, as a result, required the school to minimise contact between particular students:

> I believe the current legislation would require the exchange of that information if there's violence involved. However, I don't know whether we have to ask before we're given it. [S8]

As discussed earlier in this chapter, schools may also not be aware if there was an Apprehended Violence Order (commonly referred to as an AVO) in place. If the transfer had been between government schools, as discussed in Section 6.2.2 above), the information sharing arrangements between government schools mean that the information about past violence would be shared. However, some participants expressed concern that the Department of Education and Communities itself did not always inform schools of past violent behaviour when placing students.

6.4   Interpretation of the legislation and policy by schools

While there was evidence of appropriate information sharing, this research identifies significant gaps between legislative and policy obligations, as well as different constraints and perceptions, in relation to sharing information concerning students. These arise from inadequate understanding or poor practice. While there are some legislative issues, for example relating to interstate information sharing, the existing legislation provides for more widespread sharing, including between schools from different sectors where the sharing of information concerns the welfare of the child or is due to risk of violence.

6.5   Technological barriers, enablers and opportunities to sharing personal information

There appeared to be few technical barriers to information sharing between schools, within or across school sectors. Although it is technologically easier for state schools, particularly because some of the relevant information is held centrally, there were no reports of difficulties with technology impeding the adequate transfer of information between schools from different sectors. However, as with all technology, the relevant databases are dependent on the information within them being complete and up to date. According to a number of interviewees, this is not always the case, with many instances cited of inadequate or inaccurate information being provided to schools because relevant information had not been entered appropriately into files.

6.6   Organisational barriers, enablers and opportunities to sharing personal information

The vast majority of barriers in this case study fell into the organisational category. Poor understanding of the information sharing provisions under Part 5A and Chapter 16A emerged as the main barriers to good practice in the education case study. While training and promotion occurred between 2009–2011, staff do not remain static and further training may therefore be required for new staff, staff who have changed positions, and/or staff who have not needed to use this provision previously.

There was some confusion over how to share information in practice. Some people had a partial awareness of the relevant legislation and were confused about what it meant in

practice. Principals need to be aware of many issues and not all have clarity about factors affecting information sharing.

Cultural resistance to exchanging information was significant in this case study. Interviewees noted that some people's beliefs were an obstacle to sharing; for example where a student had done something wrong and some people wanted 'to honour peoples' confidentiality and give the child a fresh start' [S3].

Most of the interviewees again stressed the importance of trust and personal relationships between schools and with other agencies. Where there was trust and/or familiarity between the schools, sharing information became much more efficient. Where agencies mistrusted each other (legitimately or otherwise), the process became difficult for both the provider and receiver of information.

6.7 Political/policy barriers, enablers and opportunities to sharing personal information

Similar to the first case study, there were no significant legal, policy or political barriers to information sharing between schools. Several interviewees suggested legislative change, but others pointed out that in most cases, sharing could already occur under current legislation. Chapter 16A as well as the relevant educational legislation were once again considered to be very helpful. Part 5A and the *Risk Guidelines* appear to be reasonably well-known and facilitate information exchange reasonably well. In addition, occupational health and safety legislation also reportedly assisted in this respect.

One issue which was raised is that when students turn 18 years old, Chapter 16A no longer applies. However, as we describe below, the legal and policy context for adults (i.e. over the age of 18) differs considerably from that for children, and it is unlikely that this is possible to change even when the adult is a school student. However, as indicated above, Part 5A of the Education Act enables information to be sought/provided in relation to students over 18 in circumstances where this Act applies.

Another issue is the reliance on parents to provide relevant information to the new school, when children move from one sector to another. Relying on parents is generally appropriate, and most parents are responsible and reliable. However, as the scenarios above indicate, this can cause difficulties when parents do not disclose relevant information. The lack of information can affect the child in question but also other children in the new school to whom the school has a duty of care. One possible solution to this issue is for schools to require parents to confirm that information provided is

complete and accurate, or alternatively, for the parents to give explicit permission for the school to approach the child's previous school. Where a parent refuses, and a school believes on reasonable grounds there are issues, the school can request the relevant information under Chapter 16A or 5A.

Overall, however, there did not appear to be a strong case for any changes in legislation in this case study.

There were differing views about whether formalising exchange was an enabler or a barrier to sharing information. Several interviewees stated that even where there is not a strong legal framework (e.g. interstate information exchange), establishing protocols and processes such as 'a standardised form' [S9] for seeking information 'adds a sense of credibility to the process of sharing because they are established processes, and it's almost compelling then for the other school' [S3]. Whilst some interviewees wanted to formalise information sharing, others thought that an informal approach, for example by telephone, was often more effective.

This again illustrates the importance of trusting relationships between agencies/schools as being the main factor underpinning good practice, but with the rider that formal processes can also assist. Formal protocols also provide the legal and policy underpinning and ensure that agencies are accountable.

6.8 Options for progressing greater personal information sharing

Although the relationships between schools, and between schools and other agencies, are necessary for appropriate information sharing, there are a number of steps which could be taken to provide the framework for schools across sectors to work more closely together in this area. Three options were provided by interviewees:

- Many interviewees suggested additional information and promotion about information sharing. One interviewee suggested 'an information sharing website that sets out the basic legal context, the different Acts that apply, and a decision tree'. [S8]

- Protocols and processes – for example, one interviewee suggested that a standard form, similar to the one used for interstate information, could be introduced to support information sharing by non-government schools.

- One interviewee suggested a brief Memorandum of Understanding between the Department of Education and Communities, the Catholic Education Commission, and the Association of Independent Schools explaining the existing statutory basis

for information sharing and what can be exchanged (similar to an existing MOU between schools and NSW Police).

All these suggestions are consistent with good practice in exchanging information; although, as the literature review found, MOUs and protocols will not change practice in and of themselves. Only if they are used appropriately and consistently are they likely to assist day to day practice. In this regard, an interactive website as suggested above, and discussed below, has the potential for making a significant difference to practice.

6.9   Summary and discussion

There do not appear to be any significant legal constraints to sharing information between schools or between schools and other agencies. It does not appear that there are systemic problems in this area; in many cases, information is shared appropriately and smoothly. However, practice is variable and it is clear that information is not always shared appropriately.

Information exchange between government and non-government schools relies primarily on parental consent. On the whole, this works very well and parents are happy for relevant information about their children to be exchanged. However, there are some carers who are resistant to exchange of information, particularly when the change of school has been precipitated by the parents' wish for the child to have a new start with a 'clean slate'. In these circumstances, school Principals have to exercise judgement as to whether to formally request information or provide information proactively to the new school. These are the circumstances when it is important that schools have access to clear guidance on the legal and policy implications of information exchange.

The mix of a clear, statutory framework and guidelines issued under that framework appears to be an adaptive one for the purposes of promoting information sharing. One legal change that would facilitate improved practice in this area is that 5A could be amended to address the issue that it offers no protection for any breach of the criminal law to organisations and staff acting in good faith.

There is a need for clearer protocols for particular situations, mainly where parents are reluctant for information to be shared, but the school believes that this information would benefit the child. In most circumstances this is covered by Chapter 16A. Better guidance for schools on the provisions of Chapter 16A and the appropriate methods for its use would be helpful. Access to the CWU or an equivalent support service would help schools outside of the government sector.

Although information exchange between school sectors was generally regarded as relatively easy, it was noted that technically this is much easier between state schools, as they share information storage and retrieval systems. Technological compatibility between the systems across sectors would facilitate this process.

7   Case study 3: Housing support (HASI)

The Housing and Accommodation Support Initiative (HASI) for people with mental illness is a partnership program between Housing NSW, NSW Health, NGO accommodation support providers (ASPs) and community housing providers. The aim of HASI is to provide adults with a mental health diagnosis, access to stable housing, clinical mental health services, and accommodation support. SPRC has previously undertaken a longitudinal, mixed method evaluation of HASI. One of the key conclusions of the evaluation was:

> It is crucial that HASI partners promptly share information that could be relevant to staff and consumer risk management. This is the usual practice in most locations, but in some instances information sharing was delayed, especially where HASI partners did not have regular meetings … The type of information that needs to be shared promptly should be defined in the HASI Manual (Bruce, McDermott, Ramia, Bullen, & Fisher, 2012, p. 22).

The HASI case study involved 12 participants (5 policy/legal staff and 7 operational staff – see Table 1). Participants included representatives from the NSW Department of Health, NSW Department of Family and Community Services (Housing) from both central and regional offices, non-government community housing and accommodation support providers (ASP), as well as other statutory bodies. The research team attempted to attend a local HASI meeting to discuss issues of information sharing with a small group of practitioners; however, this meeting was cancelled. Interviews were therefore conducted with individuals by telephone using the topic guide presented in Appendix A. In addition to discussing the legal framework for information sharing, interviewees were presented with a number of scenarios to see whether and how they would share information in those circumstances.

7.1   Legal and policy context

HASI partners are 'subject to the overall legislative and policy framework that applies to all health [and personal] information in New South Wales Health' [H6]. This includes the *Health Records and Information Privacy Act 2002* (NSW) (*HRIP Act*), the *Privacy and Personal Information Protection Act 1998* (NSW) (*PPIP Act*), the *Privacy Act 1988* (Cth) and the New South Wales Health Privacy Manual 'which is mandatory across the New South Wales health system' [H6] and gives practical advice about applying privacy principles. A *HASI Manual*, which was produced early in the program, is currently being reviewed and is expected to be reissued later this year. The *Housing and Mental Health*

Agreement (HAMA), is also relevant to HASI. It provides an overarching framework for planning, co-ordinating and delivering mental health, accommodation support and social housing services for clients with mental health problems and disorders who are living in social housing, are homeless, or at risk of homelessness. HAMA lists, as an element of good practice, the exchange of client information with other services appropriately and effectively within the relevant privacy legislation.

7.1.1 Obtaining consent

Somewhat differently to the preceding case studies on child health and welfare and schools, within the HASI program seeking and obtaining consent to the sharing of personal information is not only desirable best practice but is, in fact, the very basis upon which the HASI program's collaboration and information sharing is based. This is because, unlike the previous case studies, the HASI program does not have its own specific legislative framework governing its information sharing activities and permitting the sharing of relevant information in the absence of consent (cf. Section 7.1.3 below). This is because the previous two case studies focused on children and young people whereas HASI is a program for adults. Adult clients, even when they are vulnerable, are assumed to know what is in their best interests and therefore to maintain full control over such matters as information sharing.

The sample HASI referral form in Appendix C, completed by applicants at time of entry into the program, embodies an applicant's agreement to apply to the program and to consent for a program partner organisation to *seek information* from other partners and agencies concerning any matter related to the application.

> If you get consent your privacy concerns as an agency just melt away. You know, you say "We want to use your personal information for these purposes. Do you agree?" They are fully informed and they say "Yes." You give them the opportunity to ask questions ... Focus on the customer, the service user. [H12]

This consent form does not expressly consent to a program partner organisation or other organisation *disclosing* personal or health information that would be relevant to the application, and to this extent it could usefully be amended to ensure that the form gives full effect to the intent behind it.

It is of course always open to a client to, at any time, withdraw consent to the disclosure of specific personal or health information. Immediately upon such consent being withdrawn, HASI partner organisations lose the right to share that information (from the

perspective of privacy law) unless they can show that relevant exemptions under privacy law apply (see below).

7.1.2 Duty of care

Depending on the circumstances of particular cases, an organisation may on some occasions owe a duty to share relevant information about a client with another organisation where to do so would assist in minimising or eliminating a risk of foreseeable harm (see Section 4.3 above). One interviewee suggested that it was crucial for agencies to:

> ... develop mutual understanding around what duty of care actually means and how it can be considered in that service development. [H5]

However, the sample HASI referral form in Appendix C would not appear to permit the disclosure of such information in the absence of consent.

7.1.3 The *Health Records and Information Privacy Code of Practice 2005* and the *Privacy Code of Practice (General) 2003*

The *Health Records and Information Privacy Code of Practice 2005* permits the exchange of health information without consent in limited circumstances:

> Despite the Health Privacy Principles, a human services agency (the authorised agency) may collect and use health information about an individual, and may disclose health information about the individual to another human services agency or an allied agency, if the collection, use or disclosure is in accordance with a written authorisation given by a senior officer of the authorised agency.

All NSW government and non-government agencies participating in HASI who are in receipt of funding from a NSW human service agency can utilise the provisions of this code to regulate their collection, use and disclosure of health information amongst themselves. Under the code, a senior officer may authorise health information exchange if the officer is satisfied that there are reasonable grounds to believe that there is a risk of substantial adverse impact[7] on the individual or some other person if disclosure of the specified information to the specified agencies does not occur. The code stresses that reasonable steps should be taken to ensure that the individual has been notified by the agency of what information is to be shared, the agencies involved, and the period for which the authorisation is to have effect.

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[7] *Substantial adverse impact* includes, but is not limited to, serious physical or mental harm, significant loss of benefits or other income, imprisonment, loss of housing, or the loss of a career.

The *Privacy Code of Practice (General) 2003* contains similar provisions enabling the disclosure of personal information about an individual by a human services agency to another human services agency or allied agency. These codes modify the Information Privacy Principles and Health Privacy Principles of NSW privacy law, permitting disclosure without consent where a client or other person is at risk of substantial adverse impacts.

The codes also operate as exemptions from the Australian Privacy Principles under Commonwealth privacy law. As mentioned in Appendix B, the *Privacy Act 1988* (Cth) contains an exemption for acts done in compliance with or authorised by another law.

This exemption has particular relevance to the HASI case study, both for personal information and health information held by the ASPs and community housing providers. The ASPs and community housing providers are regulated under the codes of practice and, therefore, to the extent those codes of practice permit information sharing, they operate as exemptions from the obligations under the *Privacy Act* as well as under the *Health Records and Information Privacy Act 2002* (NSW).

It is not clear to what extent participants in the HASI program are aware of the codes. Interviewees made no explicit mention of them or of arranging for a senior officer to authorise information sharing. Interviewees in this case study, however, were generally less likely to reference specific information sharing instruments than interviewees in the other two case studies. As noted in Appendix B, NSW and Commonwealth privacy laws provide for a range of narrower exemptions that could also be relied upon by HASI program staff on a case-by-case basis such as the exemptions for a serious and imminent threat to a person under NSW law and for a serious threat to a person under Commonwealth law.

7.1.4 Relationship to privacy and other laws

Unlike the preceding case studies, providers and recipients of personal and health information within the HASI program do not receive the benefit of a similar specific statutory protection for their HASI-related information exchanges. Compared to their peers working under the previously mentioned statutory frameworks, staff and organisations working within the HASI program are more vulnerable to allegations that they may have committed civil wrongs or criminal offences. This is particularly the case if they fail to establish that an exemption is operative in the circumstances of a particular case or have failed to effectively act in compliance with an exemption (e.g. failing to obtain a senior officer's authorisation under one of the codes). All personal and health

information held in relation to a particular client must, therefore, be strictly maintained, used or disclosed pursuant to the organisation's obligations under relevant privacy legislation and certain other laws where relevant such as the *State Records Act 1998* (NSW) and the *Government Information (Public Access) Act 2009* (NSW).

7.2 Interpretation of the legislation and policy by agency employees

Interviewees clearly understood the purpose of information sharing in this context in that it is:

> …to promote wellbeing and sustainability of tenancies [H7].

They saw the legislative and policy context as providing a good, detailed framework for multiple partners to help maintain wellbeing and sustain accommodation for participants in the HASI program. The long duration of the program was thought to have strengthened governance processes around information sharing:

> I think because the program has been going for such a long time there's some fairly strong governance arrangements around it. [H5].

Research participants also viewed information sharing in HASI as important for both risk management and service provision to ensure that individuals participated in the program or treatment in an informed way, and that staff worked together to meet the needs of the person as identified in their individual plan:

> I think the system that's in place at the moment by and large can address all those different areas. I guess it's really up to individual staff, managers, services to be very clear about how they ensure that these existing systems are adhered to. [H5]

7.2.1 Variation in information sharing practices

In practice, there is considerable variation on how partnerships operate within HASI and consequently in the levels of information sharing. One interviewee [H4] commented that whilst the HASI service agreement is quite robust, interpretation varies. In the six locations they had worked in, the focus on a client's wellbeing and involvement with HASI and mental health varied from strong to rare. Another interviewee [H7] estimated that there was collaboration 50 per cent of the time and it varied in terms of who was more willing to cooperate – NGOs or Mental Health. One interviewee suggested this was based on the strength of relationships:

> There are certain areas across the state where those relationships aren't as strong, but also where people are less clear about their roles and responsibilities. [H1].

Comments by other participants about the extent of collaboration and information sharing in particular localities in HASI support these assessments. Some interviewees reported good partnerships with effective information sharing. This was credited to the regular, thorough, local level Mental Health/Housing meetings and the strong relationships staff had with the accommodation support provider [H3]. Whilst the frequency of the meetings varied depending on service level agreements, outside of the meetings staff contacted support staff directly to discuss any particular issues [H9].

However, other interviewees reported a lack of both local level and broader meetings and failure to share key information. One participant commented that not all three partners in HASI 'were all present, to discuss what strategies to put in place to assist a client sustain their tenancy' and that there 'does not seem to be any ongoing regular structured or unstructured type of communication between the HASI worker and the mental health team' [H4]. Another said that the number of meetings had declined over the last 10 years and that the level of engagement between partners had declined [H8].

Verbal communication was not always followed up with sharing of documentation. This missed opportunity to share information between partners was identified as a key risk to the NGOs providing services:

> The NGO needs to know risk... There's varying degrees [of clarity about information sharing], there's times where [Accommodation Support Providers] are not getting [updated risk assessments and MH-OAT] and vice versa. I would say they're supposed to send us a copy of their individual support plan and a copy of their CANS assessment which is assessment of their psychosocial needs. And we very rarely get those, there's an ongoing issue we are trying to work on a project here to improve that, but document sharing could be improved, there's certainly quite good verbal conversations, case manager to case manager in each team, where they communicate regularly [H11].

Interviewees pointed to issues with information sharing involving each of the three partners: housing providers (government and non-government), non-government accommodation support providers and the Local Health District, and suggested some broad issues that affected staff from each partner.

Firstly, the different partners in HASI had different information needs. For example, Housing do not require the same level of information as the other two partners, and do not always attend local HASI meetings in all areas. Nevertheless, there were comments about the level of housing involvement:

> HASI clients are treated as any other [housing] client and so the engagement of Housing even in the senior level seemed to drop off over the years ... In many cases there's not that much information they would have to share and getting them to a meeting in some areas is very hard and in some areas it's not ... Community housing providers tend to want more information than Department of Housing or Housing New South Wales [H8].

Interviewees also suggested that due to their perceived role in advocating for their clients, some accommodation support provider staff were reluctant to disclose information to Housing where they thought it might put their client's tenancy at risk [H4]. There may also be circumstances, particularly in the NGOs, when staff 'question their right and authority to share' [H5].

Lack of clarity about information sharing and privacy issues was not limited to Housing and accommodation support provider staff. For example, one interviewee commented that some Local Health Districts were not sharing risk assessments, even when they identified aggression, as they perceived this to be a privacy issue [H8].

The HASI program has established routine ways to identify issues and potentially share information, but the interviews conducted indicated that the sharing of information did not appear to meet the needs of all stakeholders or happen consistently across the program.

7.2.2 Informed consent and withdrawal of consent

HASI's reliance on the consumer's informed consent to information sharing raises some issues. While information sharing is central to the program's operation, HASI consumers may not always be completely comfortable with sharing all information with all partners. For example, the consumer may want the service and the domestic support, but be unwilling to discuss her problems with area Health [H7].

When a HASI partner speaks with a consumer about receiving services under the program, there is a need to ensure that the consumer: is capable of giving informed consent; is fully informed, including about what will happen in practice; and that they have actually consented. This process involves telling the person about the roles of the partners and explaining how HASI will work. One interviewee explained that it was helpful not only to provide information to the person both verbally and in writing, but to also assess whether informed consent had been given based on how the person acts. They commented that '…assessing whether a person has understood the consent process can't always be determined straight away, but was demonstrated on whether they were engaged with the program and their behaviour' [H7]. The interviewees highlighted

exemplary practice in that gaining consent is not only about signing a form but ensuring that a person understands what that means.

When HASI consumers withdraw from the program, they withdraw consent to share information. However, there are other provisions to share information about people with mental illness living in social housing and not receiving support, or receiving it outside of the HASI program. For example, the Housing and Mental Health Agreement provides a broader framework for information sharing in relation to people with mental health issues living in social housing. However, housing and support workers were not necessarily clear in which situations information sharing would be appropriate. Some interviewees said they were clear about how to act in these circumstances, but others were not clear, or said their colleagues were not clear. Some suggested that staff members needed to be provided with better information on this issue. Even interviewees who did know that the PPIP Act allows for information sharing when there is a serious and imminent threat to a person were still uncertain about how to assess the level of threat in order to make this judgement.

7.2.3 Factors contributing to variation in information sharing practice

Participants identified a number of factors that contributed to a variation in information sharing practice, including relationships between departments and between staff, culture, the frequency of meetings, staff understanding of requirements, and continuity of staff.

Relationships

Interviewees suggested that there are some areas in NSW where there are long-established strong working relationships between departments, where issues around information sharing have been resolved and staff are working together. In other areas, the relationship between departments has not been as strong [H1], possibly due to the ethos of the organisation affecting how well partnerships operate and information is shared [H4].

Culture

A number of interviewees commented about the different culture of information sharing, in particular from the Health perspective where the concept of doctor-patient relationship and confidentiality seems to prevail despite specific provisions and informed consent to share information [H8], [H11]. One interviewee considered that this may be because staff have not been brought up to speed with changes that have occurred:

> There needs to be …education and training for the frontline staff in LHDs around what consent, privacy and confidentiality actually mean and how they can work. Some people still seem to be feeling that they truly are breaching confidentiality to provide information even when documents have been signed. [H8].

Another interviewee added that this different attitude to information sharing had also been identified outside of the program:

> [The issues concerning doctor-patient privacy among medical practitioners has] come out in quite a few Coroner's cases and RCAs … and even the Ombudsman has studied it. People get too literal in privacy and confidentiality and if they read 5A in the Privacy Act there's a lot of scope for information sharing, even without a person's approval if it's detrimental to their ongoing care. We would mostly, as part of involving consumer and decision making, talk to them about [contacting a GP] and make sure that they're clear and they're okay with that and the reasons why. [H11].

Overall, it appeared that a great deal of progress had been made towards appropriate information sharing in the HASI program and reportedly in wider mental health service provision. There were, however, still significant gaps in knowledge and organisational culture which caused anxiety and confusion for many practitioners.

Frequency of meetings

Many interviewees asserted the importance of having regular meetings and working to develop and maintain local relationships. One interviewee commented that the meetings are mandatory at the district level, but that it was up to each district whether they were also held locally [H3]. Interviewees identified significant variation in terms of whether meetings took place. Those that did meet highlighted that there were good relationships between the different organisations:

> In this area they do meet regularly with our specialist workers through this local Mental Health meeting[8]. … that's where all the operational stuff happens, and that's where the people who are actually dealing with the clients meet. Ours works well because we have ongoing relationships between the organisations and so we know if there's any changes in policies or staff [H3].

> A lot of work went into developing HASI there was a lot of consultation and discussion with those groups that were going to be the practitioners. That trust was there from the beginning and we got to know each other quite well and make those connections early ... We do have meetings with them to maintain that relationship outside of just specific clients [H10].

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[8] The meetings are mandatory at the district level, but it is up to each district whether they continue the local level meetings. We as a district have said absolutely we're going to continue them because

Other interviewees commented that there had been meetings earlier in the program, but some parties did not attend, or did not want other parties to attend, and eventually the meetings stopped:

> We've had for 10 years the HASI Strategic Implementation Committee and that's made up of the NGO providers, health and supposedly housing and we haven't been able to get anyone from housing there for years. Despite invite after invite after invite. Now the meeting is hosted by the LHD and I know they've tried valiantly. But now the LHD isn't having any meetings either. So more strategic interface that we had in [location] has pretty much fallen over now through the government departments [H8].

> You had the LHDs, housing and the NGOs together and then the LHD decided that the NGOs shouldn't be there. We were asked to all only come for a 10 minute/15 minute education session or something at the end at which everyone decided well there's no point. So in the end we were excluded from those meetings as well, which really was an opportunity to talk about some of those issues [H8].

Meetings between HASI partners were considered to be important for maintaining relationships between the partners as well as providing an opportunity to discuss operational issues. Both were identified as important to information sharing, as identified in section 3.3.2. Interviewees noted that collaboration was stronger when the program was first implemented as there were additional meetings to discuss challenging issues about the program [H8].

Understanding of requirements

Interviewees stated that although there had been training and development activities at the commencement of HASI, there had subsequently been a 'slippage' [H8] and 'bad habits' [H11] that contributed to poor collaboration and information sharing, and potential risks to staff [H11]. Leadership [H8], communication, coaching and mentoring [H4], and supervision and training [H8] for all partners were emphasised as means to address this. See also Section 7.2.4 below.

Continuity of staff

Staff turnover was also nominated as a cause of problems in information sharing [H5]. New staff may, for example, not have the same understanding of information sharing, the same relationships with other partners, or indeed a comprehensive understanding of their client which may only be available through their file [H9]. In some districts, a loss of staff was reportedly compounded by a lack of resources. In one example, this meant that the HASI team no longer met [H8].

Interviewees provided examples of characteristics that, when working well, positively contributed to the appropriate information sharing between HASI partners, but when working poorly, directly affected the delivery of the program and in some cases put staff and clients at risk.

7.2.4 Practical and technical issues

A number of practical and technical issues affect information sharing in HASI. Sometimes other issues, such as workplace culture or lack of understanding, compound the practical issues (see Section 7.2.3 above).

Lack of understanding of consent

Although HASI is based on the client and all three HASI partners signing a consent form, interviewees reported that in some cases issues of different professional culture mean that not all partners sign the consent form, or that partners do not understand how the form operates. This may lead to a lack of clarity about information sharing and in some cases, a lack of legal basis for sharing information. For example, some partners within a Local Health District may understand this to be an NGO internal document rather than a program-wide document [H8]; not all partners sign the form or they may duplicate this consent process with an additional internal form [H7]; other partners do not sign the consent form [H8]; and in other cases, carers may not be included in the information sharing process [H8]. This highlights a lack of understanding, both by individuals and organisations, of what should be a simplified consent process.

Discharge to a GP instead of the Local Health District

Some people, who receive low or medium levels of support, do not receive clinical support from the Local Health District clinicians, but instead from a GP who does not participate in the HASI partnership. This in itself was perceived as a stumbling block [H4]. There were differing views about the effect of this arrangement on information sharing. Some interviewees had not encountered any issues and assumed that the same systems would apply, and local arrangements would put be put in place [H5]. Other interviewees reported that GPs might not be prepared to share information with NGOs, but may well share information with the Local Health District [H8]. HASI providers implemented various mechanisms to manage the risk of not receiving information from GPs, including employing their own GPs and psychiatrists [H8] and carrying out their own risk assessment in liaison with the GP [H11].

Information systems

The lack of a state-wide patient record system was identified as a technical obstacle to information sharing. One interviewee explained that NSW Health is 'all pretty much on paper records, we're not on electronic records' [H11] although this does vary from district to district. Some consumers had paper records with '13 or 14 volumes' [H11] that were too large to store on site and so were archived. Further, some Local Health Districts may have multiple files for the same patient on one site, that is, one for each of the clinics treating them, including the Emergency Department [H11]. This can have serious implications for the HASI consumer's care in general, where 'you get all these new psychiatrists or new treating services and they start reinventing the wheel' or where 'a local hospital has not had access to acute mental health history and has made a decision to discharge them from an ED' [H11]. Not sharing information could mean that the HASI team does not have access to important information, for example, 'about how they present when they're acutely unwell' [H11].

The interviewee suggested that the ACT's Mental Health Electronic Medical Record (MHEMR) program was a good model.

Lack of information about when the person starts receiving HASI support

There are a number of reasons why housing providers may not be informed by mental health staff and accommodation support providers that a person has joined the HASI program. For example, people generally access social housing before they access HASI support. A HASI assessment and approval may take place well in advance of a place in the program becoming available. The housing provider may not be aware when a person starts (or finishes) a HASI package, what level of package they receive, what type of service is being provided, or that they should be sharing information with the other HASI partners [H4]. This does not only affect people starting packages, but also those no longer being supported. For example:

> The only thing we've ever had a problem with is we don't necessarily know when a client's no longer being supported, so then they have a problem in their tenancy and we try to get in contact with someone and we find out they're actually not being supported any more. So, we've requested that they update us if packages change and the clients are no longer getting support ... [H9].

This is not a matter of HASI policy but is a procedural gap in the programme's operational processes.

7.3   Understanding the HASI framework and relevant legislation through scenarios

Two scenarios were discussed in order to understand how privacy legislation may be applied in practice by interviewees.

7.3.1   Risk scenario

The following scenario has been developed in order to understand information sharing in relation to risk in HASI. The issue of risk was also raised earlier in this section.

Scenario 1: Risk

A HASI consumer's mental health deteriorates such that their behaviour becomes a risk to visitors. One HASI partner becomes aware of this:

- Would the partner inform the other partners? When?
- If the Mental Health Service is the first partner to become aware of the risk, would different provisions apply?
- If the risk is to themselves, is this different?
- If the mental health clinician is a psychiatrist in private practice, is this process different?
- What factors would facilitate information sharing? (Legal, organisational, professional)

Seven interviewees commented on this scenario. As suggested by the evidence presented earlier in this section, the participants provided inconsistent feedback on how they would respond. There was a tendency for interviewees to say that they would share this information, but then suggested that other partners may not. Some interviewees also noted that an accommodation support provider or housing provider might inform the local clinician, the mental health crisis team, or the Police, depending on the nature of the situation and the level of risk. Housing interviewees noted that they should review the person's file and call the accommodation support provider before attending the premises. It was also pointed out that the local health service should be advising the accommodation support provider about any client risk. However, as discussed earlier in this chapter, the lack of information transferred between service providers, for example by hospitals at discharge, leads to risks to the service providers.

The comments made by staff on this scenario demonstrate confusion about the responsibility and process of information sharing, even when the risk to the individual, staff and others is clear.

7.3.2 Hoarding scenario

The following scenario has been developed to explore information sharing about the early stages in the development of issues that have both tenancy implications and possible long-term impacts for HASI clients.

Scenario 2: Hoarding

An accommodation support provider worker becomes aware during support visits that a HASI consumer is hoarding in their apartment to an extent that their tenancy could be affected.

- What should the support worker do?
- Should the support worker share this information and with whom?

Six interviewees commented on this scenario. Hoarding is against the tenancy agreement and one housing provider spoke of a duty of care in relation to hoarding because of the risk, particularly the fire risk that can develop. Most interviewees thought that the support worker should inform the housing provider. One housing provider thought that it was the role of the support worker to deal with the hoarding problem and that it would not be necessary to inform the other partners. Another housing provider thought that they would be informed in about 50 per cent of cases and yet another thought they would not be told.

This case study demonstrates the cautious approach to sharing information due to the potential threats to the person's tenancy. As discussed in Section 7.2.1 above, many workers were protective of their clients and would not share information that might interfere with their tenancy.

7.4 Technological barriers, enablers and opportunities to sharing personal information

As with the other two case studies, the technical barriers to information sharing were not significant for HASI. The lack of a single electronic Health record was cited by some interviewees in this case study (as with the other two) as an impediment to efficient sharing of information. The fact that there is a single electronic HASI record is an enabler, and technology could also potentially address some of the inefficiencies in the operation of HASI, for example informing relevant agencies when a client begins or ends a HASI package of care.

7.5 Organisational barriers, enablers and opportunities to sharing personal information

As identified by interviewees throughout this case study, there are a number of factors that are both enablers and barriers to sharing personal information in the provision of services in the HASI program. For example, good relationships, a culture of information sharing, regular meetings between partners, clear understanding of the policies and processes, and continuity in staff were all considered to be enablers to sharing information. Equally, the same factors were often responsible for poor information sharing. Poor or absent relationships, a culture of not sharing information, irregular or no meetings between partners, a poor understanding of the policies and processes, and a lack of continuity in staff were all considered to be barriers to sharing information, with factors often compounding each other. All these factors interact with each other to produce a more (or less) efficient and effective program.

As a relatively mature program, HASI demonstrates that there are challenges in sustaining good relationships, high levels of understanding by staff members of the relevant policies, and continuing regular inter-agency meetings over long periods of time, and through inevitable changes in staffing and organisational structures. The case study indicates that programs often need renewing from time to time, and are seldom in a 'steady state' for very long.

HASI relies fundamentally on a clear understanding and implementation of policies and procedures including seeking informed consent from participants and partners, ensuring that this is understood, as well as recognising the need and enablers to sharing information outside of this consent framework when the potential risk to the person is high. The consent form signed by each client provides a good platform for information sharing, but is not a substitute for good practice, and staff need to be aware of the necessity to discuss information sharing with clients, and to be trained to do so effectively.

The different ways the HASI teams worked in different areas clearly demonstrated the enablers and barriers to information sharing, and also demonstrated that with good practice most of the barriers can be easily overcome.

7.6   Political/policy barriers, enablers and opportunities to sharing personal information

As with the previous two case studies, there were some legal and policy barriers and enablers to information sharing, but these were not fundamental to the operation of the program. As a program for adults with mental health problems, HASI is not covered by Chapter 16A or any equivalent legislation which explicitly provides for information sharing if it is in the interests of the client. Although the current legislative framework does not appear to create significant barriers to information sharing under appropriate circumstances, the existence of a clear, specific statutory framework and guidelines issued under that framework are absent from the HASI program and for adult mental health consumers generally. As a result, interviewees were less clear about the basis on which information sharing could take place in the absence of consent. Consideration should be given to enshrining information sharing practice within the HASI program through legislation accompanied by appropriate guidelines. Such legislation would need to address the serious issue that HASI information exchange arrangements offer no protection for any breach of the civil or criminal law to organisations and staff acting in good faith. Although the main legislative gap relates to protection of staff members sharing information, rather than the legality of the information exchange itself, a change of legislation could potentially have a similar effect that the introduction of Chapter 16A has had on practice in child welfare; i.e. that it would create a new context for practitioners in different sectors to appropriately share information rather than operating in a risk-averse manner.

The *Health Records and Information Privacy Code of Practice 2005* and the *Privacy Code of Practice (General) 2003* currently offer a broad basis for exemption from the obligations of privacy legislation and would appear to be capable of broader use within the current HASI environment. It would also appear to be a solid template for any clear, specific statutory scheme that may be contemplated.

One of the policy challenges involves information sharing with GPs as they are not part of the NSW health system.

7.7   Summary and discussion

Information sharing in HASI is largely based on consent forms signed by the consumer upon entry to the program. Interviewees noted, however, the lack of clarity with information sharing both where consent had in fact been provided and where consent

had been withdrawn. The frameworks with the greatest potential to resolve these conflicts are the codes of practice issued under the *HRIP* and *PPIP* Acts: the *Health Records and Information Privacy Code of Practice 2005* and the *Privacy Code of Practice (General) 2003.* These codes of practice provide for a clear mechanism by which all partners in HASI could lawfully collect, use and disclose both personal and health information for a broad variety of purposes in the absence of consent. It is noteworthy that few of the interviewees appeared to refer to the codes in their interviews.

It was noted at the beginning of this section that the HASI evaluation identified that practice around information exchange was poorer where interagency meetings were not being held regularly. This finding was confirmed in this research and practice seems to have slipped since the evaluation reported. Re-establishing regular interagency forums for discussions of issues – including information exchange – would appear to be a good way of improving practice in HASI.

There is an opportunity to repeat training in gaining consent and sharing information as well as promoting ongoing leadership and supervision. This was successfully completed when the HASI program was established and gave staff an opportunity to discuss issues in the process. This would provide an opportunity to ensure there are common understandings between partners and across different districts of the requirements and mechanisms by which to share personal information between HASI partners. It would also increase confidence in practice across all levels of all partner organisations.

8   Conclusions

8.1   Information sharing in NSW

Of the four types of information sharing regimes identified by Richardson and Asthana (2006), the review found that, overall, professionals in NSW tend to exchange information appropriately (the ideal model), with some indications of overcautious practice in which information is held and not shared appropriately. There were few occasions reported where information was shared inappropriately, although this does reportedly occur from time to time. The findings of this research were consistent with the international literature. In NSW, the two main reasons for the lack of information sharing were risk adverse cultures in some organisations and an organisational or professional culture which did not value a holistic view of interventions with clients. There was also a reluctance to discuss information sharing with the information subjects. There did not appear to be any overall difference between the views of policy and operational staff, nor between managers and front line staff members interviewed. In general, there was consensus about the barriers and opportunities for information sharing between staff at different levels. However, due to the small number of staff interviewed, this may not be the case across the board and cannot be generalised to NSW as a whole.

Information exchange worked well in all case examples when the information was fairly routine and the considerations not very complex. In more difficult cases, the review found that in all three case studies, information exchange was variable across the state and across different agencies and sectors. The key gap, found in all three case studies, was that it was not common practice for staff to discuss information sharing with the information subjects or their carers (clients/patients/parents).

While there are clearly occasions where such discussions would not be appropriate, the default should always be that, even when clients do not consent to the information being exchanged, they should at least be informed that their personal information has been shared with another agency whenever this is appropriate and practicable. This should also be common practice when information is exchanged proactively rather than on request from another agency. The reluctance to discuss information sharing with the information subjects is linked to the risk-averse nature of some agencies, where the possible negative response and the perceived breach of trust are considered to be components of the risk. More important, however, is that it appears that there is a lack of training and support for staff members in this area. These discussions are very likely to

be sensitive and difficult, and staff members need to feel both confident and competent to engage with clients and carers around these sensitive issues.

8.2 The need for more exchange of information

Both the literature review and the interviews confirmed that information sharing should not be seen as an end in itself. Exchanging information is only justified when it is done to improve assessment or service provision, or the safety of clients/students/patients or third parties. It is part of a process which facilitates holistic, collaborative and safe practice with vulnerable clients. Thus, any attempt to improve information sharing must be part of a broader focus on improved service delivery.

Effective and appropriate information sharing can only take place in a context where:

- there is a clear legal and policy framework

- there are policies and procedures which specify the appropriate mechanisms for information sharing but are flexible enough to allow for these processes to be tailored to individual situations

- the organisational cultures facilitate appropriate information sharing and collaborative practice across agencies, disciplines and sectors while being acutely aware of client's (and others') rights to privacy and confidentiality

- the human services workforce has knowledge of the legal and policy framework and is trained and supported in delivering good practice.

In addition, across all three case studies, the research found that the key to effective information exchange – and collaborative practice more generally – is that individuals and agencies trust each other to use the information appropriately. This is in line with the Australian and international empirical literature reviewed in this report.

8.3 Technical issues

Developments in technology have facilitated information exchange, and it is increasingly possible for agencies to share information across technological platforms. In no case did technology create a fundamental barrier to information sharing (or conversely provide a solution to problems around information sharing), but difficulties with technology resulted in a number of inefficiencies being identified across the three case studies. This is particularly the case for WellNet, which appears to be a rather cumbersome system, and also the diversity of health records.

The need to introduce a system for electronic records in Health was expressed by multiple participants. This would replace the multiple records in each hospital about a single patient, and in some cases, the lack of availability of information beyond the site in which it is generated. This will not be delivered by the Australian Government's eHealth record system which provides individuals a voluntary way of connecting their existing summary health records through one system.

8.4   Legal and policy framework

In all three cases there was a perception that the current legal framework was adequate although quite complex in some areas. There did not appear to be significant legal impediments to information sharing.

It would appear that awareness raising around the need for statutory bases and application of information sharing needs to acknowledge and overcome a perception that information sharing runs contrary to compliance with privacy legislation. (Confusion about laws and fear of making incorrect decisions was identified in the literature, as well as the case studies, as being a significant barrier to information sharing). Stakeholders should be provided with clear information that information sharing for the purposes provided by statute is a lawful, targeted departure from privacy obligations but that privacy compliance at both an organisational and client relationship level remains important, in particular to build the very trust with clients that lays the foundation for seeking and obtaining consent wherever possible. Privacy compliance is, therefore, a necessary precursor to best practice in information sharing which, on the whole, is best served by sharing information with the consent of a relevant party in preference to relying at first instance on statutory powers.

Nonetheless, the existence of specific legislative authority for sharing information in certain circumstances such as Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and Part 5A of the *Education Act 1990* (NSW) has clearly been helpful in the ongoing development of a culture of appropriate information sharing in New South Wales. Such provisions determine the scope and authority for appropriate information sharing and provide protection for an employee acting appropriately from any alleged breach of privacy legislation. The mix of a clear, statutory framework and guidelines issued under that framework appears to be an adaptive one for the purposes of promoting information sharing. This was best illustrated by the interagency guidance issued when Chapter 16A was first introduced. However, the case studies identified that this is a current gap in NSW and there is no specific website or

other resource which provides succinct guidance and information for all sectors. A good example of such guidance is provided by the SA Ombudsman (Ombudsman SA, 2013).

To assist public sector agencies in managing personal information, the NSW Privacy Commissioner has developed the Privacy Governance Framework (PGF), which is a dynamic online privacy tool to help agencies better understand privacy risks and opportunities, and to address their roles and responsibilities in relation to privacy management. The PGF will assist agencies embed good privacy practices in the organisation's processes to contribute to agency outcomes.[9] A key finding was that information sharing still tends to be passive rather than active; agencies tend to respond to information requests rather than proactively deciding that another agency should be provided with particular information about a client/student.

It is important that agencies in the government and NGO sector proactively share information where this is appropriate, without the need for a request to be made.

It is open to relevant policy makers to clearly specify the circumstances in which a duty to share information with another organisation may arise. Such a discussion would usefully appear within the *Guidelines* mentioned in Section 4.2 above, within the soon to be revised *HASI Manual*, and within any future guidelines to be created in support of any future statutory information sharing regime.

In light of the absence of a clear, legal mandate to this effect, it would be open for organisational policy to mandate proactive sharing (a duty to tell) wherever it would fulfil the objectives of an information sharing regime and would not be contrary to law.

Legal reform can make a significant difference. The passing of Chapter 16A and Part 5A respectively have facilitated substantial changes to practice across agencies and sectors. A key finding from the research was that professionals in both of the child Case Studies were aware of the legal framework for information exchange, whereas in the HASI scenario, service providers were less clear about the legal provisions for exchanging information in circumstances where legal provisions need to be invoked.

Consideration should therefore be given to creating a legislative framework for information sharing in the HASI program (and by extension to all services working with vulnerable adults) and to amending Part 5A to ensure that it protects staff acting in good faith from the risk of criminal prosecution.

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[9] The PGF is available on the IPC website: http://www.ipc.nsw.gov.au/privacy-governance-framework

The review of the HASI Manual should include ensuring that its content regarding consent provides for forms that address as many eventualities as possible and include instructions on the need to ensure that any forms completed are reviewed at least annually. It should specifically include a focus on less formal mechanisms for discussing and obtaining consent.

8.4.1 Policy framework

The research findings indicate that sharing of information may best be provided for in the key legislation administered across relevant sectors (e.g. the Education Act for the education sector, and the Child Care and Protection Act for those working with children), rather than within or under privacy legislation (as is the case with the HASI program).

At present there is little overarching guidance for NSW agencies on how to operationalise the decisions regarding privacy and information exchange. It is important that there is greater clarity and consistency across agencies and sectors in awareness and understanding of the need for permissible information sharing across New South Wales and the statutory bases and application of laws relating to sharing information. Any approach to ongoing education, training and promotion about the benefits of and need for personal information sharing should be undertaken across all sectors that work with vulnerable people in New South Wales. This finding is mirrored in the findings of the *Report on the Operation of the GIPA Act 2013 – 2014* (NSW Information and Privacy Commission, 2015). Training should be underpinned by best practice guides developed in consultation with relevant sectors and their peak bodies. An example would be the *Information Sharing for Effective Human Service Delivery: A Guide for Practitioners* (2006) by the NSW Human Services CEOs Forum[10], which sets out a decision-making process (p.10) to assist practitioners in understanding the key decision-making points and actions that should be taken in determining when to share information. However, this guide would need to be revised to expand on information sharing in the absence of consent.

8.5 Organisational culture and structure

The primary barrier to information sharing was found to be risk-averse organisational cultures in which the protection of the agency was viewed as the overriding consideration

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[10] http://www.community.nsw.gov.au/docswr/_assets/main/documents/iag_infosharing.pdf

in working with clients. This culture often resulted from concerns that the organisation would be vulnerable to legal action or complaints by clients.

The research identified a number of factors which were key to developing organisational cultures within which information exchange was possible. These included:

Leadership and effective management

Strong leadership within organisations was the main factor underpinning the overall organisational culture around information sharing. Clear messages from senior managers that best practice included appropriate exchange of information with other agencies provided practitioners the organisational context in which they could exercise their own judgement about the need to share information with others. This was apparent in all three case studies. In the education case study, for example, the research found that where school Principals were committed to sharing information with other schools and service providers, this greatly facilitated the process for all staff members within schools. Similarly in HASI, where leaders provided the impetus for multi-agency meetings, these tended to be sustained over time. Where leadership in this area was lacking, workers were left on their own to make difficult judgments without the backing of their organisations, and the interagency forums and protocols tended to fall into disuse.

Trust

The findings of this research confirmed those of the empirical literature reviewed above; that is, that trusting relationships between professionals in different disciplines and across different sectors was essential for effective information sharing. Across all three cases the key factor for successful information sharing was trusting relationships between different sectors or different agencies. Building trust requires organisations to work together over a period of time and for practitioners to become familiar with their counterparts in other agencies, as well as protocols or MoUs, which ensure that the information will be used appropriately by the receiving agency. This required consultation and training of staff, and structures to be put in place where issues could be resolved when difficult cases arose.

Guidance

Additionally, there needs to be clear guidance for front line staff on the process for exchanging information. In some agencies and for some client groups this is provided by Child Wellbeing Units; however, not all agencies have access to this sort of support. A resource should be available to all human service organisations which will enable them to access guidance about information exchange, alongside agency specific guidance. This

should include information about the relevant legal requirements as well as elements of good practice which should be followed in the process of sharing information.

Whether acting in accordance with frameworks that provide protection from liability (such as Chapter 16A and Part 5A) or on less well established information sharing regimes such as that used in the HASI program, all staff remain vulnerable to some degree to allegations that they may have committed civil wrongs or criminal offences in the act of disclosing personal, health or confidential information. Protection of staff and best practice in information sharing can both be advanced by ensuring that all personal information is managed effectively, holistically, and in compliance with privacy laws and other relevant laws such as the *State Records Act 1998* (NSW) and the *Government Information (Public Access) Act 2009* (NSW).

Consent

Good practice always involves seeking to obtain consent from the client or carer to exchange information. In all three case studies, the research found that, in some cases, this involved clients being provided information sheets or signing consent forms. Many workers did not feel well-trained or supported around discussing information sharing with clients when sensitive issues needed to be shared.

Notwithstanding the fact that clients may have signed a consent form, it is still important for service providers to inform clients when information is shared, that it has been shared, and what information has been exchanged. This not only shows respect to the client, but it also avoids potentially difficult situations where the client discovers that agencies have information about him/herself that he or she has not provided. This can be embarrassing or even traumatic for clients.

8.6   Limitations and further research

The three case studies provide important insights into the technological, organisational, legal and policy barriers, enablers and opportunities for information sharing in human service delivery in NSW. Although these three case studies cover different sectors and agencies (or parts of agencies), there were some clear themes which were common to all three studies, allowing some conclusions to be drawn which are likely to have more general implications across the human services. However, generalisations to the whole human services sector should be made only with caution. The three case studies do not address some significant sectors, in particular disability services and aged care, and also only peripherally touch on other services such as justice and corrections. Furthermore,

HASI, in particular, is a specific program, and the findings from the HASI program may not apply to information sharing in adult mental health services more generally, where there are no specific interagency protocols.

Although this report provides some comparisons with other jurisdictions, a thorough comparison was not possible within the time and resource constraints of this project. There are a number of further projects which could be conducted to better understand the barriers, enablers and opportunities for information sharing within NSW which would greatly enhance the findings presented here. These include:

● further case studies, particularly in the areas of disability, aged care and justice (and potentially in sensitive areas of health such as sexually transmitted diseases) which would raise issues not covered in these specific case studies, in particular where services are provided by commonwealth and private sector organisations which were not extensively covered in these case studies

● comprehensive comparisons with other jurisdictions, including primary research (in Australia) and identification of the most effective methods for promoting best practice internationally

● establishment and evaluation of programs, training materials, and/or online guidance designed to improve information sharing in different domains

● research with clients who are in a position to comment on their own experiences of information sharing between service providers.

Appendix A: Interview topic guide

The following questions were used to guide the interviews:

- What types of information are shared or sought in this area? In what context does this occur (e.g. policy development, service delivery)?

- What policies, legislation and other frameworks offer protections around personal information in this area?

- Is there clarity of understanding about these frameworks on the part of agencies?

- How are they being applied in practice?

- Are there gaps between perception of legislative and policy constraints on information sharing, and actual legislative and policy constraints?

- Is there potential to improve approaches/practice in this area?

- Are there examples of situations where approaches to sharing information could be improved? What would need to change in order for this to happen? (e.g. better communication, training, cultural change, Memorandum of Understandings)

- What are the key information sharing dilemmas in this area?

Appendix B: Overview of privacy legislation

An overarching legislative and policy context for information sharing relevant to this research is established in Commonwealth legislation (the *Privacy Act 1988*) as well as NSW legislation (*Privacy and Personal Information Protection Act 1998* and *Health Records and Information Privacy Act 2002*). Legislation specific to each case study is outlined in Sections 5 to 7.

Privacy Act 1988 (Cth)

The Commonwealth *Privacy Act 1988* regulates the handling of personal and medical information of individuals. The Act contains a set of 13 Australian Privacy Principles which govern the collection, use, storage, access and disclosure of personal information and applies to most Australian and Norfolk Island Government agencies as well as many private sector organisations.

Principles

The Australian Privacy Principles (APP), found in Schedule 1 of the *Privacy Act 1988*, concern:

- the open and transparent management of personal information (APP 1)
- the collection of solicited sensitive and non-sensitive personal information (APP 3)
- the notification of collection of personal information (APP 5)
- the use or disclosure of personal information (APP 6)
- cross-border disclosure of personal information (APP 8)
- the quality of personal information (APP 10)
- the security of personal information (APP 11)
- access to personal information (APP 12)
- the correction of personal information (APP 13)

Provisions for the use and disclosure of personal information

Section 16A stipulates permitted general situations which allow the collection, use or disclosure by an APP entity of personal information about an individual. These include when it would be unreasonable to obtain the individual's consent and when the use is

necessary to lessen or prevent a serious threat to the life, health or safety of any individual or to public health or safety (s 16A(1)(c) Item 1).

Exemptions for the disclosure of personal information

The exemptions from the APPs are contained in Schedule 1 of the *Privacy Act.* They include:

- where the collection is reasonably necessary or directly related to the entity's functions (Schedule 1, cl 3.2, cl 3.3, 3.3)

- where the collection, use or disclosure is lawfully authorised or required (Schedule 1, cl 6.2, 3.4)

- where a permitted general situation exists (Schedule 1, cl 6.2, 3.4)

- where a permitted health situation exists (Schedule 1, cl 6.2, 3.4)

- where the collection, use or disclosure is reasonably necessary or directly related to law enforcement related activities (Schedule 1, cl 6.3, 3.4).

An exemption also exists in the form of Section 3 of the Act, 'Saving of certain State and Territory laws' which outlines that the *Privacy Act* is not to affect the operation of a law of a state or territory that provides for the collection, use or disclosure of personal information and is capable of operating concurrently with this Act. In effect, this provision allows relevant provisions of State and Territory Acts that provide for the authorised disclosure of personal and medical information to act as an exemption to the *Privacy Act.* This provision is of particular relevance to the case studies in that each operates within a framework of NSW laws that authorise disclosure and are, to the extent of that authorisation, exempt from compliance with the *Privacy Act.*

A number of exemptions exist under Part 2 of the *Privacy Regulation* 2013

Provisions for the use and disclosure of medical information

The Australian Privacy Principles apply to the regulation and handling of medical information under the *Privacy Act.*

The provisions which allow for the use and disclosure of medical information are outlined in section 16B of the Act. In particular it outlines permitted health situations which allow the collection, use or disclosure of health information. The provision is broken down into five main components that relate to:

- collection for the purposes of providing a health service (s 16B(1))

- collection for the purpose of research (s 16B(2))

- use or disclosure relating to research (s 16B(3))

- use or disclosure relating to genetic information (s 16B(4))

- disclosure to a responsible person for an individual (s 16B(5))

Generally, this provision allows for the collection, use and disclosure of health information if the following circumstances exist:

- the information is necessary to provide a health service to the individual and authorised by an Australian law or collected in accordance with the rules of a competent health body (ss 16B(1)(a), (b))

- the collection, use or disclosure is necessary for research relevant to public health or safety (s 16B(2)(a)(i), s 16B(3)(a))

- it is impracticable for the organisation to obtain the individual's consent to the collection, use or disclosure and it is required under an Australian law (s 16B(2)(c), s 16B(2)(d)(i), s 16B(3)(b)) or it is collected in accordance with the rules of a competent health body (s 16B(2)(d)(ii))

- in the case of informing a responsible person for the individual:

- the individual is physically or legally incapable of giving consent to the disclosure (s 16B(5)(c))

- the disclosure is necessary to provide appropriate care or treatment of the individual or made for compassionate reasons (s 16B(5)(d))

- the disclosure is not contrary to any wish expressed by the individual (s 6B(5)(e)(i))

In most of the above cases, the use of information must be reasonably necessary for those purposes and:

- the purpose cannot be served by the collection of information about the individual that is de-identified information

- the information must be collected in accordance with guidelines approved under s 95A

- the organisation must reasonably believe that the recipient of the information will not disclose the information or personal information derived from that information.

Exemptions for the disclosure of medical information

The exemptions that apply within the Act to disclosure of medical information are the same as those that apply to the disclosure of personal information.

Privacy and Personal Information Protection Act 1998 (NSW)

The handling of personal information by the public sector in NSW is regulated by the *Privacy and Personal Information Protection Act 1998* (NSW) (**the PPIP Act**). The Act

contains a set of privacy standards, 'Information Protection Principles', which regulate the way NSW public sector agencies collect, store, use and disclose personal information (excluding health information).

Principles

The Information Protection Principles (IPPs), contained in Division 1, Part 2 of the Act, relate to the manner in which NSW Government agencies use and disclose personal information. As particularly relevant to the case studies, the IPPs concern:

- the collection of personal information for lawful purposes only (s 8)

- the collection of personal information directly from the individual only, unless it is unreasonable or impracticable to do so (s 9)

- requirements when collecting personal information to provide certain detailed information to the person and that the information collected is relevant, accurate, up-to-date and not excessive. (ss 10 and 11)

- information about and access to personal information held by agencies (ss 13 and 14)

- alteration of personal information (s 15)

- ensuring the accuracy of personal information before using it (s 16)

Provisions for the use and disclosure of personal information

Section 17 prescribes that a public sector agency must not use the information for any other purpose unless:

- the individual concerned has consented to the use of his/her information for that purpose

- the other purpose is directly related to the purpose for which the information was collected

- the use of the information for that other purpose is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual or another person (these provisions are particularly relevant to the case studies).

Section 18 stipulates that a public sector agency must not disclose the information to any other person/body unless:

- the disclosure is directly related to the purpose for which the information was collected

- the individual has been made aware (pursuant to s 10), or is reasonably likely to be aware, that the information is usually disclosed to that other person/body

- the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual or another person (these provisions are particularly relevant to the case studies).

Exemptions

There are four chief sources of exemptions from the principles:

1. In the Act

Exemptions from the IPPs are contained in Part 2 Division 3 and include:

● where non-compliance is lawfully authorised or required (s 25)

● where the individual concerned has expressly consented to the agency not complying with section 18 (s 26). (These provisions are particularly relevant to the case studies)

2. In Regulations:

● There are exemptions relating to privacy management plans under the *Privacy and Personal Information Protection Regulation 2005* (NSW) regs 5–7.

3. In a Privacy Code of Practice:

● Made by the Attorney General; see ss 29–32 of the *PPIP Act*: for example see *Privacy Code of Practice (General) 2003* (of particular relevance to the case studies; Privacy Code of Practice for NSW Health; Department of Housing Privacy Code of Practice; NSW Police Service Privacy Code of Practice; Department of Education and Training Privacy Code of Practice.

4. In a Public Interest Direction

● Made by the NSW Privacy Commissioner: see s41 of the PPIP Act.

Health Records and Information Privacy Act 2002 (NSW)

The *Health Records and Information Privacy Act 2002* (NSW) (**the HRIP Act**) contains a privacy regime for health information held in the NSW public sector and the private sector. The Act permits access to health information in certain circumstances and establishes a framework for complaint resolution concerning the handling of health information.

Principles

The 15 Health Privacy Principles (HPPs) contained in the Act specify how health information must be collected, stored, used and disclosed (Schedule 1). The Principles can be grouped into seven areas: collection; storage; access and accuracy; use; disclosure; identifiers and anonymity; and transferrals and linkage and may be said to be broadly similar to the IPPs referred to above.

As relevant to the HASI Case Study, any health information held by Housing NSW or NSW Health will be regulated by the HPPs. Unlike the *PPIP Act*, if they hold health information both the ASPs and community housing providers are regulated by the *HRIP Act*. ASPs and community housing providers are therefore regulated by both the Commonwealth *Privacy Act* and the *HRIP Act* in relation to health information.

Situations in which disclosure is permitted

The circumstances in which health information may be disclosed – listed in Schedule 1, HPPs 10 and 11 – are similar to those outlined in the PPIP Act. These include where:

● the individual has consented to the use of the information (HPP 10(1)(a))

● the individual would reasonably expect the information to be disclosed (HPP 10(1)(b))

● disclosure is necessary to lessen or prevent a serious or imminent threat to the health or safety of the individual, another person, or the public (HPP 10 (1)(c)(i)-(ii)).

However, the HRIP Act also permits the use and disclosure of an individual's health information for secondary purposes such as:

● management, planning and evaluation (HPP 10 (1)(d))

● the training of employees (HPP 10 (1)(e))

● research and compilation of statistics (HPP 10 (1)(f))

● to a family member for compassionate reasons (HPP 10 (1)(g))

In most of the above cases, the use of information must be reasonably necessary for those purposes, and:

● the purpose cannot otherwise be served by the use of information that does not identify the individual

● reasonable steps are taken to de-identify the information

● the information is not published in a generally available publication

● the use of information complies with the guidelines issued by the Privacy Commissioner.

Exemptions

The Act provides for a number of exemptions from the Principles. The bodies exempt from the Act are listed in section 17. Further exemptions are listed in Schedule 1, some of which are the subject of statutory guidelines (see Privacy NSW, *Health Records and Information Privacy Act 2002 (NSW): Statutory Guidelines on the Management of Health Services* (2004)).

Like *the PPIP Act,* the *HRIP Act* provides for health privacy codes of practice to regulate the collection, use and disclosure of health information. These codes can modify the application of HPPs.

Appendix C: Sample HASI referral form

HASI RELEASE OF INFORMATION

APPLICANT'S AGEEMENT TO APPLY & RELEASE OF INFORMATION
The Privacy Act requires the applicant to sign this form giving their consent for the release of their information and details. The referrer and the applicant agree that no information has been withheld and that all information provided is accurate, correct and necessary for <<name of organisation(s)>> to provide a Duty of Care and meet obligations to staff.

I, _____, give my consent to <<name of organisation(s)>> to seek information from the following people concerning matters related to this application

☐ Local Health District _____
☐ Medical Service / Professional _____
☐ Housing Provider _____
☐ Other _____
I also give my consent to <<name of organisation(s)>> to keep a record of my referral. I understand that this information will be coded to protect my identity and will only be accessible to relevant services that I come into contact with.
I agree to allow <<name of organisation(s)>> staff to call me (or my designated contact person if I am not contactable) in order to update my information and to see if I am still interested in this support.
APPLICANT'S SIGNATURE: _____ Date _____

REFERRER'S SIGNATURE: _____ Date _____

Applicant Details

Last Name ……………………………….First Names…………………………………

Address ….……………………………………………………………………………………

State ……………… Post Code………………

Telephone: ………………………….. Mobile: …………………………………

Date of Birth……./…../……   Male ☐ Female ☐

T - Number (if known) ....

Does the applicant identify as being: ☐ Aboriginal   ☐ Torres Strait Islander   ☐ Aboriginal and Torres Strait Islander   ☐ CALD

Interpreter required?   ☐ Yes   ☐ No   Language spoken..

Health Information
Does the applicant have a diagnosed mental illness? ☐ Yes   ☐ No   ☐ Suspected

Primary diagnosis ....

Other conditions (e.g. drug and alcohol misuse, chronic health conditions)

....

What are the applicant's goals in the care plan? Provide details of any unmet needs.

....

....

....

Is there a current Risk Assessment available?   ☐ Yes   ☐ No

Applicant's current circumstances

What are the applicant's aspirations and what do they hope to achieve by participating in the program?

....

....

....

....

....

What are the applicant's current living arrangements? Why do they need HASI support? (e.g. housing, tenancy/domestic issues or reaching goals including education, meaningful employment, social networking and community integration, etc.)

....

....

....

....

....

What types of support issue/s has the referrer identified?

....

....

....

How does mental illness impact on the applicants daily functioning?

....

....

....

....

Services Involved

Service Name and contact details

Mental Health Service provider

Psychiatrist

General Practitioner

Other

PLEASE ENSURE THAT AN UP-TO-DATE RISK ASSESSMENT IS ATTACHED TO YOUR REFERRAL AS IT CAN NOT BE PROCESSED WITHOUT ONE
Source of Referral

Name …………………………….………….Telephone………………….................

Agency ………………….………………………………………………………..

Level of support requested: (High, HIH, HASI Plus, Aboriginal HASI).........................

Date referral submitted...

This referral will be put forward to a selection committee and both the referrer and applicant will be informed of the outcome. Please forward all referrals to:

<<name of agency receiving applications and contact address including fax number>>

Note: HASI Plus has a specific referral form which has been developed by MHDAO and must be used for all referrals to that service.

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