Plan Do Study Act (PDSA) Collaborative Charter on Improving Professional Collaboration

Date Last Revised: 10/10/2023

Introduction

Child welfare professionals (i.e., child protective services professionals, youth justice professionals, tribal child welfare professionals) serve families with complex needs. There is significant overlap between families involved in the child welfare system and families who need behavioral health services (substance use and/or mental health), or supportive services for developmental, physical, or emotional disabilities (such as birth-to-three or long-term support services). The provision of effective services and treatment to improve families' well-being relies on professional collaboration across human services systems. Cross-system collaboration is critical to child welfare agencies, as the services and treatment provided by other systems may directly impact child welfare outcomes for families.

Findings from a study on multi-level influences on the practice of inter-agency collaboration in child welfare and substance abuse treatment (Smith & Mogro-Wilson, 2007) indicate that the following characteristics are significantly and more positively associated with collaborative practice:

- staff who see more advantages to collaboration or have more positive attitudes toward it, and those who are more confident in their knowledge and skills about how to collaborate,
- staff who perceive higher numbers of organizational policies promoting or requiring collaboration were more likely to collaborate (interestingly, administrator reports of the number of pro-collaboration policies were not related to collaborative practice), and
- staff working in organizations where, in general, staff report high levels of role overload and emotional exhaustion were more likely to collaborate.

Using a team-based, staff-led approach to designing and testing solutions for improving collaborative practice between child welfare and behavioral health/human services agencies supports enhancement of positive staff attitudes, improved knowledge and skills on how to collaborate, development of organizational policies, and accountability to collaborate even in the face of workload challenges.

Prevalence of Families Involved in Child Welfare Systems with Needs Associated with Substance Use, Mental Health, or Developmental, Physical, or Emotional Disabilities

In the last 20 years, child welfare systems have seen a significant increase in child maltreatment cases involving substance abuse. Child maltreatment cases involving substance abuse increased from 18.5% in 2000 to 38.9% in 2019 (National Center on Substance Abuse and Child Welfare [NCSACW], 2019). In 2019, almost 40% of child maltreatment cases involving parental substance abuse coincided with the placement of children in out-of-home care (NCSACW, 2019).

Complex systemic factors including intergenerational trauma along with health and economic disparities have contributed to high rates of substance abuse among American Indian families. Bigfoot et al. (2005) estimated that approximately 85% of all American Indian and Alaska Native child welfare cases are related to substance abuse (National Indian Child Welfare Association, n.d.). Carter (2009) found that in child welfare systems where the family is referred because of a

substance abuse problem, American Indian and Alaska Native children are 8 times more likely to be removed from their home instead of receiving in-home family preservation services than non-Native children (National Indian Child Welfare Association, n.d.).

Less is known about the true prevalence of caregivers with mental health challenges in the child welfare system as the two major federal child welfare datasets (National Child Abuse and Neglect Data System (NCANDS) and Adoption and Foster Care Analysis and Reporting System (AFCARS)) do not collect reliable data on caregiver mental health. Nationally, it is estimated that about 1 in 12 children have lived with someone with a mental health challenge and Urban Institute (2023) research has found that at least one-third of parents investigated for child maltreatment may have a mental health need. Two of the top three circumstances associated with a child's removal to out-of-home care (neglect at 64% and caretaker inability to cope at 13%) from the AFCARS data set may overlap with caregiver mental health needs (Children's Bureau, The AFCARS Report, 2021).

Approximately 50% to 70% of youth involved in the youth justice system have a diagnosable mental health condition such as anxiety or conduct disorder, compared to 10% to 20% in the general adolescent population (Wisconsin Family Impact Seminar, 2020). It's also estimated that more than 60% of youth involved in the youth justice system with a mental health condition also have a co-occurring substance use disorder (Wisconsin Family Impact Seminar, 2020). As of January 2020, 100% of females and 72% of males in Wisconsin youth corrections facilities had a mental health issue, including those who were convicted in adult court (Wisconsin Office of Children's Mental Health, 2020).

Lastly, the Report on Children with Disabilities Served by the Child Welfare System (Wisconsin Department of Children & Families, 2016) indicated that by linking data from 3 state data systems (Department of Children and Families, Department of Public Instruction, and Department of Health Systems) that an estimated 37% of children in the child welfare system have a disability. The AFCARS data set indicates that child disability is a circumstance associated with the child's removal in 2% of cases (Children's Bureau, The AFCARS Report, 2021).

Wisconsin Data Indicates the Opportunity for Improvements in Practice

The Safety Action Workgroup (SAW) was formed in 2019 with the purpose to review the aggregate qualitative and quantitative data from completed Systems Change Review (SCR) case reviews, identify common themes, and form considerations for possible systems change. Systems Change case reviews are conducted on cases involving an incident resulting in a child death, near death, or other serious or egregious injury involving a child/family that has had prior child protective services agency contact that is recent and/or extensive. When the SAW reviewed data from the 34 cases assessed as part of the System Change Reviews (SCR) in 2020-2021, issues in collaboration and teamwork were a primary or latent factor in 15 of the 34 cases indicating the need to focus on barriers, pressures, communication issues, and climate factors associated within collaborating professionals.

The Wisconsin DCF Initial Assessment (IA) Case Record Reviews also indicate improvements are needed in collateral contacts with mental health professionals and treatment providers. The IA case reviews from 2019-2020 included 600 (300 from each year) random initial assessments (IAs) from around the state. The IA case reviews found that for 188 of these IAs, a collateral contact with a mental health professional was necessary but was missed 66% (n=124) of the time, and for 77 of these IAs a collateral contact with a treatment provider was necessary but was missed 66% (n=51) of the time.

The 2015-2016 Ongoing Services Case Record Reviews, 271 cases were reviewed to examine how agencies assess the needs of children and parents and provide or procure service to meet identified needs. Reviewers found that 42% of cases needed improvement in needs assessment and services to parents and 20% of cases reviewed needed improvement in needs assessment and service to children (Department of Children and Families, 2015-2016 Ongoing Services Case Record Review Report, 2016).

In addition, a focus group of the WCWPDS Steering Committee met in 2022 to develop recommendations related to the need for secondary traumatic stress training, however after discussion, the focus group indicated there is a significant need to address agency collaboration including: tools to assist leaders in talking with key stakeholders (both internal and external) about Family First and the change in philosophical approach, helping child welfare staff understand the impact of mental health and substance abuse disorders, cross system development and cross system collaboration (joint trainings that include others beyond child welfare staff, training on connectivity and professional relationship building with child welfare and behavioral health staff).

The Opportunity

The Wisconsin Department of Children and Families (DCF) and the Wisconsin Child Welfare Professional Development System (WCWPDS) are offering a PDSA Collaborative on improving professional communication and collaboration between child welfare professionals (county and tribal CPS and/or YJ) and behavioral health/human service professionals that provide substance use, mental health, and/or supportive services for individuals with developmental, physical, or emotional disabilities.

Building collaboration across human services units in counties and tribes supports the Family First Prevention Services Act and mission of keeping families and children together with in-home resources by investing in preventative services (trauma informed behavioral/mental health services, substance-use services, and in-home parenting skills for those families whose children are at risk for removal).

What is a Plan-Do-Study-Act (PDSA) Collaborative?

The PDSA Collaborative is a systematic approach to organizational improvement in which teams of direct service professionals and supervisors/managers decide on change ideas they believe would improve their practice. Then, teams test and measure changes and share their experiences with others to accelerate learning and identify and spread implementation of best practices. The

PDSA Collaborative will offer opportunities for innovation and critical thinking in a focused environment. Agency and participant benefits include improving shared topical understanding, learning organizational improvement methods, empowerment of direct service professionals' voices in identifying and implementing practice changes, engaging in data-driven decision-making, and building connections between team members and across agencies. Child welfare agency staff have many competing demands for their time and resources that impact their ability to make changes. The structure of the PDSA Collaborative is designed to address these constraints by supplying already identified tools and resources and incorporating change strategies that will save staff time while improving direct practice.

Who would be on the PDSA team?

The child welfare agency (county or tribe) would need to recruit a team of PDSA participants that would agree to attend all PDSA Collaborative sessions and to implement changes back at their respective agencies. This PDSA team would attend PDSA planning sessions together over the 6–7-month collaborative time period and discuss issues and design and implement solutions together.

The PDSA team must at minimum include:

- At least one child welfare (CPS, YJ, ICW) supervisor,
- One or more child welfare direct service professionals (CPS, YJ, ICW),
- At least one supervisor from the behavioral health/human services agency program area targeted for collaboration, AND
- One or more direct service professionals from the behavioral health/human services agency program area targeted for collaboration.

The following are examples of behavioral health/human service professionals that could join the PDSA team:

- Behavioral health providers (substance use treatment and/or mental health providers) and their associated supervisors/managers from internal county divisions, tribal departments, or external providers (community-based treatment organizations, private treatment agencies, educational mental health coordinators) if services are contracted outside of the agency.
- Birth to three service coordinators, Comprehensive Community Services (CCS) professionals, Children's Long-Term Support (CLTS) service coordinators, and their respective program supervisors/managers.

**During the PDSA application process, you will indicate the proposed team members for the PDSA team. Collaborative facilitators will meet with your application contact person BEFORE the collaborative begins to ensure that team composition meets the criteria necessary to engage in work of this PDSA Collaborative successfully.*

Benefits to Families and Agencies of Effective Inter-system Professional Collaboration

Research indicates that effective professional collaboration benefits children and families as well as the collaborating organizations. Proficient interdisciplinary teams support trauma informed practices as they have been found to substantially minimize the degree of additional system-inflicted trauma and child trauma symptoms experienced by children and families through their collaborative information gathering and planning processes (Berberick & Milliken, 2023). Inter-system collaboration and communication also aids in shifting the focus to what a family/child needs, rather than what is the role of one specific agency or profession. Studies have also found that professionals who engage in effective interdisciplinary practice often increase the likelihood that child protection-involved families retained or regained custody of their children (Blakey, 2014).

Benefits to agencies include amplifying limited resources and increasing providers' effectiveness, expertise, and job satisfaction while decreasing burnout. According to Baker and Roberson (2023), agencies benefit from having a shared framework to understand permanency across mental health and child welfare practitioners. This leads to more effective and supportive professional consultations where child welfare professionals gain understanding of the specific issues being addressed in therapy and clinicians are more aware of the legalities, systemic policies and roles that are navigated by families involved in child welfare to better support the process.

Barriers to Effective Inter-system Professional Collaboration

However, there are barriers to effective inter-system collaboration that require leadership guidance and proactive strategies to address organizational systemic influences. Baker and Robertson (2023) indicate that mandates, directives and actual language differ across child welfare and clinical lines, which can be a barrier to effective collaboration. In addition, workplace climate, norms and atmosphere has been found to be a barrier to professional collaboration. Smith and Wilson (2007) found that organizational work climate may be more relevant to frontline practice than formal organizational policies; research indicated that both organizational conditions and personal beliefs shape the attitudes, beliefs and knowledge of frontline staff, which impacts collaboration.

Reports from agencies that participated in the Children's Bureau's Improving Child Welfare Outcomes Through Systems of Care (2003-2008) provide insight into additional challenges in interagency collaboration which include siloed structures with unique state and federal mandates, constraints on funding and service array and availability, limited time and effort required to build interagency collaboration, and staff turnover in key positions.

Different systems and client populations also face barriers to collaborative efforts. For example, early intervention programs identify inconsistent referrals for children as a persistent barrier (Ferguson et. al, 2022) and native parents have less access to effective, culturally responsive mental health and substance use treatment than their non-Native counterparts (National Indian Child Welfare Association, n.d.).

2024-2025 PDSA Collaborative - Problem Statement

Child welfare and human service/behavioral health partners are faced with collaborative and communicative challenges as their respective systems operate with separate policies, procedures, programs, technology, funding, capacity, and operating mechanisms. These system differences contribute to differing perspectives, language, philosophies, roles, timeframes, goals, and measures of progress between collaborative partners impacting communication and coordination of services for families with complex needs.

2024-2025 PDSA Collaborative Mission

The Wisconsin Department of Children and Families (DCF) and the Wisconsin Child Welfare Professional Development System (WCWPDS) have drawn upon the knowledge and expertise of the Continuous Quality Improvement (CQI) Advisory Committee for selection of this topic and for setting this collaborative's mission and goals. The CQI Advisory Committee includes participants from approximately 20 county child welfare agencies and 1 tribal child welfare agency as well as DCF staff. During 2023, the CQI Advisory Committee engaged in the following planning exercises: analysis of the Wisconsin administrative data related to professional collaboration, topic selection and topic definition discussions, a strengths-gaps analysis, and mission and goals brainstorm exercises.

The mission of the 2024-2025 Plan-Do-Study-Act Collaborative is for child welfare and human services/behavioral health to enhance their collaboration resulting in the needs of children and families being better understood and services for children and families that are family-centered, strengths-based, streamlined, supportive and flexible. Collaborating partners will facilitate strong working relationships with agreed upon plans, so family/consumer needs are met timely.

Collaborative Change Goals

Key themes were identified by the CQI Advisory Committee as top contributing factors that must be addressed during the PDSA Collaborative to achieve the collaborative mission.

CONTRIBUTING FACTOR 1: Direct service professionals lack full understanding of their collaborating partner's mission, philosophy, goals, requirements, roles, and language.

GOALS:

1. Professionals will understand their collaborating partners' mission, philosophy, goals, requirements, roles, timeframes, and language.
2. Professionals will work together to identify and clearly express shared values across systems.
3. Professionals will improve communication between child welfare and collaborating partners.

CONTRIBUTING FACTOR 2: There is a lack of clear and consistent protocols and procedures to coordinate access to information and services between collaborating partners.

GOALS:

4. Professionals will increase knowledge of the collaborating partner's screening/intake, referral, and assessment processes.

5. Professionals will establish transparent and consistent protocols for sharing information across systems while addressing confidentiality requirements. This may include inter-agency agreements such as Memoranda of Understanding (MOU) or Request for Information (ROI) procedures.

6. Professionals will have a formalized communication process to exchange feedback and updates to each system partner during planning and monitoring.

7. Professionals will develop a plan for coordinated efforts when barriers (such as insurance, waiting lists, availability of services, court orders) arise that impact the agency's ability to coordinate.

CONTRIBUTING FACTOR 3: Planning with families is negatively impacted when collaborating partners lack agreement on next steps and desired outcomes. This results in confusion and lack of family engagement and progress.

GOALS:

8. Professionals will develop a plan in conjunction with system partners that incorporates family/consumer voice, clearly identified objectives and actions, and measures of progress.
9. Professionals will understand their partner's definition of family/consumer success and each partner's role in the process.

Participating PDSA teams may choose to address <u>one or more of the goals above</u> in their improvement efforts based on their team's needs assessment that will be completed during the PDSA Collaborative process.

Collaborative Expectations

The Collaborative's Goals will be supported through the Organizational Process Improvement Unit (OPI) of the Wisconsin Child Welfare Professional Development System (WCWPDS) being held to the following expectations.

OPI will:

- Provide information on the subject matter and provide guidance on applications related to the subject matter.
- Offer technical assistance (TA) and coaching to teams on process improvement methods during and between collaborative planning sessions.
- Host technical assistance (TA) calls to promote application of knowledge and provide accountability to change; and
- Provide communication strategies to keep agencies connected to other collaborative teams and the CQI advisory group.

All members of the PDSA team are expected to:

- Connect the goals of the PDSA Collaborative to their agencies' own strategic goals and work.
- Regularly communicate about their involvement in the PDSA Collaborative with senior management at their agency.
- Recruit an inter-agency PDSA team and send them to all PDSA Collaborative planning sessions and TA calls (see application for more details) for the length of the collaborative.
- Provide the resources necessary to support their team including resources necessary to participate in collaborative planning sessions and technical assistance (TA) calls and time to devote to this effort.
- Perform tests of change leading to process improvements in their agency.
- Share information with the collaborative group including details of changes made and data to support these changes both during and between planning sessions and TA calls.

Child welfare members of the PDSA teams are also expected to:

- Measure a limited number of key monthly indicators of their work related to children, youth, and families served by both systems. Examples may include monthly counts of referrals from child welfare to the other targeted program area, amount of time from referral to service start, type of service(s) provided by child welfare and other targeted program area, and child welfare outcomes (such as safety decision(s), type of protective plan implemented, re-referrals to child welfare).

Collaborative Format Overview

See the PDSA application materials for further details and exact dates. PDSA teams and agency leadership will be expected to participate in the following components of the PDSA Collaborative.

Planning Sessions

Planning sessions are meetings bringing together participating PDSA teams to define their team's goals, design strategies, plan changes and to exchange ideas with other teams. After planning

sessions, the PDSA team is expected to communicate their PDSA plans with agency leadership and, in some cases, communicate with and spread changes to additional agency staff to make successful PDSA tests agency wide. Full participation of the PDSA team members is expected at all planning sessions.

Action Periods

Between planning sessions, PDSA teams will engage in action periods that provide time of maximal applied learning as teams engage in implementing the PDSA tests they designed during the most recent planning session. The goals of action periods are to support teams in their PDSA tests, build collaboration and shared learning, and assess progress.

Sponsor team Calls: Leadership from participating agencies and the PDSA team lead(s) will be invited to a series of one-hour calls to define/scope team project work, coordinate leadership support, and receive updates on PDSA team progress.

Technical assistance (TA) calls: PDSA team members will participate in one-hour calls with the collaborative facilitators to discuss progress on PDSA tests, plan for next steps, and address questions or barriers.

Collaborative website: Between planning sessions and TA calls, PDSA teams will share their work on a shared electronic workspace housed by WCWPDS. Teams will be able to access resources, report measures, and share their successful ideas.

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Appendix A

Brainstorm on Professional Collaboration Themes to Inform Collaborative Mission

CQI ADVISORY COMMITTEE – MARCH 9, 2023

What does it look like when we (child welfare) do our best work in professional collaboration with outside partners like law enforcement, mental health/treatment professionals, medical providers, and legal professionals?
THEME: Communication/Sharing Information Examples: · Team members share their knowledge with each other · Everyone has the ability to give input · Sharing what is necessary and relevant · Support, information and resource sharing between agencies · Sharing information and analyzing that information together · Everyone is up to date on status of child and family and any developments · Forward focused conversation – not seeking blame · Constructive dialogue
THEME: Understanding Examples: · Recognizing that every partner has challenges and limitations · Role of all collaborators is clear · Understanding (not necessarily agreement) as to why decisions were made · Constructive dialogue
THEME: Child/Family Centered Examples: · Feels like the family is centered · Forward focused conversation – not seeking blame · Applies to both YJ cases and promotion of educational stability for youth
THEME: Professional Responsibility/Collaboration Examples: · Mutual respect · Everyone has the ability to give input · No “hot potato” – everyone takes shared ownership · Recognizing that every partner has challenges and limitations · Connect between agencies is maintained, even in “down time” · Respect for each professional’s distinct role · Everyone is up to date on status of child and family and any developments · Using the information gathered to support case decision making · No finger-pointing or triangulation

Appendix B

Summary of Strengths-Gaps Analysis

CQI ADVISORY COMMITTEE – JUNE 8, 2023

In professional collaboration between CPS/YJ professionals and behavioral health/children with disabilities professionals, how do **AGENCY STRUCTURES/ENVIRONMENTS**…	
Help (Strengths)	***Hinder (Gaps)***
· Relationships – previous work together · Allows for some flexibility in support and services for family · Collaboration with other agencies could lead to families more quickly exiting child welfare and being served by other common agencies · Staff are located in the same building and same hallway with offices Monthly team meetings · Monthly triage and collaboration meetings to discuss youth on the waiting list (FSD to BH) and also youth in BH who may been needing FSD support Having a system to view youth who are in CCS, CLTS, Crisis, etc.	· Consent to share information · Balance of power "turf" issues or "power struggles" · Unclear understanding of roles and purposes · Silos of work/units and/or 'systems' – especially challenging when things change · Need for standard referral process

What **RESOURCES AND TOOLS** help or hinder collaboration between CPS/YJ professionals and behavioral health/children with disabilities professionals?	
Help (Strengths)	***Hinder (Gaps)***
· Regularly scheduled team meetings · Helping meet concrete needs of families · Being in a shared location · Checking there is no bias in getting the resources · Know what is needed · Grants that meet individual needs of agencies · Cross division consults · Multidisciplinary approach is a helpful tool	· Financial resources – MA reimbursement for team meetings · Lack of resources altogether; including timeliness in connecting need to the correct level of behavioral health care · Rigid funding requirements · Waitlists · Lack of therapeutic resources · Being very rigid about "voluntary" · Varied access/use of eWiSACWIS · Lack of therapists available to clients and/or long waitlists · Accessing services pre-court order

What are the strengths and gaps in **TEAMWORK** when collaborating between CPS/YJ professionals and behavioral health/children with disabilities professionals?

Help (Strengths)	***Hinder (Gaps)***
· Regular meetings · Standard team meetings - ongoing · Clear responsibilities between meetings · Respectful disagreements · Youth centered practice · CLTS covering a portion of foster home payments · Strength – different disciplines = different perspectives · Their ability to fund things outside of tax levy · CCS practice can help pay for some services · Being able to have supports for the family in place when court orders close	· CPS/YJ professionals have different goals than behavioral health or human services professionals. Setting clear boundaries for roles of the professionals is important to best helping the client · Time · Program barriers to providing services · Sometimes when teams are large people get missed and feelings get hurt · Lack of response from partner when information is requested · Finding a meeting time that works for everyone · Crises that get in the way of meeting/planning · Overall awareness of services available to children/families

In professional collaboration between CPS/YJ professionals and behavioral health/children with disabilities professionals, how do **PROCESSES AND PROCEDURES…**

Help (Strengths)	***Hinder (Gaps)***
· Shared cases/team meetings · When clearly understood, creates shared understanding · Include process for release/sharing information, how status/updates are shared (Frequency & Format) · When not written down, can lead to assumptions, which can make it challenging to stay on the same page · Checking the process and procedures is regular · Know what is needed · Larger table of people to innovate/be creative in planning · Broader access to support/services · Understanding of each person's role-limitations	· Different understanding of WI statutes · Criteria to meet certain levels of care · Unclear expectations and how to measure · Unclear about roles who does what and when · Different timelines · Different focus, CPS Safety/MH needs identified by consumer · CLTS has timelines regarding following up on access reports and/or incidents and if those timelines are missed · Only allowing three attempts to reach a family before the referral is closed · Court involvement creates some barriers · Processes and procedures hinder due to red tape to get through to get to a service

In professional collaboration between CPS/YJ professionals and behavioral health/children with disabilities professionals, how does our **MEASUREMENT OF PROGRESS**	
Help (Strengths)	***Hinder (Gaps)***
· Collaboration allows for consistent definitions of progress · Clear understanding of child safety and conditions of return (parents) · Understanding barriers and mission of both groups – respect, honesty and ownership · Parent/child engagement in services · Defining success and how to measure at the start of teaming process	· Gap in understanding CPS Safety Intervention Model and need for behavioral change vs. some professionals feeling like attendance alone is a measure of progress · "Progress" isn't defined the same by all, so that makes it hard to measure · Different ways of measuring – different goals and definitions of progress · Goals not the same · Sometimes partners have conflicting interests, timelines, or are running on different requirements · Sometimes wrong understanding of child needs · Lack of agreement on what success means · Differing definitions of safety · Having a treatment plan in behavioral health that does not necessarily align with the treatment goal/reunification plan

How does **LEADERSHIP** help or hinder collaboration between CPS/YJ professionals and behavioral health/children with disabilities professionals?	
Help (Strengths)	***Hinder (Gaps)***
· Shift to think more broadly · Can serve as a connection point to other counties, agencies, etc. · Can welcome new ideas – tend to be more visionary · Establish written policies & procedures, memorandum of understanding, etc. so efforts are sustainable with new leadership · When leaders have good working relationships with other leaders · Good leadership can help by leading by example and help create good relationships · Mediate conflict · Having leaders all focused on the same goal. Leaders need to have strong relationships · Leaders who share the same vision can model that for their staff	· Job focused not family focused · Rigid leadership styles · Some leadership removed – can come up with grandiose, unrealistic ideas · Time & fiscal restraints · Silos

· Mentioning collaboration frequently so that staff understand it is expected · Leadership can work on improving processes and often has connections or relationships that can break down barriers	

What **COMMUNICATION METHODS OR STYLES** help or hinder collaboration between CPS/YJ professionals and behavioral health/children with disabilities professionals?

Help (Strengths)	Hinder (Gaps)
· When the parent/child is part of the communication · Face to face · Regular meetings/collaborations · Actually attending/commitment · Defining roles · Taking time to define terminology/adopt a common language · Family teaming · Family team meetings to have open and transparent conversations around progress and areas of need · Pre-established relationships · Holding family team meetings with all professionals and family at the table to have open discussions · Family team meetings – regularly scheduled so there is a set opportunity for information sharing · Plans that reduce redundancies or conflicts for families (one family, one plan)	· Professionals limited in sharing due to confidentiality · Families end up with multiple people to communicate with and multiple plans to attend to · When partners don't answer their phones or respond to emails or we have to play phone tag, it hinders collaboration · Number of agencies/schools in that community (hard to include and coordinate everyone) · Differing policies, legal limitations, funding sources · Lack of understanding of roles and responsibilities · Professionals not attending meetings due to scheduling conflicts and/or not able to bill for the time · Thinking one role is more important than the other · Means of communication used (i.e., text only) can be a gap/not efficient or effective · Different leadership/supervisors · Taking time to regularly update all collaborators on changes/updates/current work · Providers not wanting info about children/parents in the official record or in court · Emergencies can get in the way of planning – proactive vs reactive · Billing for non-direct services · Bring up systemic issues (institutional racism) within team mtg for specific children/parents

What **DECISION-MAKING PROCESSES** help or hinder collaboration between CPS/YJ professional and behavioral health/children with disabilities professionals?	
Help (Strengths)	***Hinder (Gaps)***
· Communication · When they focus on the child/family · Avoid redundancy in services · Connecting needs together and creating cohesive/holistic plans · Being able to explain the process so all can understand is important · Making sure to share case planning decisions · Acknowledgement of systemic issues prior to working together re: specific children/parents	· Partners may not understand each other's approaches/models/tools and how decisions are made · Competing interests · Different process/policies in neighboring communities – can lead to assumptions · Different outcomes · Too many cooks in the kitchen · Different definitions of safety & child well being · Silos · Legal decisions outside the control of either professional (that may impact the case, child, etc.) · Disagreement about time needed for caregivers to demonstrate progress