Communication Pathways & Information Sharing Protocols

Purpose: When families are involved in multiple systems (e.g., CPS, YJ, Birth to 3, CLTS program, and/or BH/MH/SUD services), collaborating partners need to communicate consistently to best serve individuals/families. Defining communication pathways/protocols for sharing information has many benefits including building trust among partners and ensuring that information is shared according to confidentiality requirements. In addition, each collaborating partners brings unique knowledge of the child(ren)/youth and family's needs and strengths.

RECOMMENDATION 1: Agencies may want to consider jointly developing a singular client consent form that allows professionals to share information about progress and participation in any and all services/treatment provided.

RECOMMENDATION 2: After determining the types of information to be shared, agencies may want to establish a formal protocol that outlines the specific information to be exchanged, the method, and the frequency of exchange that can be disseminated to all partners.

During the initial meeting(s) for assessing needs and developing a service plan, professionals should discuss:

- How will individual/family voice be included in all service planning?
- Discuss family functioning (e.g., what are the family's strengths, needs, goals?)
- What are the identified options to enhance the family's strengths and meet their needs and goals?
  - What services and resources (natural or formal) are already in place? What services and resources (natural or formal) are needed to support the family?
  - How should services be planned and coordinated (which services best address the most urgent issues, and what to do now and what to do later)?
- What is the role of each professional in the clinical and support services plans?
- What is the initial estimated timeline for the services?
- Does the team have the proper documents signed by individuals/families for sharing information (e.g., ROIs)?
- Who will the family contact when they have questions and how this will be communicated?

The following information generally needs to be shared with partners at consistent intervals for monitoring progress:

- Details about individual's progress in treatment
    - In cases of substance use (SU): periods of sobriety, nature and frequency of lapses, negative drug test results, assessment of impact of SU on varied domains of functioning (including parenting/child/youth safety), and participation in treatment activities.
    - In cases of mental health treatment, the individual's: functioning, particularly as it impacts domains of functioning (including parenting/child/youth safety), and level of engagement with services/treatment.
    - *NOTE: Privacy considerations should be considered in determining the nature and extent of information disclosed for caregivers involved in substance use and/or mental health treatment. For example, some parents may only agree to share treatment attendance and drug testing results. It is important to engage the parent and to understand their concerns related to sharing.*
- Engagement in and effectiveness of services identified in the plan (e.g., parenting classes, treatment or services for children/youth, employment or other services, observable skills gained, or behavior change as a result of services).
- Consistency and quality of family interaction.
- Indicators of safety and stability for the children/youth.
- Discussions to assess if family is ready for any type of transition (i.e., children/youth return from out of home placement or if there is a change in the safety plan) or a step down in services. How will this be supported?
- Discussions of impact of interventions and identification of progress.

The following information generally needs to be shared with partners at case closure:

- Criteria/reason for case closure.
- Indicators of safety and stability for the children/youth/family.
- What natural supports and resources are available for the family?
- What relapse prevention plans are in place?
- What services are the individual/family still using after the case closes? What services can they access if necessary? Are individuals/families aware of how to access services when needs arise?

ACTIVITY: Effective information sharing between collaborating partners

STEP 1: First, read the table related to your work function. Use the blank space to add or customize the information as it relates to your agency. Consider the following questions as you fill out your table:

- What do you communicate to the collaborating team supporting the family given your system's role at each stage outlined in the table?
- Is there a timeline related to the information shared?

INFORMATION SHARED BY CHILD PROTECTIVE SERVICES

INITIAL MEETING(S)	**MONITORING PROGRESS**	**PREPARING FOR CASE CLOSURE**
• Results of the CPS initial assessment (e.g., safety decision and nature of safety concern(s), whether a case is opened) • Risk or safety factors for children in the home • CPS plan • Identified clinical services needs for caregiver(s) and child(ren) (e.g., mental health, developmental, early intervention, trauma) and referrals • Identified supportive services needs for the family (e.g., housing, transportation, childcare, education, employment, life skills) and referrals • Observations and indicators of substance use, health, or mental health concern for child(ren) and/or caregiver(s) • Known history of child welfare involvement, including any children previously removed and/or reunified • If children are or are potentially members of a tribe (ICWA implications) • List of functional strengths of child(ren) and family	• Progress and participation in the plan • Observations of the frequency and quality of family time, including opportunities for parenting skills practice and parent-child interaction, as well as any safety concerns • Indicators of safety and stability for child(ren) • Progress and participation in services for children • Any other observations pertinent to the case • Placement decisions and timeframes	• Indicators of safety and stability for the children • Assessment of natural supports available to child(ren) and/or family • Consumer awareness of how to access supportive services if needs arise

INFORMATION SHARED BY YOUTH JUSTICE

INITIAL MEETING(S)	**MONITORING PROGRESS**	**PREPARING FOR CASE CLOSURE**
• Assessment results (YASI) • YJ Status; case plan, conditions, court orders • Identified clinical services needs for youth (e.g., mental health, developmental, early intervention, trauma) and referrals • Identified supportive services needs for the youth and/or family (e.g., housing, transportation, childcare, education, employment, life skills) and referrals • Observations and indicators of substance use, health, or mental health concern for youth and/or caregiver(s) • Known history of child welfare involvement, including any children previously removed and/or reunified • If youth are or are potentially members of a tribe (ICWA implications)	• Progress and participation in the plan • Progress and participation in services for youth • Any changes notes in reassessment (YASI) results • Placement decisions and timeframes	• Indicators of safety and stability for the youth • Assessment of natural supports available to youth and/or family • Consumer awareness of how to access supportive services if needs arise • Outstanding obligations (e.g., restitution) • Recommendations for continuity of care services

INFORMATION SHARED BY SUBSTANCE USE & RECOVERY

INITIAL MEETING(S)	**MONITORING PROGRESS**	**PREPARING FOR CASE CLOSURE**
• Results of SUD assessment • Physical and behavioral observations of substance use • Drug test results • Diagnosis and level of care recommended, treatment services recommended, and SUD treatment plan • Knowledge of children in the home and any safety concerns • Identified strengths and needs of the family, including family-centered treatment or children's services • Identified need and any referrals to clinical services for parents and children (e.g., mental health, developmental services, early intervention services, trauma services) and supportive services for the family (e.g., housing, transportation, childcare, education, employment, life skills) • Medicaid or health insurance status	• Level of treatment being offered • Degree of parental participation in SUD treatment • Quality of engagement and progress in treatment, including behavioral changes and positive steps toward recovery • How family is doing within domains of recovery (SAMHSA's domains of health, home, purpose, and community) • Parental engagement with recovery supports • Observations of frequency and quality of family time including parenting skills, interaction, as well as safety • Relapse prevention plans • If parents have relapsed or left treatment • Timeframe for anticipated successful treatment completion • Discharge and aftercare recommendations/referrals	• Assessment of natural and/or community supports available to child(ren) and/or family • Relapse prevention plans • Consumer awareness of options for returning to services or finding new applicable services

INFORMATION SHARED BY MENTAL HEALTH AND/OR CRISIS

INITIAL MEETING(S)	**MONITORING PROGRESS**	**PREPARING FOR CASE CLOSURE**
• Results of assessment • Physical and behavioral observations of mental health concerns • Diagnosis and level of care recommended, treatment services recommended, and treatment plan • Knowledge of children in the home and any safety concerns • Identified strengths and needs of the family, including family-centered treatment or children's services • Identified need and any referrals to clinical services for parents and children (e.g., mental health, developmental services, early intervention services, trauma services) and supportive services for the family (e.g., housing, transportation, childcare, education, employment, life skills) • Medicaid or health insurance status	• Level of treatment being offered • Degree of parental participation in SUD treatment • Quality of engagement and progress in treatment, including behavioral changes and positive steps toward recovery • How family is doing within domains of recovery (SAMHSA's domains of health, home, purpose, and community) • Parental engagement with recovery supports • Ongoing crisis plan on file • Observations of frequency and quality of family time including parenting skills, interaction, as well as safety • Relapse prevention plans • If parents have relapsed or left treatment • Timeframe for anticipated successful treatment completion • Discharge and aftercare recommendations/referrals	• Assessment of natural and/or community supports available to child(ren) and/or family • Relapse prevention plans • Consumer awareness of options for returning to services or finding new applicable services

INFORMATION SHARED BY CHILDREN'S LONG-TERM SUPPORT

INITIAL MEETING(S)	**MONITORING PROGRESS**	**PREPARING FOR CASE CLOSURE**
• How a child's disability impacts their functioning and vulnerabilities. • How to communicate best with a child and/or family member. • Parental strengths, challenges, and overall capacities. • Family functioning • What services/supports are available to help children be a part of their home and community, complete daily living tasks, learn new skills and develop interests, live their best life.	• Sharing what is working well and what is not working well. • Discussing if the family's needs and goals are being met. Are problems being reconciled? • If things are not improving, the family and team are reexamining what the needs are and changing the supports and services. • Identifying new goals as the CLTS program understands family's goals and ideas will change over time.	• Assessment of natural and/or community supports available to child(ren) and/or family • Maintain a working relationship with the participant, the family, adult long term care programs and other community supports to ensure a smooth transition from one program to another. • Take reasonable steps to help participants know what to expect.

INFORMATION SHARED BY BIRTH TO 3 PROGRAM

INITIAL MEETING(S)	**MONITORING PROGRESS**	**PREPARING FOR CASE CLOSURE**
• Identified needs for services, clinical services and/or supportive services for parents and children • Services plan for parents and/or child(ren) • Discuss needs, supports and services for child and family. • Service plan for family (individualized family service plan - IFSP) • Discussion of location education agency (LEA) notification, LEA referral, and option to opt out	• Attendance of individual family service plan (IFSP) meeting(s), if requested by the family • Discussion of home visit with family, when appropriate or necessary • Progress in services for parents and/or children (IFSP outcomes & developmental progress)	• Assessment of whether child is potentially eligible for special education services, explanation of services • If eligible for special education services and consumer interest, an individual education plan should be implemented on child's 3rd birthday • Discussion of natural and/or community supports available to child(ren) and/or family • Consumer awareness of types of services and how to access them upon completing Birth to 3 Program (e.g., Children's long-term support program services, how to make a future referral to a local education agency for a potential individual education plan if not enrolled at completion of Birth to 3 program)

STEP 2: Share your work with your collaborating partners. You can take notes as your partner shares in the blank tables related to their work function above. As you listen, consider:

- What kind of information do you need from your partner at each stage?
- What questions do you have about their terms, information shared, or processes?

STEP 3: If time allows, reflect on these debriefing questions:

- Where is there confusion or miscommunication in our information sharing protocols?
- Where is there clarity and clear lines of communication in our information sharing protocols?

Activity adapted from: Building Collaborative Capacity Series Module 3 (National Center on Substance Abuse and Child Welfare) available at: https://ncsacw.acf.hhs.gov/topics/building-capacity/collaborative-capacity-series/collaborative-capacity-module-3/